STATE OF MARYLAND

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MARYLAND HEALTH CARE COMMISSION

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MEMORANDUM

TO: Commissioners

BAYADA Home Health Care, Inc. d/b/a Bayada Hospice
Carroll Hospice, Inc.
P-B Health Home Care Agency, Inc.

FROM: Stephen B. Thomas, Ph.D.
Commissioner/Reviewer

RE: Recommended Decision
Baltimore City Hospice Review
BAYADA Home Health Care, Inc. d/b/a Bayada Hospice,
Docket No. 16-24-2387
Carroll Hospice, Inc., Docket No. 16-24-2388
P-B Health Home Care Agency, Inc., Docket No. 16-24-2389

DATE: August 28, 2019

Enclosed is my Recommended Decision in my review of the Certificate of Need ("CON") applications of BAYADA Home Health Care, Inc. d/b/a Bayada Hospice ("Bayada"), Carroll Hospice, Inc. ("Carroll Hospice"), and P-B Health Home Care Agency, Inc. ("P-B Health") to provide general hospice services to residents of Baltimore City.

Carroll Hospice, the only applicant that is currently licensed as a general hospice in Maryland, proposes to expand its service area to include Baltimore City. Bayada and P-B Health do not yet operate general hospices in Maryland, but both of these applicants operate Maryland home health agencies. Earlier this year the Commission approved the applications of Bayada and P-B Health to establish general hospices authorized service area of Prince George's County.

Carroll Hospice was established in 1986 and currently serves Baltimore, Carroll, and Frederick Counties. It is affiliated with Carroll Hospital Center and is a member of LifeBridge Health System.

Bayada provides home health agency services in Maryland and 21 other states, and is a hospice provider in Vermont, New Hampshire, Pennsylvania, and New Jersey. As I noted above, the Commission recently awarded it a CON to establish a general hospice program in Prince George's County.

P-B Health is a proprietary home health agency headquartered in Baltimore, Maryland. It was Medicare and Medicaid-certified in 1994 and is authorized to provide home health agency services in Baltimore City, and Baltimore, Howard, and Anne Arundel Counties. P-B Health was recently awarded a CON to establish a general hospice in Prince George's County.

In 2014, Baltimore City had the sixth lowest hospice use rate[1] among the 24 Maryland jurisdictions, which was one of the bases for targeting it for consideration of additional hospice service providers, based on the need standard in COMAR 10.24.13, the Hospice Services Chapter of the State Health Plan. Baltimore City held this same rank in 2017, with a use rate of 29.2%, well below the statewide use rate of 43.7%. In 2016, the Medicare Payment Advisory Commission estimated a national hospice use rate of 48%.

I conducted a project status conference to facilitate changes that each applicant needed to make to arrive at an approvable project. Each applicant responded as needed, and I have determined that each application complies with applicable standards in the Hospice Services Chapter and the CON review criteria in the Commission's procedural regulations. Based on my consideration of the entire record in this review, I recommend that the Commission **APPROVE** each of these applications, with conditions that each:

1. Prior to first use approval, provide documentation of links it has established with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance Programs, adult day care programs, the Baltimore City Department of Social Services, and home delivered meal programs located within Baltimore City; and

2. Prior to first use approval, provide documentation of the arrangements it has made for providing respite care for the families and other caregivers of patients.

Interested Parties

No person who is not an applicant requested interested party status. I considered the comments filed by Bayada and by Carroll Hospice. Both filed comments as interested parties and I acknowledged their status in this regard. P-B Health did not file comments as an interested party in the review. Each interested party's specific comments are summarized in this Recommended Decision in the discussion of the applicable standard and/or criterion referenced by each comment along with the response of the applicant at which the comment was directed.

[1] Use rate is the ratio of the jurisdiction's resident deaths of enrolled hospice patients to total resident deaths for persons aged 35 and older.

Background

Baltimore City is the fourth most populous jurisdiction in Maryland. As previously noted, it has the sixth lowest hospice use rate in the state. The combination of a large population with a low hospice use rate means that there is significant potential benefit if these three new hospice entrants can raise hospice use rates. The need methodology described in the Hospice Services Chapter identified Baltimore City as a jurisdiction that should be opened to CON applications for additional hospice providers. Eight general hospices currently are authorized to provide services in Baltimore City. Seven of these providers actually reported serving Baltimore City residents in 2017 but just two providers dominated the market, serving about 83% of Baltimore City hospice patients in 2017. None of the other hospices achieved a market share greater than 7%.

Process and Conclusions

My review of the three applications and the entire record resulted in my finding that each applicant met all applicable standards and also warranted approval based on the other CON review criteria, but only after each applicant made certain modifications that enabled me to find them in compliance. As is in my Recommended Decision, I convened a project status conference in this review because none of the applicants had demonstrated full and clear compliance with all applicable standards and criteria.

By separate letters dated April 10, 2019, I informed each of the applicants on the need to clarify how each would provide the Minimum Services enumerated in the Hospice Services Chapter at COMAR 10.24.01.05C(1)-(2), i.e., either directly by the applicant's employees or through contractual arrangements. I also advised each of the three applicants that each would need to make significant modifications to its charity care policy and procedure in order to comply with all subparts of COMAR 10.24.13.05J, Charity Care and Sliding Fee Scale standard. In addition, I instructed both Bayada and P-B Health on the need to address other aspects of their applications, which are detailed below.

I informed Bayada that it did not comply with COMAR 10.24.01.08G(3)(d), Viability of the Proposal. Based on its statistical projections, revenue and expense projections, and manpower information, I noted that Bayada projected revenue per patient day that was 24% higher than the average for Maryland general hospices, and that its projected cost per patient day was 68% above the statewide average, based on data reported by Maryland general hospices in the 2016 Maryland Hospice Survey. I asked Bayada to explain or modify its projections.

I advised P-B Health that it needed to modify its response to the Admissions Criteria standard. Initially, P-B Health's admissions policy indicated it would serve patients 35 years of age or older. I concluded that it was important for a new hospice program to serve all adults in order to support the Commission's goal of increasing the use of this service in Baltimore City. Like Bayada, I asked that P-B Health explain or revise its statistical and financial projections that included both internal inconsistencies and significant, unexplained variation from the reported statewide experience. For example, P-B Health's staffing and service volume projections yielded very low levels of staff productivity for nurses and hospice aides (29% and 51%, respectively, below the average reported by Maryland hospices). Its projected revenue per patient day was approximately 21% higher than the statewide average.

Each of the applicants submitted modified applications that I found satisfactory.

Review Schedule and Further Proceedings

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on September 19, 2019, beginning at 1:00 p.m. at 4160 Patterson Avenue in Baltimore. The Commission will issue a final decision based on the record of the proceeding.

As provided in COMAR 10.24.01.09B, "each applicant and interested party that ... submitted comments may submit written exceptions" to the enclosed Recommended Decision. Bayada and Carroll Hospice, the only applicants that filed comments opposing another application and that I recognized as interested parties, may submit exceptions regarding my findings or recommendation that the Commission approve the applications in this review. P-B Health may submit exceptions regarding my findings or recommendations regarding its application.

Exceptions must be filed electronically no later than 1:00 p.m. on Friday, September 6, with 30 paper copies of the exceptions submitted at the Commission's offices by noon on Monday, September 9, 2019, the business day following the filing deadline. Written exceptions must specifically identify those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based.

Responses to exceptions must be filed no later than 1:00 p.m. on Thursday, September 12, 2019. Copies of exceptions and responses must be sent in pdf format by email to the MHCC, all parties, and the Baltimore City Health Officer by this filing deadline. Thirty paper copies of the response to exceptions must be submitted at the Commission's offices by 3:30 p.m. on that same day.

Oral argument during the exceptions hearing before the Commission will be limited to 10 minutes per party filing exceptions and 15 minutes for each applicant that responds to exceptions, unless extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and responses is as follows:

Submission of exceptions	September 6, 2019 No later than 1:00 p.m.
Submission of responses	September 12, 2019 No later than 1:00 p.m.
Exceptions hearing	September 19, 2019 1:00 p.m.

IN THE MATTER OF	*	**BEFORE**
BALTIMORE CITY HOSPICE REVIEW	*	
	*	**THE**
BAYADA Home Health Care, Inc.	*	
d/b/a Bayada Hospice	*	**MARYLAND**
Docket No. 16-24-2387	*	
	*	**HEALTH CARE**
Carroll Hospice, Inc.	*	
Docket No. 16-24-2388	*	**COMMISSION**
	*	
P-B Health Home Care Agency, Inc.	*	
Docket No. 16-24-2389	*	
	*	

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REVIEWER'S RECOMMENDED DECISION

September 19, 2019

(Recommended Decision Released August 28, 2019)

Table of Contents

INTRODUCTION

A. Review Cycle

COMAR 10.24.13, the State Health Plan for Facilities and Services: Hospice Services, ("Hospice Services Chapter") allows for consideration by the Maryland Health Care Commission ("MHCC" or "Commission") of applications seeking to expand the number of general hospice programs in larger jurisdictions with relatively low use of general hospice services. On the basis of this policy, in 2016, the Commission established review schedules for Prince George's County and Baltimore City. On December 16, 2016, three organizations submitted Certificate of Need ("CON") applications to provide general hospice services in Baltimore City.

B. The Applicants

BAYADA Home Health Care, Inc. d/b/a Bayada Hospice

BAYADA Home Health Care, Inc. d/b/a Bayada Hospice ("Bayada"), is a for-profit corporation that provides home health care services in Maryland and 21 other states (https://www.bayada.com/offices/). Bayada is a Medicare-certified hospice provider in Vermont, New Hampshire, Pennsylvania, and New Jersey. (DI #Bayada ("B")3, pp.7, 10). On March 21, 2019, the Commission authorized Bayada to establish a general hospice program to serve the residents of Prince George's County. (Docket No. 16-16-2383).

On October 9, 2018, Bayada requested a determination of coverage by MHCC staff regarding whether a CON was needed for an internal restructuring that Bayada planned to undertake. (DI #B15a). The restructuring, as described, would result in the sole owner of Bayada, Mr. Joseph Mark Baiada, transferring 100 percent of his ownership interest in Bayada to a to-be-formed 501(c)(3) (not-for-profit) corporation. Bayada stated that the transaction would not alter its operations or licensing.

This restructuring of the applicant entity involved a modification of Bayada's CON application more than 45 days after docketing,[1] an action is only permitted under COMAR 10.24.01.08E.(2) if the other applicants in this comparative review did not object to the change.[2] Bayada sought and received agreements from all of the other applicants in this review to allow Bayada to modify its application. (DI #B15b). On that basis, MHCC staff advised Bayada that CON review was not required for the planned restructuring and that Bayada's application could be modified. (DI #B16). On January 17, 2019, notice of, and opportunity for public comment on

[1] Bayada stated that, "[T]he restructuring of Bayada's ownership will not change the applicant entity on its pending CON application and will not change any of the other information submitted to the Maryland Health Care Commission in support of Bayada's application, other than the ownership of Bayada Home Health, Inc." (DI #15B, p. 2).

[2] COMAR 10.24.01.08E.(2) provides that "[a]n application may be modified until the 45th day after docketing or as a result of a project status conference held pursuant to Regulation .09A(2) of this chapter. After the 45th day, a modification to an application in a comparative review not made as the result of a project status conference requires the consent of each applicant."

Bayada's modified application was posted on the MHCC website. (DI #B17). No comments were received.

Carroll Hospice

Carroll Hospice, Inc. ("Carroll Hospice") is a licensed, Medicare-certified general hospice program that is affiliated with Carroll Hospital and a member institution of LifeBridge Health System. Established in 1986, Carroll Hospice states that it currently serves more than 900 hospice patients in three jurisdictions, Baltimore, Carroll, and Frederick Counties. (http://www.carrollhospice.org/Hospice-About-Us)

Table I-1: Use of Carroll Hospice, 2015 - 2016

	2015	2016
Admissions	822	910
Patients Served	880	1,005
Average Length of Stay	35.5	36.5
Average Daily Hospice Census	79.9	91.0

Source: DI # Carroll Hospice ("C") 3B, Table 2A, p. 69.

P-B Health Home Care Agency, Inc.

P-B Health Home Care Agency, Inc. ("P-B Health") is a Medicare-certified home health agency headquartered in Baltimore and has operated for about 25 years. It is authorized to provide home health agency services in Baltimore City, Baltimore County, Howard County, and Anne Arundel County (http://www.p-bhealth.com/) (DI #P-B Health ("P") 2, p. 8).

On March 21, 2019, the Commission granted P-B Health a CON authorizing it to establish a general hospice program to serve the residents of Prince George's County. (Docket No. 16-16-2385).

C. The Proposed Projects

Each of these applicants seeks CON approval to provide general hospice services to residents of Baltimore City. Carroll Hospice is the only applicant that is currently licensed as a general hospice in Maryland. Thus, it proposes to expand its service area to include Baltimore City. Bayada and P-B Health do not operate general hospices in Maryland. Both operate Maryland home health agencies. Bayada operates hospice programs in four other states, while P-B Health seeks to obtain a second CON approval to enter the field of hospice services. As noted above, the Commission granted to both CON approval earlier this year to establish new general hospices with an approved service area of Prince George's County. Thus, if authorized to serve Baltimore City, these two new Maryland hospice programs will have two-jurisdiction service areas.

The following table shows projections of expenses and use from each of the applicants' Baltimore City proposals.

Table I-2: Projected Expenses and Use
Baltimore City Hospice Applicants

Applicant	Projected Operating Expenses (Year 3)	Admissions		Average Length of Stay (Days)		Average Daily Census	
		Year 1	Year 3	Year 1	Year 3	Year 1	Year 3
Bayada	$3,509,158	167	278	50	60	23	46
Carroll	$2,495,125	123	482	35	35	12	46
P-B Health	$1,351,917	75	169	52	52	12	25

Sources: DI #B3, Exh. 1, Table 2b and DI #B18, Revised Exh. 1, Revised Table 4, Part 1; DI #C3, Table 2B, p. 70 and Table 4, pp. 74-75; and DI #P20, Exh. 10, Table 2B and Exh. 11, Table 4.

D. Summary of Reviewer's Recommended Decision

I found that the proposed expansion of the authorized service area of Carroll Hospice to include Baltimore City complies with the applicable criteria and standards for such an expansion and should be approved with conditions. I also found that the expansion of the authorized service area of the to-be-established general hospices of Bayada and P-B Health to include, in both cases, Baltimore City, complies with the applicable criteria and standards and should be approved with conditions.

Under the Hospice Services Chapter, Baltimore City qualified as a jurisdiction eligible for consideration of new general hospice service providers because of its population's low use of hospice services and the size of its population. The intent of the Hospice Services Chapter is to facilitate higher levels of hospice use in jurisdictions where such improvement will have the greatest impact by introducing new providers of the service in those jurisdictions. I have concluded that each of the three applicants demonstrated the potential for furthering that objective. I believe that each applicant's proposed project is viable and that the impact of the proposed projects, individually and collectively, is acceptable and should not serve as an impediment to approval.

For these reasons, I recommend that the Commission **APPROVE** the applications of Bayada, Carroll Hospice, and P-B Health with the conditions that each shall:

1. Prior to first use approval, provide documentation of links it has established with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance Programs, adult day care programs, the Baltimore City Department of Social Services, and home delivered meal programs located within Baltimore City; and

2. Prior to first use approval, provide documentation of the arrangements it has made for providing respite care for the families and other caregivers of patients.

II. PROCEDURAL HISTORY

A. Record of the Review

The three applications were filed on December 9, 2016 and docketed on June 9, 2017. On July 24, 2017, P-B Health submitted a modification to its CON application that included

modifications to the project budget, utilization and financial projections, and staffing, and also addressed issues with operating the home-based hospice program. These modifications complied with COMAR 10.24.01.08E(2), which allows modifications up to the 45th day after docketing.

I was appointed as Reviewer for this comparative review in May 2018. My first action as the Reviewer was to rule on requests for interested party status, which was sought by Bayada and Carroll Hospice. I recognized both as interested parties. I noted that P-B Health did not seek or qualify as an interested party in either of the other two applications. (DI #15GF).

As my review proceeded, I concluded that each applicant failed to comply with the requirements of at least two of the applicable Hospice Services Chapter standards and/or CON review criteria. However, on balance, I viewed these deficiencies as correctable and, for this reason, I informed all applicants by a March 17, 2019 letter that I would hold a project status conference on April 8, 2019. At the project status conference, I informed the applicants about those aspects of each proposed project that were inconsistent with applicable standards and/or general review criteria and provided guidance on the changes needed in each application. (DI #16GF). Following the conference, I provided each applicant with a project status conference summary outlining the needed changes. (DI #20GF).

I note that each applicant failed to comply with the Minimum Services standard, COMAR 10.24.13.05C, and with two parts of the Charity Care and Sliding Fee Scale standard, COMAR 10.24.13.05J. Those parts address determinations of eligibility and notice of the charity care policy. In addition, each of the three applicants needed to address other areas of their applications. Further details on the needed modifications for each applicant are provided below.

Bayada

At the project status conference, I informed Bayada that it needed to clarify how it would provide the Minimum Services enumerated in the Hospice Services Chapter, COMAR 10.24.13.05C, i.e., whether these services would be provided either directly by Bayada employees or through contractual arrangements. I also told Bayada that its application did not comply with COMAR 10.24.13.05J, the Charity Care and Sliding Fee Schedule standard. With regard to this standard, I pointed out deficiencies were outlined in its response to Subsection (1), Determination of Eligibility, to Subsection (2), Notice of Charity Care Policy, and to Subsection (3), Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Regarding COMAR 10.24.01.08G(3)(d), Viability of the Proposal, I had questions related to Bayada's projections of service volume, operating expenses, and its staffing. I asked Bayada to explain the basis for its projected per diem revenue and cost projections, which I identified as substantially higher than expected. (DI #20GF, p. 4).

Carroll Hospice

I told Carroll Hospice at the project status conference that it needed to address the same questions regarding Minimum Services as those I posed to Bayada. I informed it that it needed to come into compliance with COMAR 10.24.13.05J, Charity Care and Sliding Fee Schedule standard, specifically: Subsection (1), Determination of Eligibility; Subsection (2), Notice of

Charity Care Policy; and Subsection (4), Policy Provisions regarding the level of charity care commitment. (DI #20GF, p. 6).

P-B Health

At the project status conference, I informed P-B Health that it needed to address the same questions on Minimum Services as outlined for the other two applicants. I told P-B Health that it needed to bring its application into compliance with the Charity Care and Sliding Fee Scale standard's Subsections (1) through (4). Additionally, P-B Health needed to make changes to its response to the standard at COMAR 10.24.13.05B, Admissions Criteria. Finally, with respect to the Viability criterion, I had questions related to P-B Health's projections of service volume, operating expenses, and staffing. Specifically, I questioned the low productivity for nurses and hospice aides implied by P-B Health's projections, based on historic data available to me, and its per diem revenue projections, which appeared excessive.

On May 21, 2019, each applicant filed modifications to its application in response to the recommendations I made at the project status conference. I note that P-B Health made major modifications to its staffing and financial projections in response to my analysis. No comments were filed on the modified applications.

B. Interested Parties in the Review

I considered the comments filed by Bayada and by Carroll Hospice, each filed comments and sought interested party status, which I granted. As previously noted, P-B Health did not seek to become an interested party regarding either of the other two CON applications. Each applicant's specific comments are summarized in this Recommended Decision in the discussion of the applicable standard and/or criterion referenced in each comment along with the response of the applicant at which the comment was directed.

C. Local Government Review and Comment

No local government agencies submitted comments on this project.

D. Other Support and Opposition to the Project

Each of the three applicants submitted letters of support.

Bayada provided letters from public officials, physicians, and representatives of a number of other health care facilities located in Pennsylvania, Maryland, and Vermont. They are listed in those categories immediately below. (DI #B2; DI #B3, Exh. 42). Public officials providing letters of support are: Bernard C. "Jack" Young – President, Baltimore City Council; and Mario M. Scavello - 40th Senatorial District of Pennsylvania (Monroe & Northampton Counties). Physicians providing letters supporting Bayada's application are: Maxwell T. Vergo, M.D.; Nancy Shuster, M.D.; and Ravi Passi, M.D., F.A.C.P., C.M.D. Other letters were provided by representatives of the following health-related entities: Chad Trull, President & CEO, Hospicelink; Meagan Buckley, Executive Director, Genesis HealthCare, Burlington Health and Rehabilitation Center; Judy Morton, Senior Executive Director, Genesis HealthCare, Mountain View Center; Melissa Greenfield, Genesis HealthCare, Rutland Healthcare and Rehabilitation Center; Eileen Adams,

Regional Director of Operations, Brightview Senior Living; Kelly Knorr, Director of Nursing, ManorCare Health Services; and Cyndi Davenport, Enclara Pharmacia. (DI #B14).

Carroll Hospice provided a letter of support from State Senator Thomas McLain Middleton, Legislative District 28 (Charles County). (DI #C6).

P-B Health submitted letters of support from public officials, health care providers, and persons identified as home health agency patients and community members. (DI #13GF; DI #P15, Exh. 6). Public officials supporting P-B Health's application are Senator Shirley Nathan-Pulliam, Legislative District 44 (Baltimore City and Baltimore County (DI #P15, Exh. 6.) and Joan M. Pratt, Comptroller, City of Baltimore (DI #P17). Health care providers providing letters are: Dean Forman, Seasons Hospice & Palliative Care (DI #P2, Exh. 37, p. 89); Lenox S. Dingle, Jr., M.D., Past President, Monumental City Medical Society, Inc.; Maisha McCoy, Principal Owner, Breathe4Sure Pharmacy Solutions (DI #P16, Exh. 1); Charles E. Moore II, M.D., Clinical Outcome Improvement Medicine, L.L.C. (DI #P18, DI #P19). Consumers and/or community members providing letters supporting Carroll Hospice's application are: Elizabeth F. Johnson, D.S.W., J.D.; Ray H. Moseley, consumer; Sally Staehle, consumer; Joy Bramble, Baltimore Times (DI #P16, Exh. 1); and Sandra L. Coles, Founder and Past President of the Greater Greenmount Community Association (DI #P16, Exh. 1).

III. BACKGROUND: BALTIMORE CITY DEMOGRAPHIC INFORMATION AND THE MARKET FOR HOSPICE SERVICES

A. Baltimore City Demographics

Population Change and Age

Baltimore City is the fourth most populous jurisdiction in the State of Maryland with an estimated population of 602,495. (April 2019, U.S. Census Bureau).[3] The Maryland Department of Planning estimates that Baltimore City's population declined approximately 3% between 2010 and 2018, while the State's population grew approximately 4.7% during the same period.[4]

Baltimore City's age distribution skews somewhat younger than that of the State as a whole.[5] The 2010 U.S. Census showed that about 63% of Baltimore City's residents were under the age of 45, while statewide 60% were in that age group. About 11.7% of Baltimore City residents were age 65-and-over, compared to 12.3% statewide. Census projections for 2030 indicate that both Baltimore City and Maryland will grow proportionately older; 15.5% of Baltimore City residents, and 20.1% of Marylanders are projected to be 65 or older by 2030. (Appendix 2, Table 1.)

[3] Available at: http://planning.maryland.gov/MSDC/Documents/pop_estimate/Estimates/county/county-table1A.pdf.
[4] Available at: http://planning.maryland.gov/MSDC/Documents/pop_estimate/Estimates/county/county-table1C.pdf.
[5] Available at: https://planning.maryland.gov/MSDC/Pages/s3_projection.aspx.

Racial Composition

Baltimore City is a "minority majority" jurisdiction with African Americans accounting for 63.0% of the population, Whites making up 31.6%, Asian Americans 2.8%, and other racial groups comprising 2.6% ("Other"). By comparison, 59% of Maryland's population is White, with African Americans comprising 30.8% of the population, Asian Americans at 6.7% and "Other" at 3.5%.[6] (Appendix 2, Table 2.)

Income

Baltimore City had an estimated median household income of $47,350[7] in 2016, about 40% below the State's median of $78,945. The U.S. Census Bureau estimates that, as of July 1, 2018, Baltimore City had a significantly higher concentration of residents living in poverty, 22.4%, compared to 9.3% for the entire State. (U.S. Census Bureau's *Small Area Income and Poverty Estimates*).[8]

B. Use of Hospice Services in Baltimore and the State

Providers

Eight general hospice providers are authorized to serve Baltimore City. Seven of these providers reported hospice service to City residents in 2017. Two hospices, Gilchrist Hospice Care and Seasons Hospice & Palliative Care of Maryland, dominate, reportedly serving approximately 83% of Baltimore City hospice patients in 2017. No other hospice achieved a market share greater than 7%.

Table III-1: Reported Baltimore City Residents Served by General Hospice Programs

General Hospice	2013	2014	2015	2016	2017	Market Share 2013	Market Share 2017
PHR of Baltimore	24	33	12	23	27	1.2%	1.1%
Stella Maris, Inc.	166	141	148	146	154	8.3%	6.6%
Joseph Richey	223	196	99	77	99	11.1%	4.2%
Gilchrist	992	788	833	886	1,261	49.5%	53.7%
Seasons	544	370	476	783	680	27.1%	29.0%
Heartland	46	38	46	52	83	2.3%	3.5%
Amedisys of Greater Chesapeake	9	6	13	39	44	0.4%	1.9%
Total	**2,004**	**1,572**	**1,627**	**2,006**	**2,348**	**100.0%**	**100.0%**

Source: MHCC Public Use Data Set, compiled from MHCC Hospice Surveys

[6] Source: U.S. Census Bureau, QuickFacts, available at: https://www.census.gov/quickfacts/fact/table/md,baltimorecitymarylandcounty,US/PST045217.

[7] Source: U.S. Census Bureau, QuickFacts, available at: https://planning.maryland.gov/MSDC/Documents/American_Community_Survey/2016/Income/Median-Household-Income-2016.pdf

[8] Source: U.S. Census Bureau, Quickfacts, available at: https://www.census.gov/quickfacts/fact/table/md,baltimorecitymaryland/PST045218.

Hospice Use

Baltimore City had one of the lowest hospice use rates[9] among Maryland jurisdictions in 2017, at 29% of deaths compared to 44% statewide, and to the "target rate"[10] of 48%. The use rate calculated for Baltimore City has fluctuated in recent years, ranging from a low of 24% in 2010 to a high of 32% in 2012. In this decade, the statewide use rate has steadily increased from 31% to 44%.

Table III-2: Highest and Lowest Calculated Hospice Use Rates in Maryland, 2017

High-Use Jurisdictions	Hospice Use Rate
Carroll	60%
Baltimore County	59%
Frederick	58%
Anne Arundel	51%
Worcester	49%
Wicomico	49%
Montgomery	49%
Howard	48%
Low-Use Jurisdictions	**Hospice Use Rate**
Cecil	38%
Somerset	30%
Baltimore City	***29%***
Garrett	29%
Charles	28%
Dorchester	26%
Prince George's	25%
Allegany	23%
Maryland	**44%**

Source: Calculated Jurisdictional Hospice Use Rates, MHCC, FY 2017.[11]

Racial Disparities

MHCC has identified disparities in the use of hospice by African Americans and other

[9] The hospice use rate for Maryland jurisdictions is calculated by dividing the number of Maryland residents who died while in hospice care by the number of deaths of jurisdictional residents who were 35 years and older in that year. - Maryland Health Care Commission, "Maryland Hospice Use Rate by Maryland Region, FY 2017," February 2019, p 1. Available at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospice/documents/chfs_hospice_use_FY2017_Tables_and_Charts.pdf

[10] The target rate standard is the national use rate estimate published by the Medicare Payment Advisory Commission (MedPAC). This use rate is the percentage of total Medicare beneficiary decedents that used hospice. This percentage in 2014 is estimated to be 47.8%, up slightly from the 47.3% estimate for 2013. (From Report to the Congress: Medicare Payment Policy, MedPAC, March, 2016.).

[11] Available at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospice/documents/chfs_hospice_use_FY2017_Tables_and_Charts.pdf

minority populations compared with use by the White population.[12] Although hospice use by African American patients lags behind that of White patients, some progress has been made in recent years. Reports from the National Hospice and Palliative Care Organization ("NHPCO") indicate the percentage of hospice patients that are African American has grown from 7.2% in 2008 to 7.6% in 2014.[13] In Maryland, the proportion of total 2017 hospice patients that were African American patients was 21% (compared to about 31% of the State's overall population). The proportion of total hospice patients originating from the Baltimore City population who were African-American was 51% (compared to about 64% of the jurisdiction's total population).

In MHCC's 2016 hospice services update,[14] it summarized the literature on the factors underlying the observed lower use of hospice services by African Americans when compared with other racial groups. Distinct cultural attitudes, socioeconomic conditions, the degree of "health literacy," and religious/spiritual practices and beliefs found in the African American community are factors often cited in trying to explain the lower use rate. There are indicators that African Americans with advanced illness are less aware, compared with other racial groups, of their options for palliative and hospice care.

Baltimore City is one of two Maryland jurisdictions[15] that were "identified for consideration of changes in the number of hospices servicing their populations through CON review…[because they] have a combination of a hospice use rate low enough and a population large enough that the [hospice need] methodology [in the Hospice Services Chapter] identifies them as having a gap between projected use and potential use that exceeds" the threshold level in the Hospice Services Chapter for establishing a review cycle.[16]

IV. CONSISTENCY OF THE PROJECT WITH APPLICABLE CRITERIA AND STANDARDS

A. 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.

COMAR 10.24.13.05 HOSPICE STANDARDS

In this review, the relevant chapter of the State Health Plan for Facilities and Services is COMAR 10.24.13, the Hospice Services Chapter. The Certificate of Need review standards for hospice services are found in COMAR 10.24.13.05, which provides:

[12] "Update on Hospice Services in Maryland and Implementation of the State Health Plan," MHCC, April 14, 2016.
[13] NHPCO Facts and Figures: Hospice Care in America, 2009 Edition, 2015 Edition. In 2010, the proportion of the total U.S. population identified as "black" or African-American was 12.2%. (U.S. Bureau of the Census)
[14] "Update on Hospice Services in Maryland and Implementation of the State Health Plan," MHCC, April 14, 2016.
[15] The other jurisdiction is Prince George's County.
[16] "Update on Hospice Services in Maryland and Implementation of the State Health Plan," MHCC, April 14, 2016.

The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new general hospice program, expand an existing hospice program to one or more additional jurisdictions, or to change the inpatient bed capacity operated by a general hospice.

Each applicant that seeks a CON to establish or expand general hospice services in Maryland must address and document its compliance with each of the following standards in COMAR 10.24.13.05A through P.

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

Bayada, Carroll Hospice, and P-B Health each submitted a Certificate of Need application to provide hospice services in Baltimore City. Under the current policy in the Hospice Services Chapter, this review cycle is limited to applicants seeking CON approval to serve the residents of this single jurisdiction.

As previously noted, Bayada and P-B Health do not currently operate hospices in Maryland. Each is a licensed home health agency service provider in Maryland and each provides home health agency services in Baltimore City.

Reviewer's Analysis and Findings

In this review cycle, Baltimore City is the only jurisdiction targeted for expansion of general hospice service capacity and the jurisdiction in which each applicant is proposing to provide hospice services. If approved, Carroll Hospice will expand its service area to include Baltimore City. Similarly, since Bayada and P-B Health each have been granted CONs to establish new general hospices with an authorized service area of Prince George's County, approval of the applications at issue here would permit each of these new general hospices to serve a two-jurisdiction service area, Prince George's County and Baltimore City.

I find that each applicant meets this standard.

B. Admission Criteria. An applicant shall identify:

(1) Its admission criteria;

Applicants' Responses	
Bayada	Bayada Hospice will accept patients who are certified as terminally ill and elect palliative treatment based on the reasonable expectation that their physical, social, psychological, and spiritual needs can be adequately met throughout the continuum of hospice services, and will provide these services in compliance with the Medicare Conditions of Participation. Proposed admission criteria include: the client resides in the geographic area served by the hospice program and the client and/or caregiver wish to receive hospice services; the client understands and accepts the palliative nature of hospice care and no longer seeks aggressive treatment; the

	presence of a capable primary caregiver living in the home or, if lacking, the client agrees to assist the hospice in developing a plan of care to meet his or her future needs; and the hospice has adequate resources and staffing to meet the needs of the client. (DI #B3, p. 19 and Exhibit 10).
Carroll Hospice	Carroll Hospice admits patients: who are residents of the service area; who have been informed that they have a confirmed diagnosis of a life limiting illness and a life expectancy of six months or less; whose admission has been agreed to by the patient's attending physician, the Carroll Hospice Medical Director and Clinical Manager based on the patient's disease history and clinical status; and who agree with the hospice philosophy and care model. (DI #C3, Exhibit 1)
P-B Health	The admission criteria will meet the Medicare conditions of participation for hospice programs. Patients must be deemed as being terminally ill by P-B Health's medical director in consultation with the patient's primary care physician, and the patient or the patient's health representative must consent to the receipt of hospice services by the patient. (DI #P2, p.15).

(2) Proposed limits by age, disease, or caregiver.

Applicants' Responses	
Bayada	Will not accept: pediatric patients, unless there are exceptional circumstances; or patients with infectious diseases not manageable under an infection control program. There are no limits by caregiver, but if a caregiver is not living in the home the patient must agree to assist the hospice in developing a plan to meet future needs. (DI #B3, p.19).
Carroll Hospice	Admits patients regardless of age, gender, nationality, race, creed or sexual orientation, disability, diagnosis, ethnic origin, handicap, prior modality of treatment, availability of caregiver or ability to pay. (DI # C3, Exh. 1).
P-B Health	Initially, the applicant stated in its CON application that it would not accept: pediatric patients except in "extreme exceptional circumstances;" patients with "a malady not manageable per infection control program protocol;" and patients under 35 years old. (DI #P2, pp.15-16). In a July 24, 2017 modification to its CON application,[17] P-B Health states it "will accept patients with communicable diseases; will not require patients to have advance directives and will assist patients who wish to create one; and will not require patients to authorize DNR (Do Not Resuscitate) orders." (DI #P15, pp. 2-3). Finally, in its modification in response to the reviewer's project status conference, P-B Health eliminated any limitation based on age of the patient.

[17] The formal start of the review began with the publication of the Notice of Docketing in the *Maryland Register* on June 9, 2017. P-B Health submitted the modification on July 24, 2017 (DI #15), which was on the 45th day from the formal start of the review. Therefore, the modification complies with COMAR 10.24.01.08E(2).

Reviewer's Analysis and Findings

Carroll Hospice will accept patients regardless of age, and does not have a restriction on individuals with communicable diseases. In its modification to its original application, P-B Health stated it would serve adult patients of any age, accept patients with communicable diseases, not require patients to have advance directives, and not require patients to authorize DNR orders.

Bayada has the most restrictive approach, as it will not treat pediatric patients unless there are exceptional circumstances, and also has restrictions regarding patients with infectious diseases that are not under a manageable infection control program.

Each of these applicants have acceptable admission criteria, and I find that each meets the standard.

C. Minimum Services.

COMAR 10.24.13.05C, Minimum Services, lists three services under Subsection (1) that an applicant must provide directly, i.e., through an employee of the hospice. Subsection (2) specifies services that an applicant shall provide either directly or through contractual arrangements.

The three following tables profile how each of the three applicants plans to provide these services.

(1) and (2) Minimum Services

Table IV-1: Bayada Response to COMAR 10.24.13.05C, Minimum Services (1) and (2)

(1) An applicant shall provide the following services directly:			
Service		**Provided directly by agency employees? (Y/N)**	
(a) Skilled nursing care		Yes	
(b) Medical social services		Yes	
(c) Counseling (including bereavement and nutrition counseling)		Yes	
(2) An applicant shall provide the following services, either directly or through contractual arrangements			
Service	**Provided directly by employees of the hospice**	**Provided via contract**	**If by contract, with whom?**
(a) Physician services and medical direction	X	X	Physician services and medical director has not been identified yet, and could be either directly employed or via contract.
(b) Hospice aide and homemaker services	X		
(c) Spiritual services	X		
(d) On-call nursing response	X		
(e) Short-term inpatient care (including both respite care and procedures		X	Caton Manor, 3330 Wilkens Avenue, Baltimore, MD;

necessary for pain control and acute and chronic symptom management)			Homewood Center, 6000 Bellona Avenue, Baltimore, MD; Perring Parkway Center, 1801 Wentworth Road, Baltimore, MD; in addition, BAYADA also has the ability to contract with any facility of patient's choosing.
(f) Personal care	X		
(g) Volunteer services	X		
(h) Bereavement services	X		
(i) Pharmacy services		X	Enclara Pharmacia, Cherry Street, Philadelphia, PA
(j) Laboratory, radiology, and chemotherapy services as needed for palliative care		X	Lab: Laboratory Corporation of America; 13900 Park Center Road, Herndon, VA Radiology: Mobilex, 101 Rock Road, Horsham, PA; Chemotherapy: In order to provide continuity of care for any patient enrolled in hospice and wishing to receive palliative chemotherapy, BAYADA will contract with the patient's oncologist.
(k) Medical supplies and equipment		X	Medical Supplies: Med Cal Sales (Medline), One Medline Place, Mundelein, IL Medical Equipment: HospiceLink, 2145 Highland Avenue, Birmingham, AL
(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services	X	X	PT/OT/ST: BAYADA Home Health Care, 8600 LaSalle Road, Suite 335, Towson, MD Dietary: Individual will be employed by BAYADA

Table IV-2: Carroll Hospice Response to COMAR 10.24.13.05C, Minimum Services (1) and (2)

(1) An applicant shall provide the following services directly:			
Service		**Provided directly by agency employees? (Y/N)**	
(a) Skilled nursing care		Yes	
(b) Medical social services		Yes	
(c) Counseling (including bereavement and nutrition counseling)		Yes	
(2) An applicant shall provide the following services, either directly or through contractual arrangements			
Service	**Provided directly by employees of the hospice**	**Provided via contract**	**If by contract, with whom?**
(a) Physician services and medical direction	X		
(b) Hospice aide and homemaker services	X		
(c) Spiritual services	X		

(d) On-call nursing response	X		
(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management)	X	X	FutureCare for respite. Dove House, Sinai or Northwest for GIP
(f) Personal care	X		
(g) Volunteer services	X		
(h) Bereavement services	X		
(i) Pharmacy services		X	Optum PBM
(j) Laboratory, radiology, and chemotherapy services as needed for palliative care		X	Carroll Hospital Center
(k) Medical supplies and equipment		X	Medline for supplies, Anchor and Nations for DME (durable medical equipment)
(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services		X	Home Care of MD

Table IV-3: P-B Health's Response to COMAR 10.24.13.05C, Minimum Services (1) and (2)

(1) An applicant shall provide the following services directly:			
Service		**Provided directly by agency employees? (Y/N)**	
(a) Skilled nursing care		Yes	
(b) Medical social services		Yes	
(c) Counseling (including bereavement and nutrition counseling)		Yes	
(2) An applicant shall provide the following services, either directly or through contractual arrangements			
Service	**Provided directly by employees of the hospice**	**Provided via contract**	**If by contract, with whom?**
(a) Physician services and medical direction		X	Martina Callum, M.D.
(b) Hospice aide and homemaker services	X		
(c) Spiritual services		X	Ted Payton, residing Pastor of Grace Through Faith Worship Center of Bowie, and iLife Alliance Pastoral Care Providers
(d) On-call nursing response	X		
(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management)		X	Seasons Hospice
(f) Personal care	X		

(g) Volunteer services		X	Called to Care Program, Liberty Grace -Church of God, Southern why Baptist Church, Hubert Memorial, Zeta Center for Healthy and Active Aging Adults, Langston Hughes Community Business Resource Center, Nu Day Nu Season Ministries, Volunteer Match
(h) Bereavement services	X		
(i) Pharmacy services		X	Enclara
(j) Laboratory, radiology, and chemotherapy services as needed for palliative care		X	Quest Diagnostics, Lab Corp, Dynamic Mobile Imaging, Nation's Home Infusion, L.L.C.
(k) Medical supplies and equipment	X	X	Medline and Austin Durable Medical Supplies
(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services	X	X	Mr. Stuart Trippe (speech therapy)

Reviewer's Analysis and Findings

I find that each applicant will provide minimum services required under this standard.

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

Applicants' Responses	
Bayada	Bayada will provide bereavement services to families for at least one year following patient's death. (DI #B3, p. 24).
Carroll Hospice	Carroll Hospice will provide bereavement services to families for up to 13 months following patient's death. (DI #C3, p. 14).
P-B Health	P-B Health will provide bereavement services to families for at least one year following patient's death. (DI #P2, p. 22).

Reviewer's Analysis and Findings

Each applicant commits to meeting the requirement to provide bereavement services to families for at least one year following the death of a patient. Based on those commitments, I find that each applicant meets this part of the standard.

D. Setting. An applicant shall specify where hospice services will be delivered: in a private home; a residential unit; an inpatient unit; or a combination of settings.

Applicants' Responses	
Bayada	Bayada will provide hospice services in private homes, residential facilities such as assisted living facilities and retirement homes, and inpatient facilities such as nursing homes and hospitals. (DI #B3, p. 25).

Carroll Hospice	Carroll Hospice will provide services in a combination of residential settings that include private homes and skilled nursing and assisted living communities (DI #C3, p. 15).
P-B Health	P-B Health will provide services in a combination of settings including private homes, residential units such as assisted living facilities and retirement homes, skilled nursing facilities, and hospitals. (DI #P2, p. 22).

Reviewer's Analysis and Findings

As previously noted, Carroll Hospice operates an inpatient hospice facility, located in Carroll County, under its general hospice license. Neither Bayada nor P-B Health have included plans to operate an inpatient hospice facility in the applications under review. Each applicant has identified the settings in which services will be delivered. Therefore, I find that each applicant meets 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.

Applicants' Responses	
Bayada	Bayada states that it will aim to maintain a volunteer staff sufficient to provide administrative or direct client care in an amount which minimally equals 5% of the total client care hours of all hospice paid and contracted staff. Bayada will employ volunteer coordinators who will carry out the selection, training, and supervision of volunteers, and track the hospice's compliance with regulations governing the use of volunteers. Bayada notes that its hospice programs in other states are experienced in recruiting and deploying volunteers. (DI #3, pp. 26-27). The volunteer policy provided by Bayada states that it will perform background checks and assess the level of skills and experience as well as provide orientation and training for each volunteer. (DI #B3, Exh. 19)
Carroll Hospice	Carroll Hospice states that it will draw on the resources of LifeBridge Health and work with various faith-based organizations to recruit volunteers to serve Baltimore City patients. Every volunteer will attend a six-week, 21-hour training program and receive relevant training manuals, Carroll Hospice's Volunteer brochure, and the Doula Volunteer Training packet. (DI #C3, p. 15; DI #10, p. 5 and Exh. 15)
P-B Health	P-B Health states that it will directly train volunteers according to its training guidelines and volunteer policy, which includes a completion of a criminal background check and the completion of a 16-20 hour orientation/ training program. Each volunteer will be required to complete orientation and training, and volunteers will be under the supervision of a designated hospice employee. (DI #P2, p. 22; DI #P6, App. F, Exh. 1 & 2).

Reviewer's Analysis and Findings

I find that each applicant meets 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.

Applicants' Responses	
Bayada	Bayada states that it provides extensive instruction and support for caregivers. Educational activities include: assessment of caregivers' needs, abilities, and knowledge; instruction as needed; and support groups for peer learning. Once a caregiver's educational needs are identified, a licensed clinician will utilize the educational resources available to Bayada Hospice to provide the caregiver with the appropriate instruction. (DI #B3, p. 28; DI #B9, p. 14).
Carroll Hospice	Carroll Hospice states that it will employ and provide professional and non-clinical staffing in ratios consistent with the National Hospice and Palliative Care Organization guidelines and provide individualized care that meets the assessed needs of the patient and family. Carroll Hospice will support family members by: training them to understand the patient's individualized plan of care; providing pain and symptom management; providing personal care for the patient; explaining what to expect during the dying process; educating them about when to call for help; and making resources available through Carroll Hospice. (DI #C3, p. 15; DI #C10 p. 5).
P-B Health	P-B Health states that its Outreach Team will provide education to caregivers and family members, providing the appropriate educational materials in a variety of formats matched to the needs of each individual situation. Topics include pain management, effective and safe administration of medications, handling and disposal of hazardous waste, home safety, and infection control precautions. (DI #P2, pp 22-25).

Reviewer's Analysis and Findings

I find that each applicant meets the standard, based on its stated intent to provide a level of instruction and support to caregivers who will care for a hospice patient.

G. Impact. An applicant shall address the impact of its proposed hospice program, or change in inpatient bed capacity, on each existing general hospice authorized to serve each jurisdiction affected by the project. This shall include projections of the project's impact on future demand for the hospice services provided by the existing general hospices authorized to serve each jurisdiction affected by the proposed project.

Applicants' Responses	
Bayada	Bayada projected that it would service 128 hospice deaths in Baltimore City in 2019. It created a model to assess the impact of its entry that apportioned the market share that each incumbent hospice would lose based on its current share, and calculated that, accounting for the growth of hospice service

	volumes projected by MHCC[18] between 2014 and 2019, "the impact on Baltimore City's incumbent hospice providers would be minimal, ranging anywhere from 4-17 fewer deaths per hospice." (DI #B3, p. 29 and App. 22). Further, Bayada expects to expand the market by improving hospice utilization in Baltimore City, through a commitment to community engagement, education and outreach, and raise awareness of the benefits of hospice in the jurisdiction, stating that it conservatively estimated that its market entry will cause the hospice utilization rate in Baltimore City to increase from 26.1% to 28.3% of deaths. Under this scenario, incumbent hospices would all see volume growth. (DI #B3, p. 29; DI #B9, pp. 10-11 and Revised Exh. 22).
Carroll Hospice	Carroll Hospice expects that projected growth in the general hospice market "will allow existing providers to increase volume even as an additional provider enters the market." (DI #C3, p. 16). Citing MHCC's Hospice Need Projections,[19] Carroll Hospice states that there would be a total of 2,756 hospice deaths in Baltimore City in FY 2019, a net need of 1,233 patients for this jurisdiction by FY 2019. Carroll Hospice states that there were seven providers delivering outpatient hospice services to 1,433 Baltimore City residents in FY2015, with Gilchrist Hospice and Seasons Hospice serving about 82% of this jurisdiction that year. With the projected need of 2,756 deaths by FY2019, Carroll Hospice states "existing hospice providers should expect a growth in overall hospice volume even as Carroll Hospice enters the market." (DI #C3, p. 18). Since Seasons Hospice serves a portion of the LifeBridge Health-aligned patients, the applicant expects as it expands into Baltimore City, that there will be an initial volume shift from the Seasons program to the Carroll Hospice program, but that Seasons and the other hospice providers will regain and backfill this volume. Taking into account MHCC's hospice need projection of 2,756 deaths by 2019, the applicant expects its impact (about 482 patients) will be minimal as Carroll Hospice and the seven existing hospice providers address the substantial need for additional hospice providers and services projected for the residents of Baltimore City. Carroll Hospice expects to expand hospice use by investing heavily in patient education and working closely with faith community leaders and the Interfaith Network to identify specific needs in the congregations, educate volunteers on end of life care options and identify champions within those communities. The applicant will develop "an advocacy network of respected, trusted voices to assist community members in accessing quality, end of life care tailored to an individual's unique needs and preferences." (DI #C10, p. 6).

[18] Maryland Hospice Need Projections For Target Year 2019: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospice/documents/con_hospice_need_projections_20160527.pdf.
[19] Ibid.

P-B Health	P-B Health also cited MHCC's Maryland Hospice Need Projections for Target Year 2019,[20] pointing out that the Commission projects a net need to serve 1,233 more patients in Baltimore City by 2019. P-B Health expects that the establishment of its general hospice program will help bridge a portion of the unmet need currently in Baltimore City, but does not expect to have an adverse impact on the current hospice programs operating in this jurisdiction, because the impact on existing hospices "will be nominal since P-B Health's hospice patients will be less than 20% of the projected unmet need for 2021 based on the Commission's Hospice Care projections for 2019." (DI #P2, pp. 25-2; DI #P9, p. 10). P-B Health recognizes "the need for hospice educational programs for the poor and underserved minority community" in Baltimore City, and that "with aggressive teaching and understanding of general hospice in the home" the margin of patients transferred to hospital emergency rooms, admittance in hospitals and in inpatient hospice facilities will decrease. (DI #2, pp. 25-26).

Reviewer's Analysis and Findings

Each applicant states that it will not have a significant impact on the existing hospice programs in Baltimore City. Common themes expressed in each applicant's statements are: (1) the jurisdiction has a large level of unmet need that would be tapped by the applicant; and (2) the applicant will expand the size of the market through its focus on hospice education and outreach. Each applicant states that the minority population of Baltimore City underutilizes hospice services and expresses an intent to raise levels of use by African-Americans and Hispanic-Americans through robust outreach and education programs targeted to community and/or faith-based organizations.

Each applicant projects a service volume at full utilization that would make it a significant provider in the jurisdiction. Bayada projects 278 admissions, Carroll Hospice projects 482, and P-B Health projects 169. Only two of the seven hospices serving Baltimore City reported that they served serving more than 169 Baltimore City patients during 2017. If the applicants had operated in Baltimore City in 2017 and achieved the numbers cited above, their respective market share of the jurisdiction's hospice patients would have ranged from 7.1% (P-B Health) to 20.5% (Carroll Hospice).

Each applicant discussed the impact of its market entry, concluding that the level of unmet need combined with efforts to expand hospice use would result in little if any impact on existing providers.

In their interested party comments, both Bayada and Carroll Hospice pointed out that the level of unmet need exceeded the volume of service that new entrants projected to serve. Bayada noted that the projected net need in Baltimore City for 2019 is 1,233 cases, while it projects serving 167 hospice patients in that year. Carroll Hospice's projection of 482 admissions in 2019 is equivalent to 52.6% of the total projected hospice net need for 2019, as provided in the Hospice

[20] Ibid.

Services Chapter. (DI #9GF, p. 2). Carroll Hospice further stated that not only would the combined service projections of the three applicants [570 hospice patients in 2019] meet less than half of the net projected need but that "the unmet need projected by the Commission is so great in Baltimore City that even at full utilization in subsequent years, the total patients projected to be served by all three applicants is less than [MHCC's] projected need projection for 2019." (DI #11GF, p. 3). Bayada's and Carroll Hospice's comments are more fully discussed under the need criterion later in my Recommended Decision.

I find that each of the applicants has satisfied the terms of this standard. Each has addressed the impact of its proposed hospice program on the existing general hospices authorized to serve Baltimore City, with information that permits projections of the each proposed project's impact on future demand for hospice services provided by the existing general hospices serving Baltimore City.

This standard does not require that I make a specific finding regarding the accuracy of each applicant's assessment of impact but, as Reviewer, I think it is important for me to provide an assessment. I initially note that three general hospices dominated the provision of hospice services to Baltimore City in 2017. Gilchrist and its affiliated hospice, Joseph Richey, accounted for just under 58% of the total hospice patients originating in Baltimore City in that year. Seasons Hospice and Palliative Care accounted for an additional 29%. Stella Maris was a distant third with a 6.6% market share. I assume that these three providers are likely to experience the largest potential nominal loss of patients through entry of new hospice service providers because of their substantial market share. However, all three of these hospices serve multiple jurisdictions and the reduction in their overall business volume that they may experience if the Commission awards CONs to these three applicants should not threaten the continued viability of those hospices.

Baltimore City accounted for 25% of Gilchrist and Joseph Richey's total 2017 patients; 16.9% of the total patients of Stella Maris, and 15.6% of the total patients at Seasons. If the three new entrants were all successful in their service projections, they would capture a number of patients (1,013) equivalent to 43% of the City's total hospice patients in 2017. If the three dominant hospices had experienced total losses that, cumulatively, equaled 1,013 patients in 2017, at levels proportional to their relative market share, all would still be among the State's largest hospices. Gilchrist/Joseph Richey would have served a volume of hospice patients that was 11.4% less than actually reported for 2017; Stella Maris would have served 7.8% fewer patients; and Seasons would have served 7.2% fewer patients.

Among the non-dominant hospice service providers in Baltimore City, one, PHR, has a relatively high dependence on Baltimore City, at 37% of total patients. However, this hospice reported serving only 73 total hospice patients in 2017, so it is not large enough to warrant great concern with respect to impact. Heartland obtained 11.9% of its patients from Baltimore City and Amedisys only obtained 3.1% of its total patients from Baltimore City, so, as with the larger hospices, the potential impact of new competitors in Baltimore City would not appear to represent an existential threat to these existing hospices, even if their market share losses were significant.

It is important to recognize that the Commission's – and the General Assembly's – intent is that injecting more competition into the Baltimore City market will boost the use of hospice

services to levels that are closer to those of other Maryland jurisdictions. If some growth in demand of this kind is realized, the level of impact experienced by the existing providers of service in the jurisdiction will be more marginal.

I find that each of the applicants has met this standard.

H. Financial Accessibility. **An applicant shall be or agree to become licensed and Medicare-certified, and agree to accept patients whose expected primary source of payment is Medicare or Medicaid.**

Applicants' Responses	
Bayada	Bayada agrees to become a licensed, Medicare-certified hospice, and accept Medicare and Medicaid patients in Maryland. (DI #B3, p. 30).
Carroll Hospice	Carroll Hospice is licensed and Medicare-certified, and accepts patients whose primary source of payment is either Medicare or Medicaid. (DI #C3, p. 19).
P-B Health	P-B Health states that it is a Medicare- and Medicaid-certified and licensed home health agency in the Maryland, and agrees to establish Medicare and Medicaid certification for its proposed hospice and to serve these patients. (DI #P2, p. 26).

Reviewer's Analysis and Findings

Each applicant operates hospices and/or home health agencies that serve Medicare and Medicaid patients and each states its intent to provide hospice services in Baltimore City to Medicare and Medicaid patients. I find that each applicant meets this standard.

I. Information to Providers and the General Public.

(1) General Information. An applicant shall document its process for informing the following entities about the program's services, service area, reimbursement policy, office location, and telephone number:

(a) Each hospital, nursing home, home health agency, local health department, and assisted living provider 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.

Applicants' Responses	
Bayada	Bayada plans to provide information about its services in Baltimore City to each hospital, nursing home, home health agency, local health department, and assisted living provider; at least five physician offices; the Senior Information and Assistance Offices; and the general public. Bayada will employ a community liaison to communicate the information and utilize its medical director to engage in collaboration and outreach with these referral sources. It

	will also provide information to the general public through its website (https://www.bayada.com/hospice/). (DI #B3, p.31).
Carroll Hospice	Carroll Hospice states that it will provide information about its services, service area, reimbursement policy, office location, and telephone number to each hospital, nursing home, assisted living community, home health agency, the Baltimore City Health Department; at least five physicians who practice in Baltimore City; the Department of Aging and other senior services located in Baltimore City; and the general public in Baltimore City. Carroll Hospice plans to communicate this information by: publication on its website (https://www.carrollhospice.org/home); use of public service announcements; correspondence to hospitals, providers, and agencies in Baltimore City; and outreach by liaisons' community education endeavors. It provided examples of its printed material with the CON application. (DI #C3, p.19; DI #C10, Exh. 18).
P-B Health	P-B Health plans to utilize an Outreach Team that will include marketing personnel, social workers, and a nurse, It plans to contact Baltimore City's hospitals, nursing homes, home health agencies, local health department, and assisted living providers. It has committed to meeting with at least five physicians and the Senior Information and Assistance Offices within Baltimore City, and will communicate with the general public through local city papers, radio stations, and on its website. The applicant states that its Outreach Team will introduce hospice services through "meet and greet" sessions, correspondence, and educational pamphlets, personal contact, and low-cost advertising (e.g., hospital patient and visitor guides, community resource guides, and The Medicine Shoppe Pharmacy bags). (DI #P2, pp. 26-27; DI #P6, pp. 12-13).

Reviewer's Analysis and Findings

Each applicant provides a commitment and plan to provide information to the general public and providers. I find that each applicant meets this standard.

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

Applicants' Responses	
Bayada	Bayada states that it will disclose its fees to prospective patients and families before beginning services. Its fee schedule is based on Medicare-published hospice reimbursement rates. (DI #B3, p. 31).
Carroll Hospice	Carroll Hospice states that it will make its fees known to prospective patients and their families before services are begun. (DI #C3, p. 19).
P-B Health	P-B Health notes that its home health agency makes its fees known to prospective patients and families before services begin, and will do the same if granted CON approval for hospice services. (DI #P2, p. 27).

Reviewer's Analysis and Findings

Each applicant states a commitment to disclose fees to prospective patients prior to beginning services meet this standard. Based on these commitments, I find that each applicant meets this standard.

J. Charity Care and Sliding Fee Scale. Each applicant shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to hospice services regardless of an individual's ability to pay and shall provide hospice services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) 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 hospice shall make a determination of probable eligibility.

Applicants' Responses	
Bayada	Bayada's charity care policy provides that "Bayada will make an initial determination of probable eligibility within two business days" upon receipt of a patient's request for charity care, and "ensures access to hospice services regardless of an individual's ability to pay." (DI #B3 Exh. 23). In response to my April 10, 2019 project status conference, Bayada modified its application, revising its Charity Care Policy (Form #0-8407) to implement a two-step process for determining eligibility for charity care. (DI #B18, Revised Exh. 54) The first step in its revised policy is a determination of probable eligibility where the determination is made either by an in-person or phone interview between the prospective client or representative and a Bayada office director or designee, and takes into account the financial resources available to the client, as well as whether the prospective client has insurance or is eligible for Maryland Medicaid. (DI #B18, p. 4). Bayada will communicate its determination of probable eligibility to the prospective patient within two business days of the initial request. The second step, the determination of final eligibility, is detailed in Form #0-9506 and is based on a completed application and the submission of required documentation. (DI #B18, Exh. 66).
Carroll Hospice	Carroll Hospice's original response to this standard stated that Carroll Hospital Center, Carroll Home Care, and Carroll Hospice collectively utilize the same charity care policy "to provide medically necessary care to individuals who do not have the resources to pay for medical care." This original policy provided that it will make a determination of eligibility for charity care and/or Medical Assistance within two business days of a patient's applying for either program. The applicant will assist families in determining whether or not the patient is eligible for any medical or insurance coverage, and will work with each family on a case by case basis if a person does not have any financial coverage. (DI #C3, pp.19-20). Carroll Hospice included copies of the Financial Assistance Policy and Financial Assistance Application with its CON application. (DI #C3, Exh. 2, 3).

	My April 10, 2019 project status conference informed Carroll Hospice that requiring a *completed application* does not comply with the standard. Carroll Hospice modified its application, submitting a revised charity care policy specifically for Carroll Hospice that describes a two-step process for charity care determinations which differentiates between the determination of probable eligibility and the final determination of eligibility. The policy functions as follows: *Step One: Determination of Probable Eligibility* must be made and communicated within two business days following a patient's initial request for charity care services, application for Medical Assistance, or both. The policy provides that Carroll Hospice will conduct an interview with the patient and/or patient's representative covering family size, insurance, and income. Carroll Hospice will make this determination of probable eligibility based solely on the information provided in this interview without requiring an application or documentation. *Step Two: Final Determination of Eligibility* will require the patient to complete the Uniform Financial Assistance Application and provide supporting documentation of eligibility. All available financial resources shall be evaluated in making the final determination of eligibility. (DI #C15, pp. 1-2, p. 13 and Exh 22).
P-B Health	The charity care policy that P-B Health originally submitted during completeness review stated that it will make "a determination of probable eligibility within two business days" following patient's request for charity care services, application for medical assistance, or both, and that it will communicate this information to the patient both verbally and in writing. (DI #P9, p. 5; DI #P9, App. K, Exh. 1). In response to the project status conference, P-B Health modified its application, revising its Charity Care and Sliding Fee Scale policy to differentiate its processes for determining probable and final eligibility. Under the replacement policy, it will determine probable eligibility within two business days of a client's initial request for charity care services if the patient (1) does not have insurance, (2) is not eligible for Medical Assistance, and (3) does not have the resources to pay. This information will be obtained from an interview with the referral source or patient. (DI #P20, Exh. 9, pp. 1-2). Final determination may require documentation of this information.

Reviewer's Analysis and Findings

I find that each applicant meets the requirement of Subsection (1) of this standard, which requires it to make a determination of probable eligibility for charity care within two business days of receiving a patient's request for charity care services, application for medical assistance, or both.

(2) Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population. Notices regarding the

hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, if such a site is maintained. Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families, and provide individual notice regarding the hospice's charity care policy to the patient and family.

Applicants' Responses	
Bayada	Bayada initially stated it would disseminate its policy annually in its Baltimore City office, post this information on its website, and make this information available to both the patient and family as part of the admission packet. Bayada plans to distribute this policy through referral sources and relationships it develops with health care providers in this jurisdiction. (DI #B9, p. 15). It stated that, as part of the admission process, it would discuss and work with the patient and family to address any financial concerns with regard to covering the cost of care. (DI #B9, pp. 15-16). Through the project status conference I informed Bayada that it had not provided adequate detail describing how it provides individual notice of its charity care policies to potential patients and their families prior to the provision of services. (DI #20GF, p. 4). As a result of the project status conference, Bayada modified its response, stating that it will post its Charity Care Policy on its website and Facebook page, as well as post the notice in its office, and provide a copy of "Notice of Charity and Reduced Fees" (Form #0-7657) to all prospective patients. (DI #B18, p. 6).
Carroll Hospice	Carroll Hospice initially stated that Carroll Hospital Center, Carroll Home Care, and Carroll Hospice utilized the same Charity Care policy "to provide medically necessary care to individuals who do not have the resources to pay for medical care." While the instructions for this standard address "Notices regarding the hospice's charity care policy," the applicant's response to this standard is in the perspective of a patient who receives care from the hospital. Carroll Hospice's original response stated that it posts the Financial Assistance Policy on the hospital website, all patient bills, and the patient information sheet provided to the patient and family before discharge. (DI #C3, Exh. 2). The original policy frequently made references from the perspective of Carroll Hospital Center. In response to the project status conference I held on April 10, 2019, the applicant modified its application, submitting a "Carroll Hospice Charity Care and Financial Assistance Policy" that was approved by the Carroll Hospital Center's Board of Trustees. (DI #C15, Exh. 22). The replacement policy now states that Carroll Hospice will provide individual notification to patients and their families regarding its charity care policy prior to the provision of services by providing individual notice in an intake packet distributed before each admission. (DI #C15, Exh. 22, p. 24). Carroll Hospice states that it will post public notice of the availability of charity care in its business office, annually post this notice in a newspaper of general circulation in each jurisdiction it

	serves, and on its website, at www.carrollhospice.org/financial-services. (DI #C15, p. 2).
P-B Health	P-B Health initially stated that it would publish its charity care policy annually "in the classified section of the newspaper in a format that is understandable to the service population" and also post this policy in its business office and on its website. (DI #P2, pp. 28-29; DI #P6, p. 13). Its original response provided that it would inform the patient, caregiver and/or family regarding the charity care financial assistance options when the staff reviews the payment section of the admissions consent packet with the patient and/or representative. (DI #P2, pp. 28-29, and App. K, Exh. 1, pp. 12-13). As a result of the project status conference, P-B Health modified its response, stated that its replacement Charity Care Policy "will be published annually in both English and Spanish in the Washington Post, Baltimore Sun, Afro-American, and other newspapers in P-B Health's service area and published in community association newsletters, church bulletins, community college publications, and other venues that reach residents of the service area." (DI #P20, pp. 6-7). The applicant said that it will also include the charity care policy in all of its brochures, and post the notification in its business offices and on its website.

Reviewer's Analysis and Findings

I find that each applicant meets Subsection (2) of this standard, which requires it to address the financial concerns of patients and families prior to providing hospice services and to give public notice of its charity care policy using methods designed to best reach the population in its service area, and in a format understandable by the service area population (including posting in its business office and on its website). Each applicant specifically commits to provide the required individual notice of its charity care policy to the patient and family prior to the provision of hospice services.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each hospice's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income patients who do not qualify for full charity care, but are unable to bear the full cost of services.

Applicants' Responses	
Bayada	Bayada initially provided a copy of its sliding scale based on household income, size of family, demographic of residence and Federal Poverty Guidelines. (DI #B9, p.16). The applicant made reference to having time payment plans available, but did not provide details or explain the type of plans offered in its CON application. (DI #B3, Exh. 23). In response to the project status conference I held on April 10, 2019, Bayada modified its response to include a provision for a time payment plan in a revised charity care policy and "Notice of Charity and Reduced Fees" (DI #B18, p. 7).

Carroll Hospice	The applicant initially stated that it provides hospice services on a sliding fee scale based on family income and Federal Poverty Guidelines, and included sliding schedules for: (1) Income Scale for Carroll Hospital Center, Carroll Home Care, and Carroll Hospice (CHC's) Financial Assistance; and (2) Carroll Hospital Center's Medical Hardship Assistance. (DI #C3, Exh. 5) In response to recommendations I made at the project status conference, Carroll Hospice's revised Charity Care Policy includes language that provides discounted care for low income patients who are not eligible for full charity care but are unable to bear the full cost of services, and contains a Medical Financial Hardship provision that allows for discounted care for a person with a medical financial hardship. (DI #C15, pp. 1-2). The policy also includes provisions for a time payment plan (DI #C15, Exh. 22, p. 17).
P-B Health	P-B Health initially stated that it would "offer patients with low income who may not qualify for full charity care but are still unable to bear the full cost of services . . . a sliding scale fee or time payment plan option.". It stated that it would have a sliding fee scale based on patient income and the Federal Poverty Guidelines but had no provision for low-income patients to qualify for full charity care. (DI #P2, App. A, Exh. 23). After the project status conference, P-B Health modified its application to include a revised sliding fee scale schedule that follows the Federal Poverty Guidelines and includes guidelines for the provision of full (100%) charity care. (DI #P20, pp. 7-8). The applicant states that it will work with clients and their families to develop a time payment plan that will cover a twelve-month period and will not charge interest on owed charges. (DI #P20, p 8). P-B Health will be flexible to accommodate and work with the patients on the terms of the time payment plan.

Reviewer's Analysis and Findings

Each applicant's charity care policy includes provisions for both a sliding fee scale based on household income and the Federal Poverty Guidelines, and offers time payment plan options. I find that each applicant meets Subsection (3) of the charity care standard.

(4) Policy Provisions. An applicant proposing to establish a general hospice, expand hospice services to a previously unauthorized jurisdiction, or change or establish inpatient bed capacity in a previously authorized jurisdiction shall make a commitment to provide charity care in its hospice to indigent patients. The applicant shall demonstrate that:

(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and

Applicants' Responses	
Bayada	Bayada states that it "is committed to providing hospice services on a charitable basis…," and makes a commitment to provide 1% of revenue to charity care. (DI #B3, p. 32). It notes that, across its multi-state service area,

	from 2011 through the second quarter of 2016, it provided $167,443 in charity care which accounted for 0.25% of its total $67,553,302 in gross revenue for that time period. In addition, Bayada reported that it never billed or collected $114,639 in services that occurred prior to patients becoming Medicare-certified. In total, Bayada represents that it provided $282,082 in total charity care, which represented 0.42% of gross revenue for this time period. (DI #B9, pp. 16-17).
Carroll Hospice	Carroll Hospice initially stated that it has provided charity care historically and will continue to offer the same financial assistance to patients from Baltimore City. It projected that 0.9% of total revenue will be provided in Charity Care for Baltimore City residents. (DI #C3, p. 21). Carroll Hospice also stated that it had provided $54,908 in charity care between FY 2012 and FY 2016, but did not provide the amount of operating revenue during that period, making a calculation of the percent of charity care impossible. In response to my pointing this out in the project status conference, Carroll Hospice provided data on total operating revenue for FY 2012 through FY 2016 ($25.7 million), which comes to approximately 0.2% of operating revenue. (DI #C15, Exh. 26).
P-B Health	As a home health agency, P-B Health submitted data that indicates that it provided a total of $96,800 in charity care between 2012 through 2016. (DI #P20, pp. 8-9). However, P-B Health did not provide data on the amount of total operating expenses between 2012 through 2016. In response to the recommendations I made at the project status conference, P-B Health provided the required information, showing that its historical level of charity care over that five-year period was equivalent to about 0.37% of total operating expenses. (DI #P20, pp. 8-9). In responding to my additional recommendation that it provide further information on its charity care commitment P-B Health states that its level of charity care will exceed 0.54%, which is the average percentage of charity care days provided in all jurisdictions served (i.e., includes Baltimore County, Anne Arundel County, etc.) by the seven existing hospice agencies that currently are authorized to serve Baltimore City as reported by MHCC's 2017 Public Use Data Base. (DI #P20, pp. 10-11).

Reviewer's Analysis and Findings

Historically, provision of charity care reported by hospice providers is quite small in comparison to the value of care reported by other types of health care facilities. While CMS' Continuation of Care Standard requires that a hospice not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for care, it does not provide guidance on how much charity care a hospice must provide. Hospices are allowed to vary the amount of charity care provided based on a patient's ability to pay.

In 2017, two of the general hospices that served Baltimore City residents, PHR of Baltimore Hospice and Stella Maris, did not report providing any charity care in MHCC's annual

survey of hospice services. Of the five hospices that did report the provision of charity care, the reported level of charity care ranged from 0.4% of total patient days (Heartland) to 1.6% of total patient days (Joseph Richey), with an average of 0.6% of days for the five programs overall. I note that this figure includes all charity care provision in all areas served by these hospices, not only charity care provision in Baltimore City.

Each applicant's commitment to providing charity care is in line with the reported provision of charity and reduced fee care by existing Baltimore City hospice providers and at that each applicant has demonstrated that its commitment is credible. For these reasons, I find that each applicant meets the requirements of Subsection (4)(a) of the standard.

(b) It has a specific plan for achieving the level of charity care to which it is committed.

Applicants' Responses	
Bayada	As previously discussed, Bayada has committed 1% of its revenue from Baltimore City to charity care. The applicant states that "by serving a demographic that is predominantly low-income and uninsured, and in line with…. not turning anyone away due to an inability to pay, Bayada Hospice is confident it will be able to achieve the level of charity care it has projected for Baltimore City." (DI #B9, p. 17). Bayada states that "the provision of charity care is tracked …to achiev[e] a planned annual level of charity care." (DI #B9, p. 18). In the recent Prince George's County Hospice Review (Docket No. 16-16-2383), Bayada described a plan for achieving its charity care commitment. The applicant states that a copy of Bayada's Charity Care Policy would be included with information about its hospice program in outreach information provided to physicians, facilities, and senior information and assistance offices with which it has developed relationships through its residential service agency and home health programs in Maryland. To assess if its efforts are working, Bayada plans to evaluate its level of charity care at least annually and if it is not meeting its target goal, Bayada "'will look for additional measures to identify and attract charity care clients.'" (Reviewer's Recommended Decision, Prince George's County Hospice Review, Docket No.16-16-2383, p. 44). Bayada also reports having a foundation that makes donations and provides grants to help families pay for funeral and burial expenses. (DI #B3, p. 32 and DI #B9, pp. 17-18).
Carroll Hospice	Carroll Hospice states that every patient referred will be admitted following the same processes, which includes determining eligibility for financial assistance. (DI #C10, pp. 9-10). It is confident that these processes, as well as its community outreach and education efforts, its publication of the charity care notice, and its targeted media efforts will reach those in need in Baltimore City. (DI #C3, p. 21). To achieve this level of commitment, Carroll Hospice

	will employ a full-time community outreach staff member to educate organizations on the availability of charity care. (DI #C15, p. 3).
P-B Health	In compliance with recommendations I made at the April 10, 2019 project status conference, P-B Health modified its response, stating that it will monitor the amount of charity care it provides at least quarterly. Its administrator will develop a quarterly report to show the year-to-date cumulative number of charity care patients, the percentage of total patient days, and their equivalent charges, as well as the cumulative annual total patient days. (DI #P20, p. 7). P-B Health states that it will consider this information at its management meetings and, if the level of charity care provided falls below its commitment, the applicant would: notify all referring entities, reminding them of the availability of charity care; and remind staff who interact with patients that charity care is available.

Reviewer's Analysis and Findings

Each applicant reports that it has provided charity care in the past, Bayada and Carroll as hospices and P-B Health as a home health agency. Each has submitted a plan to support the level of charity care that it will provide. I find that each of the applicants meets Subsection (4)(b) of this standard.

In summary, I find that Bayada, Carroll Hospice, and P-B Health have met the all subsections of the charity care standard.

K. Quality.

(1) An applicant that is an existing Maryland licensed general hospice provider shall document compliance with all federal and State quality of care standards.

(2) An applicant that is not an existing Maryland licensed general hospice provider shall document compliance with federal and applicable state standards in all states in which it, or its subsidiaries or related entities, is licensed to provide hospice services or other applicable licensed health care services.

(3) An applicant that is not a current licensed hospice provider in any state shall demonstrate how it will comply with all federal and State quality of care standards.

Applicants' Responses	
Bayada	Bayada notes that it is not an existing Maryland licensed general hospice, but operates hospices in New Jersey, Pennsylvania, Vermont, and New Hampshire. It states that each of its hospice programs serving these four states has been surveyed and re-accredited by Community Health Accreditation Program

	("CHAP")[21] for a three-year accreditation period (10/10/2017-10/10-2020) and meets the Medicare requirements for participation as a hospice. (DI #3, pp. 33-34 and Exhibit 25). Bayada referenced Family Caregivers' survey and Hospice Item Set ("HIS") Comprehensive Assessment Measure results for its New Hampshire, Vermont, and Media, Pennsylvania hospice programs[22] on the CMS' Hospice Compare website. (https://www.medicare.gov/hospicecompare/).
Carroll Hospice	Carroll Hospice notes that it is an existing Maryland licensed hospice that has been surveyed and re-accredited by CHAP for a three-year accreditation period (8/27/2017-8/27/2020)[23] and that it meets the Medicare requirements for participation as a hospice. Carroll Hospice referenced Family Caregivers' survey and Hospice Item Set ("HIS") Comprehensive Assessment Measure results on the CMS' Hospice Compare website (https://www.medicare.gov/hospicecompare/). (DI #3, p. 21).
P-B Health	P-B Health states that, as a home health agency, it currently participates in surveys and complies with CMS requirements for measuring quality. (DI #2, p. 31). P-B Health's survey results on Quality of Care Measures and Home Health Consumer Assessment of Healthcare Providers and Systems ("HHCAHPS"). Measures are reported on the CMS' Home Health Compare website (https://data.medicare.gov/data/home-health-compare).

(4) An applicant shall document the availability of a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09.

Applicants' Responses	
Bayada	Using a form developed by MHCC staff, Bayada submitted responses that address how its proposed general hospice program will comply with each of the Quality Assurance and Performance Improvement ("QAPI") elements set forth by the Office of Health Care Quality ("OHCQ") in COMAR 10.07.21.09, its regulations for hospice care programs. (DI #9, Revised Exh. 26).
Carroll Hospice	Using the same form, Carroll Hospice submitted responses that address how it complies with each of the QAPI elements set forth by OHCQ in COMAR 10.07.21.09, its regulations for hospice care programs. (DI #10, Exh. 19)
P-B Health	P-B Health (also using the form developed by MHCC staff) submitted responses that that address how the applicant complies with each of the QAPI elements set forth by OHCQ in COMAR 10.07.21.09, its regulations for hospice care programs. (DI # 11, pp. 15-17).

(5) An applicant shall demonstrate how it will comply with federal and State hospice quality measures that have been published and adopted by the Commission.

[21] Further information available at: https://locator.chaplinq.org/
[22] CMS' Hospice Compare website reports "Results are not available for this reporting period" for the New Jersey and East Stroudsburg, PA programs.
[23] Further information available at: https://locator.chaplinq.org/

Reviewer's Analysis and Findings

The first three subsections of this standard require an applicant that is a general hospice to document compliance with all federal and State quality of care standards. The fourth subsection requires an applicant to document that it has a quality assurance and improvement program consistent with the requirements of COMAR 10.07.21.09. The fifth subsection requires an applicant to demonstrate how it will comply with any of those federal and State hospice quality measures that have been published and adopted by the Commission. This subsection is not applicable, as the Commission has not yet officially adopted any hospice quality measures.

I will address each of the applicable subsections immediately below.

Subsections (1), (2), and (3): compliance with all federal and State quality of care standards.

At the time the Hospice Services Chapter was updated in 2013 federal and State quality standards had not yet been written. Noting the importance of these measures, the Hospice Services Chapter made the following policy statements in the Hospice Services Chapter:

> **Policy 1.0: The Commission, in conjunction with the Hospice and Palliative Care Network of Maryland, needs to monitor the availability and accessibility of hospice programs on an ongoing basis.**
>
> **(2) Quality Measurement.**
>
> Hospices have been required to have Quality Assessment and Performance Improvement (QAPI) programs in place since December 2008 in order to comply with Medicare Conditions of Participation. Section 3004 of the Affordable Care Act (ACA) of 2010 requires the establishment of a quality reporting program for hospice. Measures of quality as well as patient and family satisfaction are increasingly becoming the focus of health care assessment, both nationally and in Maryland. In addition to the federal (CMS) and National Quality Forum (NQF) measures, the Commission will select and publish measures for assessing the quality of hospice programs. The success of hospices in meeting these quality measures will also be reported in the Commission's Consumer Guide to Long Term Care.
>
> **Policy 2.0: As measures are developed, the level of quality achieved by hospices, as indicated by measurement and reporting of performance on the quality measures, will be incorporated into the review criteria and standards used in Certificate of Need reviews.**
> (COMAR 10.24.13.03B, "Statement of Issues and Policies.").

At the time that the applicants prepared and submitted their CON applications in the Fall of 2016, and during the period when the review of the applications began, CMS had not yet published information on its Hospice Compare website regarding hospice quality performance. However, CMS began publishing limited quality data late in the fourth quarter of 2017 at https://data.medicare.gov/data/hospice-compare. I have reviewed the findings reported on the

CMS Hospice Compare website for Bayada and Carroll Hospice, the two existing hospice providers currently participating in this review.

While the third applicant, P-B Health, is not an existing hospice provider and therefore does not report any data that is published on the CMS Hospice Compare website, it is an existing home health agency that for which data[24] is reported to the CMS Home Health Compare website at https://www.medicare.gov/homehealthcompare/search.html. The most recent conclusions regarding the applicant's compliance for Quality of Care Measures are for the period January 2017-June 2018[25] and its HHCAHPS® Experience of Care Measures for the period July 1, 2017-June 30, 2018.

The following two tables provide the findings from my review of the two CMS quality performance websites. Table IV-1 compiles the comparative ratings of Bayada and Carroll Hospice, and Table IV-2 shows the quality ratings for the sole home health agency applicant, P-B Health. These tables follow immediately below, along with my observations on the quality reports.

Table IV-1: CMS Hospice Compare Scores for Bayada and Carroll Hospice (as reported May 2019)

Family Caregivers' Survey[26] Results (for Period 4/1/2016 thru 3/31/2018)	National Average	Carroll Hospice	Bayada - (NJ)	Bayada - (SE - PA)	Bayada - (NE - PA)	Bayada - (VT)
Communication with family	80%	80%	NA[11]	83%	NA[11]	74%
Getting timely help	78%	81%	NA[11]	78%	NA[11]	73%
Treating patient with respect	91%	93%	NA[11]	92%	NA[11]	90%
Emotional and spiritual support	90%	92%	NA[11]	89%	NA[11]	90%
Help for pain and symptoms	75%	78%	NA[11]	75%	NA[11]	69%
Training family to care for patient	75%	73%	NA[11]	74%	NA[11]	74%
Rating of this hospice	81%	85%	NA[11]	78%	NA[11]	75%
Willing to recommend this hospice	85%	91%	NA[11]	84%	NA[11]	83%

[24] The CMS Home Health Compare website includes: home health quality measures (both outcome and process measures) on the Outcome and Assessment Information Set (OASIS); information collected and reported from state surveys by Maryland's Office of Health Care Quality to the Quality Improvement Evaluation System (QIES); and Medicare claims data for utilization-based home health quality measures. Further information is available at: https://www.medicare.gov/HomeHealthCompare/Data/Data-Sources.html.

[25] Depending on the Quality of Patient Care measure, the collection period for each quality measure is updated on a rolling basis by quarter, hence the reporting period for each measure can vary. Home Health Compare current data collection periods are located at: https://www.medicare.gov/HomeHealthCompare/Data/Current-Data-Collection-Periods.html#

[26] The Experience of Care survey asks a family member or friend of a hospice patient about the patient's hospice care experience.

Hospice Item Set Comprehensive[27] Assessment Measure (for Period 4/1/2017 thru 3/31/2018)	National Average	Carroll Hospice	Bayada - (NJ)	Bayada - (SE - PA)	Bayada - (NE - PA)	Bayada - (VT)
Patients who got an assessment of all 7 HIS quality measures at the beginning of hospice care to meet the HIS Comprehensive Assessment Measure requirements	84.2%	97.4%	100.0%	95.4%	91.7%	95.2%
Seven HIS Comprehensive Assessment Measures	**National Average**	**Carroll Hospice**	**Bayada - (NJ)**	**Bayada - (SE - PA)**	**Bayada - (NE - PA)**	**Bayada - (VT)**
Patients or caregivers who were asked about treatment preferences like hospitalization and resuscitation at the beginning of hospice care	98.9%	100.0%	100.0%	100.0%	97.2%	99.8%
Patients or caregivers who were asked about their beliefs and values at the beginning of hospice care	95.8%	99.0%	100.0%	99.8%	97.2%	99.8%
Patients who were checked for pain at the beginning of hospice care	96.3%	99.8%	100.0%	97.8%	91.7%	98.9%
Patients who got a timely and thorough pain assessment when pain was identified as a problem	87.8%	98.5%	NA[1]	99.1%	NA[1]	98.4%
Patients who were checked for shortness of breath at the beginning of hospice care	98.1%	100.0%	100.0%	99.7%	97.2%	100.0%
Patients who got timely treatment for shortness of breath	95.8%	97.3%	NA[1]	97.7%	NA[1]	96.0%
Patients taking opioid medication who were offered care for constipation	93.9%	99.1%	NA[1]	100.0%	NA[1]	99.2%

Source: https://www.medicare.gov/hospicecompare/
11 Results are "Not Available" for this reporting period. Agency is too new or too small to be required to participate in the CAHPS® Hospice Survey, or no cases met the criteria for the measures for this reporting period.
[1] The number of patient stays is too small to report (fewer than 20 patient stays).

Hospice Compare results for Carroll Hospice indicate a strong performance on both the Family Caregivers' Survey, which asks a family member or friend of a hospice patient about the patient's experience with the hospice, and the HIS Comprehensive Assessment Measure, which measures if hospice staff completed each of the seven quality of care measures. With the exception of one Family Caregiver measure regarding "Training family to care for patient," where Carroll had a score of 73% which is slightly lower than the national average of 75%, the applicant's results either equaled or exceeded the national averages for all of the other survey results or quality measures.

[27] Hospice Item Set (HIS) measures if the hospice staff completed all of the comprehensive assessment measures identified in the table below when a patient was admitted to hospice care.

Bayada is licensed to provide hospice services in three states other than Maryland, and the CMS Hospice Compare website reports the findings for its hospice programs in New Jersey, Pennsylvania, and Vermont. The website indicates that each of the Bayada programs performed well on the HIS Comprehensive Assessment Measures, with each of Bayada's quality measures either meeting or exceeding national averages. The Hospice Compare website only provided findings for the southeast Pennsylvania ("SE-PA") and Vermont programs' Family Caregivers' Survey.[28] While the program in SE-PA had good results, with the Vermont program only four out of eight of the experiential scores either met or exceeded the national averages.

As I previously noted, P-B Health, as an existing home health agency, is rated on both Quality of Care Measures[29] and HHCAHPS® Experience of Care Measures[30] to Medicare. Its results are shown in Table IV-2, below.

Table IV-2: CMS Home Health Compare Scores for P-B Health Home Health Agency

	P-B Health	Maryland Average	National Average
Quality of Patient Care[31]			
Number of Stars	4.5	4	3.5
Managing Daily Activities			
How often patients got better at walking or moving around	85.8%	78.4%	75.6%
How often patients got better at getting in and out of bed	85.0%	78.6%	74.8%
How often patients got better at bathing	85.4%	80.4%	77.9%
Managing Pain and Treating Symptoms			
How often patients had less pain when moving around	89.3%	81.7%	78.6%
How often patients' breathing improved	94.1%	83.3%	77.8%
How often patients' wounds improved or healed after an operation	97.1%	92.6%	91.2%
How often patients developed new or worsened pressure ulcers	0.4%	0.3%	0.4%
Preventing Harm			
How often the home health team began their patients' care in a timely manner	95.8%	94.8%	94.3%
How often the home health team taught patients (or their family caregivers) about their drugs	99.8%	99.1%	98.2%
How often patients got better at taking their drugs correctly by mouth	76.9%	70.2%	66.7%

[28] Bayada's hospice program in New Jersey did not receive Medicare certification until June 2015, and the East Stroudsburg, Pennsylvania program only received this certification in September 2017. CMS' footnote for these two locations states that the "[a]gency is too new or too small to be required to participate in the CAHPS® Hospice Survey, or no cases met the criteria for the measures for this reporting period." Available at:https://www.medicare.gov/hospicecompare/#about/theData.

[29] From data collected by contractor and submitted directly to Outcome and Assessment Information Set (OASIS) database and from Medicare claims. Further information at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/HomeHealthQualityInits/Home-Health-Quality-Measures.html.

[30] From patient survey results. Ibid.

[31] Data collected quarterly, reporting period varies depending on quality measure. Data collection schedule available at: https://www.medicare.gov/HomeHealthCompare/Data/Current-Data-Collection-Periods.html#.

	P-B Health	Maryland Average	National Average
How often the home health team checked patients' risk of falling	100.0%	99.7%	99.6%
How often the home health team checked patients for depression	99.4%	96.8%	97.6%
How often the home health team made sure that their patients have received a flu shot for the current flu season	95.3%	84.1%	78.5%
How often the home health team made sure that their patients have received a pneumococcal vaccine (pneumonia shot)	93.8%	83.2%	81.4%
For patients with diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care	98.9%	98.8%	97.7%
How often physician-recommended actions to address medication issues were completed timely	87.6%	92.3%	92.3%
Preventing Unplanned Hospital Care			
How often home health patients had to be admitted to the hospital	16.8%	15.3%	15.8%
How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room - without being admitted to the hospital	17.4%	13.0%	13.0%
How often home health patients, who have had a recent hospital stay, had to be re-admitted to the hospital	Worse than expected	NA	NA
How often home health patients, who have had a recent hospital stay, received care in the hospital emergency room without being re-admitted to the hospital	Same as Expected	NA	NA
How often patients remained in the community after discharge from home health	Better than Expected	NA	NA
Payment & Value of Care			
How much Medicare spends on an episode of care at this agency, compared to Medicare spending across all agencies nationally	1.06	NA	1.00
Experience of Care (for Period 7/1/2017 thru 6/30/2018)			
Number of Stars	2	NA	NA
How often the home health team gave care in a professional way	78.0%	88.0%	88.0%
How well did the home health team communicate with patients	76.0%	85.0%	85.0%
Did the home health team discuss medicines, pain, and home safety with patients	73.0%	81.0%	83.0%
How do patients rate the overall care from the home health agency	69.0%	83.0%	83.0%
Would patients recommend the home health agency to friends and family	57.0%	76.0%	78.0%

Source: https://www.medicare.gov/homehealthcompare/search.html

The data on the Home Health Compare website show mixed results for P-B Health. P-B Health did very well on the Quality of Patient Care Measures, outperforming both the Maryland and national averages in seventeen (17) of twenty-two (22) categories, and receiving an overall rating of 4½ stars out of five. However, P-B Health's results on the Experience of Care measures fell below the national and State average in each of the five categories. Thus, the overall patient experience rating for P-B Health was only two (out of five) stars.

Each applicant currently participates in the appropriate CMS quality reporting instruments, thereby demonstrating its intent and ability to comply with federal and State quality of care standards. For these reasons, I find that each applicant meets the requirements of Subsections (1), (2), and (3) of the Commission's quality standard.

Subsection (4): document the availability of a QAPI consistent with the requirements of COMAR 10.07.21.09.

COMAR 10.07.21.09 requires a hospice program to conduct ongoing quality assurance and utilization review, and details expectations about the content of such programs. Monitoring compliance with 10.07.21.09 is the responsibility of the Office of Health Care Quality ("OHCQ"). During completeness review, MHCC staff worked with OHCQ to adapt the survey form used by OHCQ to measure compliance with COMAR 10.07.21.09 and asked each applicant to document their QAPI's compliance with the points measured by OHCQ.

I find that each applicant meets Subsection (4) of the quality standard, which requires it to document a quality assurance and improvement program consistent with COMAR 10.07.21.09.

Each applicant meets the requirements of the Quality standard.

L. Linkages with Other Service Providers.

(1) An applicant shall identify how inpatient hospice care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

Applicants' Responses	
Bayada	Bayada is currently a preferred provider with Genesis Healthcare and plans to establish contracts with Genesis providers in Baltimore City such as Caton Manor and Homewood Center for both inpatient hospice and respite care. (DI #B3, pp. 37-38).
Carroll Hospice	Carroll Hospice states that it will enter contractual relationships with existing Baltimore City hospice providers and skilled nursing facilities for provision of inpatient hospice care. It notes that LifeBridge Health patients will be able to rely on the Seasons inpatient hospice programs operating both at Sinai and Northwest Hospitals to provide this level of care and quality service. (DI #C3, p.23).
P-B Health	P-B Health reports that it has spoken with Seasons Hospice, Gilchrist Hospice, and Future Care as well as a number of skilled nursing facilities about entering into a contract for inpatient hospice services. Seasons Hospice provided a letter of support while Future Care provided verbal support. P-B Health currently refers home health patients to Gilchrist Hospice for inpatient hospice services. (DI #P2, p. 33; DI #6, pp. 16-17 and App. G, Exh. 13).

Reviewer's Analysis and Findings

I find that each applicant has met the requirement of Subsection (1) of the linkages standard by identifying how each will provide inpatient hospice care to patients.

(2) An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services (AERS), Senior Information and

Assistance Programs, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

Applicants' Responses	
Bayada	Bayada agrees to document before licensure that it has established links with facilities and programs within Baltimore City. Bayada plans to leverage its existing relationships developed through its home health agencies with existing health care providers. (DI #B3, pp. 38-39).
Carroll Hospice	Carroll Hospice agrees to comply with this standard and document its established links with facilities and programs within the City of Baltimore. (DI #C3, p. 23).
P-B Health	P-B Health states that it currently has links and, if approved as a general hospice to serve Baltimore City, agrees to document before licensure that it will have established links with facilities and programs within Baltimore City. (DI #P2, p. 33; DI #P6, p. 16-17).

Reviewer's Analysis and Findings

Each applicant has made a commitment to establish linkages with existing health care providers and programs in Baltimore City. Although I find that each applicant has meet the requirement of Subsection (2) of the linkages standard, I recommend that, if the Commission awards Certificates of Need to Bayada, Carroll Hospice, and P-B Health, it include a condition that each shall:

> Prior to first use approval, provide documentation of links it has established with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance Programs, adult day care programs, the Baltimore City Department of Social Services, and home delivered meal programs located within Baltimore City.

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

Applicants' Responses	
Bayada	Bayada states that it will contract with one or more Medicare and/or Medicaid certified inpatient facilities in Baltimore City to offer respite services on an as needed basis up to five days per respite admission in accordance with the patient's care plan and will be responsible for coordinating the patient's transfer to and from the respite care facility. (DI #B3, p. 40). In a modification to its original application made after the project status conference, in response to my request that the applicant detail how it will provide the required Minimum Services, Bayada states that either Caton Manor (in Baltimore City) or Perring Parkway Center (in Baltimore County) would provide respite care. (DI #B18, pp. 1-3).
Carroll Hospice	Carroll Hospice anticipates that it will utilize the resources at Levindale Nursing Home, an affiliate of LifeBridge Health, to serve the majority of Baltimore City patients who require or request respite care. It also expects to utilize FutureCare

	Lochearn Nursing Home as well as the inpatient hospice settings at Sinai and Northwest Hospital as options for respite care. (DI #3, p. 23).
P-B Health	P-B Health states that it will arrange respite care if the usual caregiver needs a rest, and that it will facilitate the transfer of each patient to the inpatient respite care facility and will coordinate the patient's plan of care while at the respite facility. (DI #P2, pp 33-34). In a modification to its original application timely made after its application was docketed on June 9, 2017 (DI #P15, p. 3), P-B Health stated that it "will contract with Seasons Hospice to provide support for home hospice patients in need of respite care," enhancing its original response that it would develop working relationships and execute contracts with a Medicare-certified inpatient hospice facility, hospital, or nursing home in Baltimore City to provide respite care.

Reviewer's Analysis and Findings

While I find that each applicant has met this standard, I recommend that, if the Commission awards Certificates of Need to Bayada, Carroll Hospice, and P-B Health, it include a condition that each shall:

> Prior to first use approval, provide documentation of the arrangements it has made for providing respite care for the families and other caregivers of patients.

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 individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce the disparities in hospice utilization. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups that have used hospice services at a lower rate than the overall population in the proposed hospice's service area.

Applicants' Responses	
Bayada	Bayada explains that its outreach and education plan consists of seven main elements: hiring a community liaison; connecting with health care institutions and stakeholders; collaborating with physicians and other referral sources; providing education programs for community and religious leaders; making cultural competency a core component of staff training; enacting the *Caring Connections*[32] model as an outreach program tailored to Hispanic American and African American communities; and developing and disseminating educational and outreach resources. (DI #B3, pp. 41-42).
Carroll Hospice	Carroll Hospice's educational program will include, but is not limited to: providers; facility partners; patients; families; and communities. Carroll Hospice states that it will base its education program on the book "Being Mortal" by Atul Gawande, M.D.,[33] which is rooted in respect for the individual and personalized

[32] A description of the *Caring Connections* - African American Outreach Guide and Latino Outreach Guide is included with the Bayada's application (DI #3, Exh. 36, 37)
[33] Further information available at: http://atulgawande.com/book/being-mortal/

	to address key decision points in the care for the needs of the patient and his/her family during the end of life. Carroll Hospice will also utilize a program titled *A Progressive Palliative Care Educational Curriculum for the Care of African Americans at Life's End* ("A.P.P.E.A.L.") to educate health care professionals with essential clinical competencies and practical skills needed to provide culturally appropriate palliative and quality end of life services to African American patients and their families. The applicant notes that it has specialized teams of hospice professionals that will work within the LifeBridge Health system as well as with other healthcare facilities throughout Baltimore City to educate facility colleagues about hospice and palliative care. Carroll Hospice anticipates: establishing a hospice rotation within the LifeBridge Health residency program to help guide care planning earlier in the patient care experience; working closely with hospitalist programs and private physician offices; and developing relationships with nurses, case managers, physician liaisons and care navigators to provide the support and guidance required to transition patients to palliative or hospice care. Finally, Carroll Hospice plans to seek the assistance of non-traditional referral sources and respected community voices to promote a higher level of acceptance for palliative and hospice care. It will work with the faith communities participating in the LifeBridge Health Faith Health Network to provide community-based forums on end of life care training and care options, reaching out to African American and other underserved populations. Working with the Baltimore City Department of Aging and the Baltimore City Health Department, Carroll Hospice will become active in community-based health fair opportunities in the Greater-Baltimore City community to promote hospice services and introduce Carroll Hospice to Baltimore City residents. (DI #C3, pp. 23-25; DI #C10, pp. 1-3).
P-B Health	P-B Health states that it "will expand its current Outreach Program to include an aggressive educational program to educate, inform, and increase awareness to the underserved incurable patients in Baltimore City." The Outreach Program will work in consultation with various church organizations, churches, and ministerial staff to form a leadership management team that addresses a viable outreach alliance to serve minorities and underutilized African American communities. P-B Health states that "as an African-American minority owned business, it sees disparities everyday which affords the applicant the capabilities and knowledge to better serve, educate, and address the needs of this growing population." (DI #2, pp. 34-35). In addition, it provided a list of hospice educational and/or outreach programs and seminars that it will conduct with various minority groups that include working with minority organizations, clergy, outreach services, senior care centers, in-home aide programs, and the Veterans Administration. (DI #P6, p. 5).

Reviewer's Analysis and Findings

Each applicant offers an acceptable approach for educating the residents of Baltimore City regarding the provision of hospice services. Each will utilize staff to perform education and outreach programs to increase the awareness and use of hospice services. While P-B Health is a minority-owned business that acknowledges disparities in the use of hospice services by minority populations, each applicant states that it will have resources in-place to educate and perform outreach that is directed to increase the awareness and use of general hospice services by minority populations such as African-American and Hispanic-American communities in Baltimore City. As a part of this outreach, each will develop relationships with community and religious individuals and organizations to promote hospice services in this jurisdiction.

I find that each applicant meets this standard.

O. Patients' Rights. An applicant shall document its ability to comply with the patients' rights requirements as defined in COMAR 10.07.21.21.

Applicants' Responses	
Bayada	Bayada documented its compliance with COMAR 10.07.21.21 by submitting a copy of its Client Rights Supplement-Maryland and its Addendum to Client Rights Supplement-Maryland. (DI #B3, Exh. 38, 39). Bayada states that it will have personnel and volunteers complete a mandatory online course as well as attend ongoing in-service trainings that address the admissions criteria, procedures and policies, including respecting each patient's rights. (DI #B9, p. 21).
Carroll Hospice	Carroll Hospice submitted a copy of its Patients' Rights and Responsibilities Policy, stating that it "is hardwired in its work flow and practiced in every patient encounter, ensuring that every patient is provided with quality, safe care, and treated with the utmost respect and compassion." (DI #C3, p. 25 and Exh. 8).
P-B Health	P-B Health provided a copy of its Patient's Rights and Responsibilities policy, and affirms that the hospice's patients' rights policy will comply with COMAR 10.07.21.21. P-B Health also included the language from its statement of expectations regarding patients' responsibility to inform P-B Health about their illness, needs, medications, and provide feedback regarding the care received. (DI #P2, pp. 35-36; DI #P6, pp. 17-18).

Reviewer's Analysis and Findings

I find that each applicant meets the Patients' Rights standard.

P. Inpatient Unit: In addition to the applicable standards in .05A through O above, the Commission will use the following standards to review an application by a licensed general hospice to establish inpatient hospice capacity or to increase the applicant's inpatient bed capacity.

This standard is not applicable. Carroll Hospice, the only applicant that is an existing Maryland general hospice, is not proposing any changes in its inpatient facility as part of its

application. The two entities seeking to establish general hospices are not proposing to operate their own inpatient facilities.

B. COMAR 10.24.01.08G(3)(b) NEED

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.

Applicants' Responses	
Bayada	Bayada points out that the MHCC projected additional need for hospice services in Baltimore City (*Maryland Register*, Volume 43, Issue 11, May 27, 2016). Bayada opined that, since the current hospice providers have achieved a current baseline use rate of just 25% in Baltimore City (as of 2014, the latest data available at the time of the application), the incumbent providers will not be able to boost the use rate to the target use rate of 47.3%, nor would they be able to meet the projected net need for this jurisdiction. (DI #3, p. 44). Bayada added that the increasing number of residents who are age 65 and over (this cohort grew by approximately 7% between 2010 and 2015 in Baltimore City) and the relatively low use of hospice by the large African American population of Baltimore are also indicators of need. Bayada states that its experience in other states, where it claims to have raised hospice use rates (Vermont) and served populations heavily dependent on Medicaid (Philadelphia) has prepared it to succeed in Baltimore. (DI #B3, pp. 45-46).
Carroll Hospice	Carroll Hospice cited the Maryland Hospice Need Projections for Target Year 2019 (published in the *Maryland Register* on May 17, 2016), which identifies a need to provide services to an additional 1,233 patients in Baltimore City by Year 2019. (DI #C3, p.27). Carroll Hospice identified the underutilization of hospice services in Baltimore City, particularly underuse by the African-American community, as an indicator of need. (DI #C3, pp. 27-30). It noted that, while the hospice use rate[34] for the State was 43% in 2014, the rate for Baltimore City was relatively low at 25%.[35] While about 65% of Baltimore City's population is African-American, only about 57% of the hospice patients are. Carroll Hospice stated that new care management models will boost hospice use, specifically citing the increasing use of palliative care, Maryland's total cost of care model for regulating hospital charges, and the growth of

[34] As reported by the MHCC in "Update on Hospice Services in Maryland and Implementation of the State Health Plan," Table 3: Hospice Use Rates, Maryland and Jurisdictions, 2007-2014 (April 14, 2016), p. 13.
[35] Of the 24 jurisdictions, only Allegany and Garrett Counties in western Maryland and Dorchester County along the Eastern Shore had lower hospice use rates in 2014.

	accountable care organizations ("ACOs"). (DI #C3, pp. 30-32). The applicant expects that the increased use of palliative care will increase the growth in hospice referrals by as much as 30% over the coming years. It expects that implementation of the total cost of care model will increase the demand for utilizing alternative service settings such as hospice care, in order to reduce spending related to hospital readmissions. Increased enrollment in ACOs will motivate physicians to utilize hospice as a lower cost alternative. Carroll Hospice also points to growth of the elderly population in Baltimore City. According to the Maryland Department of Planning, the elderly population (age 65 years and over) in Baltimore City is projected to grow by nearly 4,800 residents from 2014 to 2020, an increase of about 6.2%. (DI #C3, p. 32). It projects that it will serve 482 of the projected net need of 1,233 Baltimore City hospice deaths by FY 2019. (DI #C3, p. 44).
P-B Health	P-B Health's need discussion centered on the apparent unmet need for hospice services among Baltimore City's minority population, evidenced by MHCC data showing that African-Americans made up only 46.8% of hospice deaths in 2013 and 57.3% in 2014, despite making up 64.8% of the age 35 and older population in the jurisdiction. (DI #P2, p. 38 and DI #P2, App. A, Exh. 7). P-B Health quotes from a 2007 journal article that states that "though studies have documented that hospice improves quality at the end of life, underutilization of hospice by members of the African American community continues to be documented, and disparities in care at the end of life exist."[36] P-B Health points out the need to educate the underserved communities in Baltimore City about "the benefits of hospice services, community empowerment, and meaningful interventions." P-B Health states that, as an African-American minority-owned business, it is very familiar with these disparities, and states that it has a "proven record of making a positive change in these communities." (DI #P2, p. 38 and DI #P6, p. 19).

Interested Party Comments

Comments on Carroll Hospice's Application

Bayada's Comments

Bayada states the most recent hospice need projection identifies the projected net need in Baltimore City for 2019 as 1,233 cases. Bayada projects that it will service 167 Baltimore City patient admissions in 2019 and notes that Carroll Hospice projects serving 482 patient admissions for the same time period. Together, these projections represent 52.6% of the total projected hospice net need for 2019. (DI #9GF, p. 2). Bayada states "if the Commission determines that

[36] "African American Bereaved Family Members' Perceptions of the Quality of Hospice Care: Lessened Disparities, But Opportunities to Improve Remain." *The Journal of Pain and Symptom Management*, November 2007 (p.473)

both Bayada's application and Carroll Hospice's application meet the CON standards, that the Commission could approve both applications." (DI #9GF).

Comments on All Applications

Carroll Hospice's Comments

Carroll Hospice does not find fault with either Bayada's or P-B Health's application, but instead states that the applicants' projections and the MHCC-projected need suggest that the market can absorb all three, and that their differentiated approaches to community education and promotion of hospice use can be mutually-reinforcing and more likely to reach varying market segments than any one applicant alone could.

With regard to need, Carroll Hospice notes the MHCC calculated Baltimore City's net need to be an additional 1,233 patients in 2019, and points out that the combined service projections of the three applicants is to serve 570 hospice patients in that year, less than half of the net need projection. Further, Carroll Hospice points out that "the unmet need projected by the Commission is so great in Baltimore City that even at full utilization in subsequent years, the total patients projected to be served by all three applicants is less than [MHCC's] projected need projection for 2019." (DI #11GF, p. 3)

Carroll Hospice states that the three applicants will help increase hospice utilization in Baltimore City because the applications they submitted suggest that they "will develop and implement differing methods and approaches to strengthen community outreach and education, build support among community leaders, and build the cultural competence in the delivery system to respond to community need." Further, increasing the number of options for consumers in Baltimore City represents greater opportunity for introducing hospice services to different religious groups and minority and cultural groups. (DI #11GF, p. 4).

Applicants' Responses to Interested Party Comments

Carroll Hospice's Response to Interested Party Comments of Bayada Hospice

Carroll Hospice agreed with Bayada's comment that "there is enough unmet need in Baltimore City for hospice services to accommodate the approval of both the Carroll Hospice Application and the Bayada Hospice Application." It states that there is more than enough need to accommodate the approval of Bayada's application if it also meets the remaining requirements in the Hospice Services Chapter. Carroll Hospice asserts that "increasing the number of options for consumers in Baltimore City can help to increase outreach and education efforts to various groups and the potential to achieve the goal of increasing utilization of hospice services within Baltimore City." (DI #14GF, p. 2).

Reviewer's Analysis and Findings

For these projects, the applicable need analysis in the Hospice Services Chapter employs a calculation of hospice use as a benchmark for targeting jurisdictions where applications for additional hospice providers can be considered by the Commission. Baltimore City has a large

enough population such that, combined with its relatively low hospice use rate, it qualified as a "target jurisdiction." Thus, under the terms of this criterion, a demonstration of need by the applicants is not actually required because there is an applicable need analysis in the State Health Plan. However, because there are multiple applicants, it is useful to review their responses to the criterion.

The applicants' responses to this criterion reflected common themes. Both Bayada and Carroll Hospice cited the Maryland Hospice Need Projections for Target Year 2019 (published in the *Maryland Register* on May 17, 2016), which identified a need to provide services to an additional 1,233 patients in Baltimore City by Year 2019. Both also cited the increasing 65-and-over population. Carroll Hospice also pointed out that there are systemic and structural changes occurring in the health care marketplace that would be likely to increase hospice use, such as the increasing interest in palliative care, and emphasis by both the federal and State governments on utilizing alternative service settings to reduce spending on hospital admissions and readmissions to reduce unnecessary and costly care.

P-B Health emphasized the apparent unmet need among Baltimore City's minority population, and its roots in the community as a long-standing home health agency experienced in building coalitions focused on improving community health.

As I noted in my analysis of the impact standard,[37] each of the three applicants projected service volumes at full utilization (projected as no later than 2021) that would make them significant providers in the jurisdiction (Bayada projects 278 admissions, Carroll Hospice projects 482, and P-B Health projects 169). Each of those volume projections exceeds the volume reported by Stella Maris, currently the third largest incumbent hospice, which served 154 patients in 2017. The utilization projections by the three applicants, if realized, will significantly address the need for additional hospice services in Baltimore City.

The Commission has identified a need to "open up" Baltimore City to new hospice competitors as a possible way to stimulate hospice utilization and has also projected a need to serve additional hospice patients that is sufficient to permit approval of all three of the applications. Each of the applicants has shown an understanding of the need that MHCC seeks to address in this review and each has made demonstrated an ability to contribute to addressing that need. I believe that, in this situation in which the Commission seeks to accomplish significant growth in use of hospice services, the Commission should approve these three applications.

I find that each applicant satisfies the need criterion.

C. COMAR 10.24.01.08G(3)(c) AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

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.

[37] See discussion beginning at p. 17, *supra.*

Applicants' Responses	
Bayada	Bayada states that its experience and scale will bring efficiencies to the provision of hospice care for the residents of Baltimore City. It points out that it has provided home-based health care for over forty years, and is one of the largest private home-based health care organizations in the country, and operates hospice programs in New Jersey, Pennsylvania, Vermont, and New Hampshire (DI #B3, pp. 47-48; DI #B9, pp. 22-27).[38] It states that it is able to share centralized shared corporate support services, including electronic health records and claims systems that allow Bayada to interface with other providers to facilitate hospice admissions and improve care coordination. Bayada's states that its hospice programs are accredited by the Community Health Accreditation Program ("CHAP")[39] and has corporate accreditation from the Commission on Accreditation of Rehabilitation Facilities ("CARF")[40] in the area of habilitation. (DI #B9, p. 23).
Carroll Hospice	Carroll Hospice states that it has the "necessary experience and a 30-year history of caring for patients and families through end of life issues." Its nursing and hospice aide team members are certified in hospice and palliative care, and the supportive services staff members have credentials consistent with the National Hospice and Palliative Care Organization ("NHPCO") recommendations. Carroll Hospice has CHAP accreditation and participates in the Hospice Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") survey. (DI #C3, pp. 47-50). Carroll Hospice notes that it has increased patient volume by 40% over the last three years, and has one of the highest hospice use rates in Maryland. (DI #C3, pp. 49-50). Carroll Hospice states that it will work closely with the LifeBridge Health staff and volunteers and with the faith community leaders of the Interfaith Network in Baltimore City to identify specific needs in their congregations; educate volunteers on end of life care options; and identify champions within those communities to develop an advocacy network that addresses end of life issues. (DI #C10, p. 6) Carroll Hospice rejected the option of relying on the inpatient hospice services provided by Seasons Hospice at Northwest and Sinai Hospitals, and on existing providers in Baltimore City for outpatient hospice care because: (a) patients admitted to these inpatient hospice units do not benefit from the earlier introduction of home-based hospice care to reduce unnecessary hospital utilization; (b) patients and families may not respond to the continuum of care offered by Seasons; and (c) for whatever reason, the hospice providers currently

[38] Available at: https://www.bayada.com/hospice/our-locations.asp.
[39] Further information available at: https://education.chaplinq.org/chap-standards-of-excellence.
[40] Further information available at: http://www.carf.org/home/.

	serving Baltimore City have not been effective at increasing hospice utilization among the underserved population. (DI #C3, pp. 48-49).
P-B Health	P-B Health states that general hospice programs in Maryland are reimbursed at the same rate by Medicare and Medicaid, and that it distinguishes itself by its "over 22 years of experience servicing…the multicultural and the African American Communit[ies]…[making a] difference [through]…effective communication, outreach to the community, church organizations and [focus on] the care of the patient." (DI #P2, pp. 38-39). P-B Health provided copies of several recognitions it has received, including the Maryland House of Delegates Official Citation for outstanding quality of health care to the community and the Comptroller's Office Certification for Community Service as evidence of the quality of care its staff provides. (DI #P2, App. A, Exh. 35; DI #P6, App. F, Exh. 8).

Interested Party Comments

Comments on P-B Health's Application

Bayada's Comments:

Bayada questioned whether P-B Health, which it describes as "an entity with no hospice experience and which has suffered financial losses in two of the past three years," would be able to successfully deliver hospice services, stating that "P-B Health… proposes to provide less care, less often, than hospice patients in Baltimore City need and deserve." Bayada stated that P-B Health's projections included an unrealistically low average length of stay ("ALOS") of about three weeks compared to a national average of 72 days, "call[ing] into question its ability to increase access to hospice care, and positively impact end-of-life care for terminally ill patients," stating that "[e]ffective public education and outreach should translate into ALOS *gains* rather than losses, as the relevant stakeholders and communities become familiar with the new hospice and the benefits of hospice generally, and seek enrollment in the hospice earlier in the end-of-life phase."

Bayada also pointed out that P-B Health projected visits per admission that would be well below industry standards.[41] Bayada also pointed out that the "only discipline for which P-B Health has not estimated visits per admission well below industry standards is nursing, where P-B Health estimates visits per admission well above the industry standard," and that such a "high number of visits per admission is unsupported by P-B Health's staffing projections." This set of projections led Bayada to the conclusion that the apparent imbalance between nursing services and nursing staff "indicates that P-B Health is unprepared to undertake this project." (DI #10GF).

[41] Bayada presented data showing P-B Health's projected visits/patient for social workers, hospice aides, and chaplains that were well below the national averages complied by the National Hospice and Palliative Care Organization.

Applicants' Responses to Interested Party Comments

P-B Health's Response to Interested Party Comments of Bayada Hospice

In a modification to its original application submitted on July 24, 2017 which was timelyu made after the application was docketed (DI #P15, p. 3), P-B Health responded to Bayada's comments critiquing its projected service volumes and staffing levels, acknowledging "an error in its ALOS calculation…agree[ing] that updated budget and operating projections are warranted" and stated that it was providing such revisions in a modification to the application. (DI #13GF, p.6).

Reviewer's Analysis and Findings

The Hospice Services Chapter, which forms the basis for this review, is premised on the desirability of increasing the use of hospice services as a more cost-effective approach to meeting the medical care needs of most terminally ill persons, when compared with reliance on hospital or other institutional services. In establishing this review cycle for Baltimore City, the Commission took action that could possibly further its goal of reducing the expenses associated with end-of-life care and providing a more effective and satisfying approach to the care management needs of dying persons and their families. Thus, in this case, the burden of addressing this criterion is not focused on alternative approaches to meeting an objective. If each applicant can credibly demonstrate an ability to provide quality hospice care to Baltimore City residents, there are no substantive questions concerning the costs and effectiveness of alternatives that need to be addressed.

The responses to this criterion from Bayada and Carroll Hospice both evidenced this ability. P-B Health's response to this criterion focuses on its longstanding experience working in minority communities and its effectiveness in delivering home health agency services which, like hospice care, use a service delivery model that is primarily home-based.

In its comments on P-B Health's application, Bayada questions P-B Health's readiness to provide hospice services, basing its position on service and staffing projections that would call into question P-B Health's understanding of hospice service provision. My review raised similar questions, which I addressed at the April 10, 2019 project status conference. P-B Health modified its application, providing revised statistical, budget, and work force projections. I raised these questions not under the Availability of Cost Effective Alternatives criterion but under the Viability criterion that follows immediately.

I find each application satisfies this criterion.

D. COMAR 10.24.01.08G(3)(d) VIABILITY OF THE PROPOSAL

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.

Applicants' Responses	
Bayada	Bayada states that its status as the largest home health and hospice provider in the country suggests that its proposed entry into Baltimore City as a general hospice will be viable and sustainable. Bayada Home Health Care, Inc. provided a copy of its audited financial statements. (DI #B9, Exh. 64). Bayada described its business plan that projects "break-even by its second year through operating revenue generated by a sustained, reasonable pace of volume growth," projections that are based on "its experience in the Philadelphia Metro market which is similar to Baltimore City and in which BAYADA Hospice has already established hospice care programs." (DI #B3, p. 49). Bayada modified its application as a result of recommendations I made at the April 10, 2019 project status conference. At the project status conference, I questioned Bayada's projected revenue-per-patient-day ($221.20), which was approximately 24% higher than the average for Maryland general hospices and also questioned its projected cost per patient-day ($210.23), which was about 68% above the average for Maryland general hospices. In its modified application, Bayada submitted a revised Table 4, Part 1. Bayada stated that certain projected revenues and expenses (particularly Medicaid room and board) are 100% pass-throughs and should be excluded from calculations of revenue and cost per patient day…. With these adjustments, Bayada's projected revenue-per-patient day is $184.88 (instead of $221.20), and its projected cost-per-patient-day is $164.23 (instead of $210.23). Although these projected revenues and expenses are still higher than the Maryland average, Bayada believes that its projections are well-founded and reasonable, and that its proposed hospice program fully satisfies the viability criterion. (DI # B18, p. 10). Bayada's revised projections show its expectation it will break even in its first year of operation and turn a profit by the second full year of operation (2020). (DI #B18, Revised Table 4, Part 1).
Carroll Hospice	Carroll Hospice states that the total cost of the project is $52,750, which it identifies as the cost for preparing its CON application. The source of funds is available cash funded through existing operating cash reserves of Carroll Hospice and Carroll Hospital Center. (DI #C9, p. 24). Carroll Hospice provided a copy of its audited financial statements. (DI #C3, Exh. 11). It states that it based its charges on the Medicare per diem rate for hospice services and submitted a copy of the projected per diem rates for Medicare, Medicaid, and third party payers during completeness review. (DI #C9, pp. 24-25). Carroll Hospice projects that its Baltimore City hospice program will break even in its first year of operation and turn a profit by its second full year of operation (2020). (DI #3, Table 4, pp. 74-75). It states that the proposed project will not have an impact on charges for similar facilities. (DI #C3, p. 51). Carroll Hospice expects that as other hospice providers in the jurisdiction experience an increase in outpatient hospice volume, that the increase in patient

	volume "will increase the costs for existing providers with a corresponding increase in revenue based on applicable per diem rate for Federal and commercial payers." (DI #C3, p. 51).
P-B Health	P-B Health has submitted a number of revisions to its Project Budget, Statistical Projections, and Revenue and Expense statements during the review of this CON application both during application review and as a result of the project status conference. As previously discussed in this report, P-B Health submitted a modification on the 45th day after docketing with revised versions of its project budget and financial projections. (DI #P15). P-B Health submitted a modification to its CON stating the total cost of the project is $57,500. (DI #P15, Exh. 1, Table 1). These costs include: $10,000 for contingencies; $17,500 for CON legal fees and application costs; and $30,000 for working capital start-up funds. The applicant will fund this project with available cash. P-B Health submitted a copy of audited financial statements for CY 2014 through CY 2016. (DI #P15, Exh. 3). The financial statements indicate that the home health agency generated net income of $308,415 in 2015 but experienced losses in in 2014 ($221,985) and 2016 ($95,171). Operating since 1994, P-B Health states that the loss in 2014 was due "to upgrades to infrastructure and reorganization of its business to adjust to current business conditions." (DI #P6, p. 23). It states that these adjustments helped P-B Health increase its revenues by almost 20% in 2015. It indicates that the net income gain in 2015 helped to offset the loss incurred in 2016. (DI #P15, pp. 1-2). To document the financial strength of P-B Health as a 25-year provider of home health care services, the applicant submitted a letter from M&T Bank to provide an operating line of credit for short term borrowing needs and from Englare, Inc.[42] to provide accounts receivable financing up to $500,000. (DI #P15, Exh. 4) In addition, the applicant submitted a letter from Ted Payton Realty stating the owners of P-B Health had substantial equity of over $420,000 in property located in Baltimore City. (DI #P15, Exh. 5). The applicant submitted a prospective fee schedule for routine home care (DI #P6, p. 13). P-B Health states the establishment of its general hospice program will have little impact on existing Baltimore City hospices' costs and charges, who "will have room to grow their patient base to manage the projected unmet need." (DI #P6, p. 23). At the April 10, 2019 project status conference, I pointed out the following issues related to P-B Health's financial viability and recommended modifications: (1) P-B Health projects low productivity for nurses and hospice aides, which are 29% and 51%, respectively, below the Maryland hospice averages based on data from the 2016 Maryland Hospice Survey; and (2) P-B Health projects a revenue-per-patient day, at $216.66 per patient-day, which is

[42] Further information available at: http://www.englare.com/#.

	approximately 21% higher than the average for Maryland general hospices. (DI #20GF, p. 9). In response, P-B Health modified its applications, revising its financial projections as follows: Reduced projected admissions (2021) from 253 to 169 (33.2% decrease); Reduced projected patient days from 13,832 to 9,204 (33.5% decrease); Reduced projected nursing visits from 3,804 to 3,505 (7.9% decrease); Increased projected hospice aide visits slightly from 3,262 to 3,292 (0.9% increase); Reduced projected nursing full time-equivalents ("FTEs") from 6 to 4 (33.3% decrease); Reduced projected hospice aide FTEs from 5 to 2.75 (45.0% decrease). These modifications resulted in P-B Health revising its projected revenue per patient day, increasing from $216.66 to $217.32 (0.3% increase), while maintaining its ALOS at 52 days. (DI #P20, pp. 12-14). As a result of the project status conference, P-B Health modified its staffing to raise the productivity for its nurses from 634.0 to 876.25 annual nursing visits/FTE (about 38.2%) and for hospice aides from 652.4 to 1,197.1 annual hospice aide visits/FTE (around 83.5%), which would be more in-line with the averages observed for Maryland hospices for 2016 and with the two applicants in the Baltimore City review. With regard to the projected revenue per patient day of $216.66, P-B Health states that the reimbursement rate in Baltimore City for routine home care hospice days increased from $178.94 for 2016 to approximately $190 in 2019. (DI #P20, pp. 13-14). As a result, the applicant is confident that the projected revenues and expenses are comparable with hospice programs for this jurisdiction. With these revisions in staffing and utilization, the applicant projects the general hospice program will breakeven and turn a profit within the first year of operation. (DI #P20, Exhibit 11, Table 4).

Interested Party Comments

Comments on P-B Health's Application

Bayada's Comments

Bayada states that "P-B Health, an entity with no hospice experience and which has suffered financial losses in two of the past three years, proposes to provide less care, less often, than hospice patients in Baltimore City need and deserve." (DI #10GF, p. 2). Bayada states "P-B

Health fails to provide adequately the hospice services mandated in the Hospice Chapter,[43] that P-B Health projects treating hospice patients too late and too infrequently to be effective." (Ibid.).

To support this observation, Bayada states P-B Health estimates an unrealistically low average length of stay of less than three weeks per patient for its proposed program, declining from just under 21 days in 2018 to 19 days in 2021, whereas the NHCPO[44] reports that the ALOS nationally is about 72 days. Bayada questions P-B Health's ability to increase access to hospice care and positively impact end-of-life care for terminally ill patients with such a short ALOS. (DI #10GF, pp. 2-3). Bayada states "effective public education and outreach should translate into ALOS gains rather than losses," as patients and communities become familiar with the benefits of hospice generally and as patients seek enrollment in hospice care earlier in the end-of-life phase. Conversely, it is hard to create a positive end-of-life experience when the patient and family enter hospice care late and when they are typically in a state of crisis.

In addition, Bayada states P-B Health reports a number of disciplines have "projected visits per admission that are well below industry standards." (DI #10GF, pp. 3-5). Using the data submitted by P-B Health, the applicant indicates the number of visits per admission for social worker, hospice aides, paid physicians, and chaplain are lower than national averages reported for the year 2014 by NHPCO. Bayada questions how P-B Health can offer adequate and effective end of life care with so few patient encounters.

Bayada also pointed out that the "only discipline for which P-B Health has not estimated visits per admission well below industry standards is nursing, where P-B Health estimates visits per admission well above the industry standard," an estimate at odds with P-B Health's staffing projections, which project that just 0.8 FTE skilled nursing staff will provide 30.3 visits per admission for 75 admissions. Bayada questions whether P-B Health can achieve and sustain such a ratio.

Finally, Bayada questions whether P-B Health has the financial resources necessary to sustain and establish the new hospice program in Baltimore City, with operating losses of nearly $320,000 in 2014 and a loss of about $120,000 in 2016. Bayada questions P-B Health's financial viability for the hospice in Baltimore City, and what Bayada views as an unrealistic total project cost of only $7,500 to cover working capital start-up costs.

Applicants' Responses to Interested Party Comments

P-B Health's Response to Interested Party Comments of Bayada Hospice

P-B Health submitted timely modifications to its CON application after it was docketed. (DI #13GF; DI #P15). These changes included the following: (1) revised Project Budget and Tables 2B, Statistical Projections; Table 4, Revenue and Expense Statement; and Table 5, Manpower Information for CY 2021; (2) Updated Financial Statements and Independent Accountants' Compilation Report for the Years ended December 31, 2014, December 31, 2015, and December 31, 2016; (3) a letter from Austin L. Pearre, Business Banking, M&T Bank,

[43] COMAR 10.24.13.05C
[44] National Hospice and Palliative Care Organization

expressing an interest in extending an operating line of credit for short-term borrowing needs to P-B Health Home Care Agency, Inc., dated June 12, 2017. (4) a letter from Ted Payton, Broker, Ted Payton Realty, stating that Bailey & Associates, a company owned by the persons who own P-B Health Home Care Agency, Inc., has six properties located on Saint Paul Street in Baltimore with an appraised value of approximately $1.1 million and a total mortgage remaining of $678,700 (as of June 12, 2017), leaving an equity value of $421,200 to the owners of P-B Health; and (5) an additional five letters of support for the P-B Health CON application.

P-B Health states it is a "financially viable, capable provider of home based services [that] can be an effective addition to the health care delivery system," and that its expansion into hospice care in Baltimore City is "an appropriate and logical extension of its capabilities." (DI #13GF; DI #P15, p. 3).

Reviewer's Analysis and Findings

Carroll Hospice has been a general hospice in Maryland for many years and is part of LifeBridge Health. It currently operates in Baltimore, Carroll and Frederick Counties and would only need to expand these services in order to serve Baltimore City.

Bayada recently received CON approval to establish a general hospice in Baltimore City, which would be its first foray into the provision of hospice services in Maryland. It does, however, have experience in establishing viable hospice programs in other states and has demonstrated that it has the resources to implement the proposed project.

Over the course of the review P-B Health submitted three versions of its core projections covering service volume, revenues and expenses, and staffing. That seeming uncertainty led me to be concerned about P-B Health's business planning because it indicated a lack of knowledge of the hospice service line. On the other hand, P-B Health has successfully operated its home health agency operation for over twenty-five years. P-B Health did acknowledge that it had lost money in 2014 and 2016, but characterizes these losses as "not problematic results [in the context of]…a 25 year, successful experience…as a home health provider meeting the needs of a challenged patient population and community," and that [a]dding hospice capability will only strengthen P-B Health's performance." (DI #13GF).

In the case of P-B Health, I believe that P-B Health can obtain the financial and non-financial resources to implement the project and can probably sustain its project if it is successful in quickly generating a customer base. I believe that MHCC should allow P-B Health an opportunity to launch a new hospice program in Baltimore City. Baltimore City's low hospice use rate was the basis for creating this opportunity for new market entry and the lower acceptance and use of hospice services by the African American community is a primary reason for the relatively low use rate seen in Baltimore City. P-B Health has sought to distinguish its application by pointing to its many years of serving the African-American community as a home health agency, realized by its "effective communication, outreach to the community, church organizations and [focus on] the care of the patient." (DI #P2, p. 38-39).

I find that each of the applicants is consistent with the viability criterion.

E. COMAR 10.24.01.08G(3)(e) COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

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.

Applicants' Responses	
Bayada	At the time of this application, Bayada had not received a prior Certificate of Need from the Commission. (DI #B3, p. 52).
Carroll Hospice	The applicant has not received a prior Certificate of Need. Carroll Hospital Center acquired Carroll Hospice as an existing health care facility in 1995. Carroll Hospice received authorization to provide hospice services in Carroll, Baltimore and Frederick Counties on August 18, 2003 under the terms of Health General §19-906. (DI #C3, p. 52 and Exh. 12).
P-B Health	P-B Health received two CON approvals (1993 and 1994) authorizing it to establish home health agency services in the jurisdictions of Anne Arundel, Baltimore, and Howard Counties, and Baltimore City. The applicant complied with the terms of the CONs.

Reviewer's Analysis and Findings

At the time these applications were submitted, only P-B Health had received a prior Certificate of Need and appears to have complied with all conditions. On March 21, 2019, the Commission awarded CONs to both Bayada Hospice (Docket No. 16-16-2383) and to P-B Health Home Care Agency (Docket No. 16-16-2385) to establish general hospice programs in Prince George's County. Each applicant is currently in compliance with this criterion.

F. COMAR 10.24.01.08G(3)(f) IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

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.

Applicants' Responses	
Bayada	As previously discussed under the Impact standard, COMAR 10.24.13.05G, Bayada states that the establishment of additional hospice providers will have minimal impact on existing hospice programs in Baltimore City. (DI #B3, p. 29; DI #B9, pp. 10-11). It expects that projected growth in the population who need hospice services, combined with the new providers' efforts to expand hospice use will more than offset any volume loss existing providers might face.

	As to the broader impact on the health care system, Bayada states that its entry to the Baltimore City hospice market would decrease the cost of the health care delivery system and improve access to quality care. Bayada states that it "will help decrease the overall spending on end-of-life care, creating savings for the health care delivery system" by coordinating care and reducing unnecessary hospital admissions and readmissions. As an example, Bayada cited a 2007 Dartmouth Atlas study showing that the total average Medicare spending at the end-of-life is about $3,212 in the hospice setting, versus $26,511 in the inpatient setting and $9,335 in the skilled nursing facility setting. (DI #B3, pp. 53-54). Bayada also states hospice services increase care effectiveness. Based on findings from an article published in *Health Affairs*,[45] Bayada states "[T]raditional settings typically provide care that is highly fragmented and of poor quality," …[which] fail to help patients "in identifying individualized goals of care and developing comprehensive treatment plans to achieve these goals." This fragmented care in traditional settings leads to dissatisfying outcomes for patients. The article concludes by stating that "[h]ospice provides an effective, high quality approach to care . . . with reductions in symptom distress, improved outcomes for caregivers, and high patient and family satisfaction."
Carroll Hospice	As previously discussed in response to the Impact standard, COMAR 10.24.13.05G, Carroll Hospice expects projected growth in the general hospice market "will allow existing providers to increase volume even as an additional provider(s) enter the market." (DI #C3, p. 16). While Carroll Hospice acknowledges that market share for the existing providers will likely decline with the establishment of new hospice programs, it believes that the projected growth in the number of hospice cases in Baltimore City should allow each existing provider to increase its patient volume. (DI #C3, p. 52). Carroll Hospice states that the establishment of new hospice programs will positively affect the health care system by reducing hospital mortality rates and readmissions while improving patient satisfaction, reducing readmissions and potentially avoidable utilization among nursing home patients, and reducing the total cost of care. (DI #C3, pp. 52-53).
P-B Health	As previously discussed under the Impact standard, COMAR 10.24.13.05G, P-B Health expects the establishment of its general hospice program will help meet a portion of the unmet need identified for Baltimore City, but does not expect to have an adverse impact on the current hospice programs operating in the jurisdiction. (DI #P2, pp. 25-26). P-B Health states that providing hospice services in the home setting is more cost effective, will reduce costs for hospitalization, and decrease emergency

[45] Kelley, Amy S., *et al.* "Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay." *Health Affairs,* 32.3 (2013): 552-561 at p. 552.

	room visits. The applicant states that a change of setting from a hospital focus to home-based hospice services in the community "can lead to a more positive and comfort(able) level for the patient/caregiver, and their loved ones." (DI #P2, pp. 41-42).

Reviewer's Analysis and Findings

This CON project review criterion requires an applicant to address not only the impact on existing health care providers in the health planning region, but also the impact on access to services and on costs.

Impact on Existing Hospice Providers

I discussed the impact on existing health care providers earlier in this Recommended Decision under the impact standard, COMAR 10.24.13.05.G.[46] I summarized the applicants' common position that the amount of projected need in Baltimore City is sufficient to provide enough growth, assuming that the new entrants will combine with incumbent providers to boost the population's use of hospice services to a level more comparable with the state average, such that the applicant's entry into the market can be accommodated without shifting volume from existing providers.

My review focused on the size of the impact that would occur on the overall volume of service provided by existing hospices serving Baltimore City if the applicants succeed in realizing their projected business volumes, which would make them substantial providers of hospice care in this jurisdiction. The important existing providers of this service, which stand to lose the most potential future service volume, are all large enough to withstand the impact of successful competitors.

Impact on Access to Services and Costs

The impact criterion, COMAR 10.24.01.08G(3)(f), goes beyond the impact standard by requiring applicants to also address the "impact on geographic and demographic access to services…and on costs to the health care delivery system." The availability and access of hospice care in Baltimore City is likely to be enhanced by each applicant's project. Hospice services have the potential to dramatically lower the cost of care in the final stages of life, while often bringing a more satisfying experience for the patient and his or her family and loved ones. It is hoped that expanding the number of hospice providers operating in the jurisdiction will have a positive impact on demand for hospice services and, to the extent this occurs, it is very likely to have a positive impact on cost reduction.

In conclusion, I find that each applicant satisfies this criterion.

[46] See my discussion of the Impact standard, *supra*, pp. 17-21.

V. SUMMARY AND RECOMMENDATION

The latest data available shows Baltimore City to have one of the lower hospice use rates among the State's jurisdictions, 29% compared to 44% statewide and to the "target rate" of 48%. It is also one of the largest jurisdictions in the State. This combination of a low hospice use rate and a large population means that there is significant potential benefit if new hospice service providers can contribute to raising hospice use rates. That is the basis for the identification of Baltimore City as a jurisdiction that should be opened to additional hospice providers.

The Commission's goal is to encourage the development of new health care facilities and services when there is an identified need. While there are no guarantees that adding new hospice services providers in Baltimore City will raise use rates, it is the tool available to the Commission under current law.

The three applicants are proposing to establish hospice services in Baltimore City. Two of those applicants are experienced hospice services providers, although one of them, Bayada, has not yet begun providing hospices services in Maryland. It recently received approval to provide hospice services in Prince George's County, as did P-B Health, an existing home health agency serving four jurisdictions in Maryland.

I find that each applicant ultimately provided appropriate responses to the applicable standards in the Hospice Services Chapter, in compliance with the recommendations I made at the project status conference, and otherwise complied with the CON review criteria.

For reasons cited in this Recommended Decision, I recommend that the Commission approve the applications of Bayada, Carroll Hospice, and P-B Health for Certificates of Need to provide general hospice services in Baltimore City, with conditions that each shall:

1. Prior to first use approval, provide documentation of links it has established with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance Programs, adult day care programs, the Baltimore City Department of Social Services, and home delivered meal programs located within Baltimore City; and

2. Prior to first use approval, provide documentation of the arrangements it has made for providing respite care for families and other caregivers of patients.

IN THE MATTER OF	*	**BEFORE**
BALTIMORE CITY HOSPICE REVIEW	*	
	*	**THE**
BAYADA Home Health Care, Inc.	*	
d/b/a Bayada Hospice	*	**MARYLAND**
Docket No. 16-24-2387	*	
	*	**HEALTH CARE**
Carroll Hospice, Inc.	*	
Docket No. 16-24-2388	*	**COMMISSION**
	*	
P-B Health Home Care Agency, Inc.	*	
Docket No. 16-24-2389	*	
	*	

*** ***

FINAL ORDER

Based on the analysis and findings in the Reviewer's Recommended Decision, it is this 19th day of September 2019, **ORDERED**:

That each of the applications for Certificates of Need submitted by Bayada Home Health Care, Inc. d/b/a Bayada Hospice, Carroll Hospice, Inc., and P-B Health Home Care Agency, Inc. to provide general hospice services in Baltimore City is **APPROVED**, with conditions that each shall:

1. Prior to first use approval, provide documentation of links it has established with hospitals, nursing homes, home health agencies, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance Programs, adult day care programs, the Baltimore City Department of Social Services, and home delivered meal programs located within Baltimore City; and

2. Prior to first use approval, provide documentation of the arrangements it has made for providing respite care for the families and other caregivers of patients.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1

RECORD OF THE REVIEW

Record of the Review

General File for 2016 Baltimore City Hospice Review

Bayada Hospice – Docket #16-24-2387
Carroll Hospice – Docket #16-24-2388
P-B Health Hospice – Docket #16-24-2389

Item #	Description	Date
1GF	Representatives on behalf of: Bayada Home Health Care, Inc.; Caring Hospice Services; Carroll Hospice; and P-B Health Home Care Agency, Inc., each submitted, between August 17 through October 11 of 2016, a letter of intent seeking to establish a licensed general hospice program in Baltimore City. Commission staff acknowledges receipt of the four Letters of Intent on October 11, 2016.	10/11/16
2GF	Sign –in Sheet for the October 19, 2016 Baltimore City Hospice Pre-Application Conference	10/19/16
3GF	Commission staff requested the *Baltimore Sunpaper* publish legal notice of receipt of Certificate of Need ("CON") applications on December 9, 2016 from Bayada Hospice, Carroll Hospice, and P-B Health.	12/13/16
4GF	Commission staff requested that the *Maryland Register* publish notice of receipt of three CON applications.	12/14/16
5GF	*Baltimore Sun* published notice of receipt of three CON applications.	12/21/16
6GF	Commission staff requested the *Baltimore Sunpaper* publish formal start of review of CON applications for Bayada Hospice, Carroll Hospice, and P-B Health.	5/23/17
7GF	Commission staff requested the *Maryland Register* publish formal start of review of CON applications for Bayada Hospice, Carroll Hospice, and P-B Health.	5/23/17
8GF	*Baltimore Sun* sent affidavit of publication regarding formal start of review.	6/2/17
9GF	Johnathan Montgomery, Esq., Gordon-Feinblatt, LLC, submitted written comments on behalf of Bayada Home Health Care, Inc. to the CON application of Carroll Hospice.	7/10/17
10GF	Johnathan Montgomery, Esq., Gordon-Feinblatt, LLC, submitted written comments on behalf of Bayada Home Health Care, Inc. to the CON application of P-B Health Home Health Care, Inc.	7/10/17
11GF	Marta D. Harting, Esq., Venable, LLP, submitted written comments on behalf of Carroll Hospice to the CON applications of Bayada Health and P-B Health.	7/10/17

12GF	Peggy Funk, Executive Director of Hospice & Palliative Care Network of Maryland, submitted written comments on July 1, 2017 regarding concerns with the review of the CON applications for Baltimore City. Ben Steffen, Executive Director, Maryland Health Care Commission, acknowledged receipt of the letter and the Commission's review of three CON applications for general hospice services in Baltimore City.	7/21/17
13GF	Howard L. Sollins, Esq., Baker Donelson, submitted written Response to Interested Party Comments on behalf of P-B Health Home Care Agency, Inc., to the CON applications of Bayada Home Health Care, Inc. and Carroll Hospice.	7/24/17
14GF	Marta D. Harting, Esq., submitted Carroll Hospice's response to Bayada Hospice.	7/25/17
15GF	Commissioner Stephen B. Thomas announces appointment as the Reviewer, and recognized Carroll Hospice and Bayada as interested parties in the review of the Baltimore City Hospice review. The Reviewer acknowledged that P-B Health did not seek or qualify as an interested party in this review.	5/22/18
16GF	Commissioner Stephen B. Thomas determines need to conduct Baltimore City Hospice Review Project Status Conference Meeting and request availability of possible dates for meeting.	3/17/19
17GF	E-mail response from Margaret M. Witherup, Esq., Marta D. Harting, Esq., and Howard L. Sollins, Esq., regarding date for Project Status Conference Meeting	3/18/19-3/19/19
18GF	Sarah E. Pendley, Esq., submits e-mail response confirming date for Project Status Conference Meeting Is Monday, April 8, 2019 at 11:00 a.m.	3/28/19
19GF	Copy of sign-in sheet for Baltimore City Hospice Review Project Status Conference Meeting	4/8/19
20GF	Commissioner Stephen B. Thomas issues summary of findings from Baltimore City Hospice Review Project Status Conference Meeting to Bayada Hospice, Carroll Hospice, and P-B Health Home Care Agency, Inc.	4/10/19
21GF	Marta D. Harting, Esq. requests filing modification responses to Project Status Conference Meeting on May 21, 2019.	4/15/19
22GF	Howard L. Sollins, Esq., requests submission date for the modification responses be the same for all of the applicants.	4/15/19
23GF	Commissioner Stephen B. Thomas advises the three applicants that the submission date for the modification responses are due no later than 4:30 pm. on Tuesday, May 21, 2019.	4/25/19

Record of the Review

Bayada Hospice – Docket #16-24-2387

Item #	Description	Date
B1	J. Mark Baiada and Adam Groff, Bayada Home Health Care, Inc. submit letter of intent to establish general hospice program in Baltimore City.	9/19/16
B2	Letter of Support from Cyndi Davenport, Enclara Pharmacia.	9/26/16
B3	Johnathan Montgomery, Esq., Gordon Feinblatt, LLC, submits a Certificate of Need ("CON") application on behalf of Bayada Home Health Care, Inc. to establish a licensed general hospice program in Baltimore City.	12/9/16
B4	Commission staff acknowledges receipt of the CON application.	12/13/16
B5	Johnathan Montgomery, Esq. submits affidavit that Bayada has submitted a copy of its CON application to Baltimore City Health Department.	12/13/16
B6	Following completeness review, Commission staff requested additional information (revised completeness letter).	2/3/17
B7	Copy of e-mail sent to applicant with Word version of request for additional information attached.	2/7/17
B8	Exchange of e-mails between Johnathan Montgomery, Esq. and Commission requesting extension to file response to completeness questions to March 3, 2017.	2/14/17
B9	Commission staff receives responses to additional information request of February 3, 2017.	3/3/17
B10	After review of completeness responses, Commission staff requested additional information.	3/31/17
B11	Johnathan Montgomery, Esq., sends via e-mail a request for clarification to March 31, 2017 completeness questions.	4/10/17
B12	Commission staff sent notice of the docketing of Bayada's CON application.	5/23/17
B13	Commission staff sent request to the Baltimore City Health Department for review and comment.	5/23/17
B14	Margaret M. Witherup, Esq., submitted, on behalf of Bayada Hospice, a letter of support from Bernard C. "Jack" Young, President, Baltimore City Council.	9/17/18
B15a	Alison Hollender, Esq., submitted, on behalf of Bayada Home Health Care, Inc., notice seeking determination of exemption from CON review regarding internal restructure of Bayada effective December 31, 2018	10/9/18
B15b	Margaret M. Witherup, Esq., submitted request to amend the pending CON application with regard to a change of ownership effective	11/30/18

	December 31, 2018 from a solely owned shareholder to a new non-profit corporation.	
B16	Ben Steffen submitted to Alison Hollender, Esq. and Margaret M. Witherup, Esq., that the acquisition or change of ownership does not require CON review.	12/21/18
B17	Commission gives notice that Bayada Hospice has modified its CON application to reflect a change of ownership, and requests comments from public regarding this modification.	1/27/19
B18	Leslie M. Cumber, Esq., submitted modification responses to Project Status Conference held on April 8, 2019 and summary issued on April 10, 2019.	5/21/19

Record of the Review

Carroll Hospice – Docket #16-24-2388

Item #	Description	Date
C1	Regina M. Bodnar, Carroll Hospice, submits letter of intent to establish general hospice program in Baltimore City.	9/9/16
C2	Teresa A. Fletcher, Carroll Hospital, submits confirmation that Carroll Hospice meets the MHCC's General Docketing Criteria for establishing or expanding hospice services into a new jurisdiction.	10/24/16
C3	Marta D. Harting, Esq., Venable, LLP, submits a Certificate of Need ("CON") application on behalf of Carroll Hospice, Inc. to establish a general hospice program in Baltimore City.	12/9/16
C4	Commission staff acknowledges receipt of the CON application.	12/13/16
C5	Marta D. Harting, Esq. submits affidavit that Carroll Hospice has submitted a copy of its CON application to Baltimore City Health Department.	12/12/16
C6	Senator Thomas McLain Middleton, Legislative District 28, Charles County, submits letter of support for Carroll Hospice.	1/10/17
C7	Following completeness review, Commission staff requested additional information (revised completeness letter).	2/3/17
C8	Copy of e-mail sent to applicant with Word version of request for additional information attached.	2/7/17
C9	Exchange of e-mails between Marta D. Harting, Esq. and Commission requesting extension to file response to completeness questions to February 24, 2017.	2/15/17
C10	Commission staff receives responses to additional information request of February 3, 2017.	2/24/17
C11	After review of completeness responses, Commission staff requested additional information.	3/31/17
C12	Regina S. Bodnar submitted response to additional information request of March 31, 2017.	4/13/17
C13	Commission staff sent notice of the docketing of Carroll Hospice's CON application.	5/23/17
C14	Commission staff sent request to the Baltimore City Health Department for review and comment.	5/23/17
C15	Regina Bodnar submitted modification responses to Project Status Conference held on April 8, 2019 and summary issued on April 10, 2019.	5/21/19

Record of the Review

P-B Health Hospice – Docket #16-24-2389

Item #	Description	Date
P1	Matthew H. Bailey, Corporate Counsel & Chief Financial Officer for P-B Health Home Care Agency, Inc., submits letter of intent to establish general hospice program in Baltimore City.	10/3/16
P2	Lena M. Woody, submits on behalf of P-B Health Home Care Agency, Inc., a copy of the CON application to the Maryland Health Care Commission and Mr. Andrew L. Solberg to establish a hospice program in Baltimore City.	12/9/16
P3	Commission staff acknowledges receipt of the CON application.	12/13/16
P4	Following completeness review, Commission staff requested additional information.	2/3/17
P5	Copy of e-mail sent to applicant with Word version of request for additional information attached.	2/7/17
P6	Commission staff receives responses to additional information request of February 3, 2017.	2/17/17
P7	After review of completeness responses, Commission staff requested additional information, amended.	3/31/17
P8	Exchange of e-mails between Lena Woody and Commission requesting extension to file response to completeness questions to April 21, 2017.	4/11/17
P9	Lena Woody submitted response to additional information request of March 31, 2017.	4/14/17
P10	Lena Woody sent via e-mail additional information.	4/18/17
P11	Copy of P-B Health's response to Quality Assurance and Performance Improvement ("QAPI") table	4/18/17
P12	Commission staff sends via e-mail follow-up regarding response to two standards in the QAPI table that were left unanswered.	4/25/17
P13	Commission staff sent notice of the docketing of P-B Health's CON application.	5/23/17
P14	Commission staff sent request to the Baltimore City Health Department for review and comment.	5/23/17
P15	Howard L. Sollins, Esq., Baker Donelson, submitted on behalf of P-B Health Home Health Care Agency, Inc., a modification to the CON application that address the project budget; staffing and operating projections; financial information; letters of support; and miscellaneous information regarding care provided to hospice patients.	7/24/17
P16	Howard L. Sollins, Esq., submitted additional information to supplement the CON application.	8/21/17

P17	Howard L. Sollins, Esq., submitted additional information to supplement the CON application.	8/23/17
P18	Howard L. Sollins, Esq., submitted additional information to supplement the CON application.	9/11/17
P19	Howard L. Sollins, Esq., submitted additional information to supplement the CON application.	11/2/17
P20	Howard L. Sollins, Esq. submitted modification responses to Project Status Conference held on April 8, 2019 and summary issued on April 10, 2019.	5/21/19
P21	Howard L. Sollins, Esq., submitted revisions to Table: COMAR 10.24.13.05c: Minimum Services.	5/28/19

APPENDIX 2

BALTIMORE CITY
DEMOGRAPHICS AND SOCIO-ECONOMIC DATA

Table 1

2017 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender (January 2018))
Prepared by the Maryland Department of Planning, Projections and State Data Center

		0-44	% 0-44	65 plus	% 65 plus	Total
Baltimore City	**2010** Total	391,798	63.1%	72,812	11.7%	620,961
	2030 Total	383,582	61.4%	96,943	15.5%	625,084
State of Maryland	**2010** Total	3,467,938	60.1%	707,642	12.3%	5,773,552
	2030 Total	3,668,258	56.3%	1,310,434	20.1%	6,518,798

QuickFacts
Maryland; Baltimore City, Maryland (County); United States
QuickFacts provides statistics for all states and counties, and for cities and towns with a population of 5,000 or more.

Fact	Fact Note	Maryland	Value Note for Maryland	Baltimore City, Maryland (County)	Value Note for Baltimore City, Maryland (County)	United States	Value Note for United States
Population estimates, July 1, 2018, (V2018)		6,042,718		602,495		327,167,434	
Population estimates base, April 1, 2010, (V2018)		5,773,798		620,862		308,758,105	
Population, percent change - April 1, 2010 (estimates base) to July 1, 2018, (V2018)		4.70%		-3.00%		6.00%	
Population, Census, April 1, 2010		5,773,552		620,961		308,745,538	
Persons under 5 years, percent		6.10%		6.40%		6.10%	
Persons under 18 years, percent		22.30%		20.70%		22.60%	
Persons 65 years and over, percent		14.90%		13.60%		15.60%	
Female persons, percent		51.50%		53.00%		50.80%	
White alone, percent		59.00%		31.60%		76.60%	
Black or African American alone, percent	(a)	30.80%		63.00%		13.40%	
American Indian and Alaska Native alone, percent	(a)	0.60%		0.40%		1.30%	
Asian alone, percent	(a)	6.70%		2.80%		5.80%	
Native Hawaiian and Other Pacific Islander alone, percent	(a)	0.10%		0.10%		0.20%	
Two or More Races, percent		2.80%		2.10%		2.70%	
Hispanic or Latino, percent	(b)	10.10%		5.30%		18.10%	

White alone, not Hispanic or Latino, percent	50.90%	27.70%	60.70%
Veterans, 2013-2017	380,555	29,428	18,939,219
Foreign born persons, percent, 2013-2017	14.90%	8.00%	13.40%
Housing units, July 1, 2018, (V2018)	2,458,801	293,653	138,537,078
Owner-occupied housing unit rate, 2013-2017	66.80%	47.40%	63.80%
Median value of owner-occupied housing units, 2013-2017	$296,500	$153,200	$193,500
Median selected monthly owner costs -with a mortgage, 2013-2017	$1,954	$1,424	$1,515
Median selected monthly owner costs -without a mortgage, 2013-2017	$598	$525	$474
Median gross rent, 2013-2017	$1,311	$1,009	$982
Building permits, 2017	16,224	438	1,281,977
Households, 2013-2017	2,181,093	239,791	118,825,921
Persons per household, 2013-2017	2.68	2.48	2.63
Living in same house 1 year ago, percent of persons age 1 year+, 2013-2017	86.30%	83.10%	85.40%
Language other than English spoken at home, percent of persons age 5 years+, 2013-2017	18.00%	9.50%	21.30%
Households with a computer, percent, 2013-2017	90.20%	81.80%	87.20%

Households with a broadband Internet subscription, percent, 2013-2017		82.80%	69.50%	78.10%
High school graduate or higher, percent of persons age 25 years+, 2013-2017		89.80%	84.20%	87.30%
Bachelor's degree or higher, percent of persons age 25 years+, 2013-2017		39.00%	30.40%	30.90%
With a disability, under age 65 years, percent, 2013-2017		7.40%	11.70%	8.70%
Persons without health insurance, under age 65 years, percent		7.00%	7.60%	10.20%
In civilian labor force, total, percent of population age 16 years+, 2013-2017		67.50%	61.40%	63.00%
In civilian labor force, female, percent of population age 16 years+, 2013-2017		63.70%	59.90%	58.20%
Total accommodation and food services sales, 2012 ($1,000)	(c)	12,516,782	1,607,810	708,138,598
Total health care and social assistance receipts/revenue, 2012 ($1,000)	(c)	40,821,901	11,349,171	2,040,441,203
Total manufacturers shipments, 2012 ($1,000)	(c)	39,532,989	5,043,278	5,696,729,632
Total merchant wholesaler sales, 2012 ($1,000)	(c)	60,734,191	7,954,322	5,208,023,478

Total retail sales, 2012 ($1,000)	(c)	76,379,707		3,647,668	4,219,821,871
Total retail sales per capita, 2012	(c)	$12,980		$5,871	$13,443
Mean travel time to work (minutes), workers age 16 years+, 2013-2017		32.7		30.7	26.4
Median household income (in 2017 dollars), 2013-2017		$78,916		$46,641	$57,652
Per capita income in past 12 months (in 2017 dollars), 2013-2017		$39,070		$28,488	$31,177
Persons in poverty, percent		9.30%		22.10%	12.30%
Total employer establishments, 2016		138,480	1	12,555	7,757,807
Total employment, 2016		2,282,725	1	295,343	126,752,238
Total annual payroll, 2016 ($1,000)		121,952,023	1	18,040,257	6,435,142,055
Total employment, percent change, 2015-2016		1.90%	1	Z	2.10%
Total nonemployer establishments, 2016		487,540		39,520	24,813,048
All firms, 2012		531,953		50,735	27,626,360
Men-owned firms, 2012		276,630		21,952	14,844,597
Women-owned firms, 2012		209,119		24,599	9,878,397
Minority-owned firms, 2012		203,394		27,673	7,952,386
Nonminority-owned firms, 2012		314,902		20,782	18,987,918
Veteran-owned firms, 2012		50,976		4,216	2,521,682
Nonveteran-owned firms, 2012		462,232		43,918	24,070,685
Population per square mile, 2010		594.8		7,671.50	87.4

Land area in square miles, 2010	9,707.24	80.94	3,531,905.43
FIPS Code	"24"	"24510"	"00"

NOTE: FIPS Code values are enclosed in quotes to ensure leading zeros remain intact.

Value Notes

1 Includes data not distributed by county.

Fact Notes

(a) Includes persons reporting only one race

(b) Hispanics may be of any race, so also are included in applicable race categories

(c) Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data

Value Flags

- Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.

D Suppressed to avoid disclosure of confidential information

F Fewer than 25 firms

FN Footnote on this item in place of data

NA Not available

S Suppressed; does not meet publication standards

X Not applicable

Z Value greater than zero but less than half unit of measure shown

Table 1A. Total Resident Population for Maryland's Jurisdictions, April 1, 2010 to July 1, 2018

State/Jurisdiction	Census April 1, 2010	Census April 1, 2010 E	Estimate July 1, 2010	Estimate July 1, 2011	Estimate July 1, 2012	Estimate July 1, 2013	Estimate July 1, 2014	Estimate July 1, 2015	Estimate July 1, 2016	Estimate July 1, 2017	Estimate July 1, 2018
Maryland	5,773,552	5,773,798	5,788,642	5,838,991	5,887,072	5,923,704	5,958,165	5,986,717	6,004,692	6,024,891	6,042,718
Baltimore Region	2,662,691	2,662,813	2,667,917	2,685,285	2,706,108	2,719,847	2,731,507	2,741,294	2,745,220	2,748,920	2,752,538
Anne Arundel	537,656	537,631	539,277	544,744	550,311	555,438	559,691	563,502	567,665	571,592	576,031
Baltimore	805,029	805,229	806,560	812,797	818,023	822,238	825,006	827,471	828,616	828,603	828,431
Carroll	167,134	167,142	167,212	167,019	167,032	167,199	167,317	167,133	167,110	167,620	168,429
Harford	244,826	244,826	245,235	246,704	248,556	248,892	249,330	249,589	250,361	251,890	253,956
Howard	287,085	287,123	288,628	293,579	299,213	303,583	306,998	311,449	315,619	319,374	323,196
Baltimore City	620,961	620,862	621,005	620,442	622,973	622,497	623,165	622,150	615,849	609,841	602,495
Suburban Washington Region	2,068,582	2,068,704	2,076,238	2,102,775	2,127,365	2,147,324	2,168,257	2,184,845	2,195,408	2,208,004	2,217,523
Frederick	233,385	233,391	234,204	237,263	239,643	241,143	243,417	245,114	247,224	250,959	255,648
Montgomery	971,777	971,964	976,287	991,833	1,005,852	1,016,064	1,025,617	1,033,994	1,040,245	1,048,244	1,052,567
Prince George's	863,420	863,349	865,747	873,679	881,870	890,117	899,223	905,737	907,939	908,801	909,308
Southern Maryland Region	340,439	340,447	341,906	346,058	349,180	352,315	354,844	357,125	360,053	363,229	366,170
Calvert	88,737	88,739	88,988	89,318	89,715	90,438	90,545	90,468	91,028	91,365	92,003
Charles	146,551	146,565	147,156	149,182	150,660	152,649	154,373	155,692	157,336	159,451	161,503
St. Mary's	105,151	105,143	105,762	107,558	108,805	109,226	109,926	110,965	111,689	112,413	112,664
Western Maryland Region	252,614	252,616	252,841	253,476	252,936	252,524	251,716	251,013	251,091	250,935	251,064
Allegany	75,087	75,047	74,966	74,562	73,936	73,566	73,007	72,462	72,055	71,386	70,975
Garrett	30,097	30,139	30,141	30,148	29,964	29,964	29,649	29,435	29,371	29,261	29,163
Washington	147,430	147,430	147,734	148,766	149,036	148,994	149,060	149,116	149,665	150,288	150,926
Upper Eastern Shore Region	239,951	239,941	240,116	240,898	240,840	240,775	240,829	241,127	241,262	241,805	242,732
Caroline	33,066	33,078	33,054	32,887	32,631	32,647	32,535	32,591	32,836	33,108	33,304
Cecil	101,108	101,102	101,167	101,561	101,753	101,891	102,201	102,418	102,567	102,573	102,826
Kent	20,197	20,195	20,212	20,247	19,970	19,812	19,771	19,713	19,662	19,437	19,383
Queen Anne's	47,798	47,789	47,809	48,262	48,503	48,527	48,793	48,991	49,074	49,667	50,251
Talbot	37,782	37,777	37,874	37,941	37,983	37,898	37,529	37,414	37,123	37,020	36,968
Lower Eastern Shore Region	209,275	209,277	209,624	210,499	210,643	210,919	211,012	211,313	211,658	211,996	212,691
Dorchester	32,618	32,623	32,688	32,694	32,473	32,559	32,495	32,404	32,261	32,145	31,998
Somerset	26,470	26,470	26,464	26,253	26,034	25,960	25,577	25,684	25,837	25,913	25,675
Wicomico	98,733	98,733	98,971	100,051	100,556	100,850	101,368	101,800	102,136	102,363	103,195
Worcester	51,454	51,451	51,501	51,501	51,580	51,550	51,572	51,425	51,424	51,577	51,823

* 2010 Census estimates base reflects changes to the April 1, 2010 population due to the Census Count Question Resolution program.
Source: Population Division, U.S. Census Bureau, release date April 18, 2019
Prepared by the Maryland Department of Planning, Projections and State Data Center Unit, April 2019

2017 Total Population Projections for Non-Hispanic White, Non-Hispanic Black, Non-Hispanic Other and Hispanic by Age and Gender (January 2018))

Prepared by the Maryland Department of Planning, Projections and State Data Center

Baltimore City

	2010	2015	2020	2025	2030	2035	2040	2045
	Total	Total	Total	Total	Total	Total	Total	Total
0-4	41,152	38,201	38,475	38,110	38,121	36,863	39,141	37,485
5-9	35,441	35,686	33,495	33,918	33,979	33,963	33,386	34,207
10-14	34,339	33,585	34,489	32,543	33,339	33,288	33,904	32,717
15-19	44,278	37,047	37,628	39,120	37,779	38,395	39,679	39,287
20-24	56,460	50,872	42,028	43,869	44,458	44,489	48,258	47,721
25-29	57,675	62,340	56,671	46,348	49,925	48,597	51,647	54,511
30-34	45,889	53,199	58,011	53,073	43,838	47,051	46,463	48,311
35-39	37,565	42,031	49,338	53,979	49,947	41,211	44,548	43,544
40-44	38,999	35,913	40,560	47,743	52,196	48,185	40,154	42,681
45-49	43,572	36,903	34,503	39,171	46,407	50,470	46,994	38,743
50-54	43,873	41,077	34,937	32,812	37,303	44,191	48,029	44,410
55-59	37,978	40,383	38,347	32,810	31,131	35,396	42,274	45,332
60-64	30,928	33,579	36,123	34,491	29,718	28,239	32,340	38,292
65-69	22,098	25,968	28,596	30,925	29,685	25,419	24,338	27,583
70-74	16,454	17,754	21,364	23,818	26,261	25,219	22,062	20,693
75-79	13,397	12,420	13,741	16,723	19,063	21,007	20,677	17,518
80-84	10,513	8,765	8,502	9,584	12,061	13,794	15,899	14,957
85+	10,350	10,084	9,484	9,263	9,873	11,542	13,610	15,636
Total	620,961	615,807	616,292	618,300	625,084	627,319	643,403	643,628

State of Maryland

	2010	2015	2020	2025	2030	2035	2040	2045
	Total	Total	Total	Total	Total	Total	Total	Total
0-4	364,488	360,727	365,406	383,962	395,451	401,434	409,702	413,465
5-9	366,868	367,326	361,901	368,271	387,202	398,203	404,991	412,751
10-14	379,029	385,423	382,711	379,306	383,409	400,668	411,042	417,861
15-19	406,241	393,998	395,706	399,929	398,024	404,926	427,313	439,365
20-24	393,698	403,639	378,407	390,905	392,789	393,688	405,211	426,765
25-29	393,548	422,117	422,436	401,092	411,755	407,953	410,901	422,669
30-34	368,494	406,792	430,470	434,664	413,572	423,416	418,611	421,282
35-39	377,409	377,414	414,137	440,006	444,734	423,293	432,639	427,469
40-44	418,163	379,804	377,585	415,603	441,322	446,482	426,300	435,907
45-49	461,585	415,024	377,209	376,597	414,253	439,371	445,446	425,938
50-54	440,619	454,966	409,913	375,034	374,155	411,026	435,542	441,995
55-59	377,989	426,690	441,635	400,390	368,153	367,522	403,984	427,759
60-64	317,779	356,984	401,620	419,362	383,545	354,496	354,695	389,616
65-69	226,596	290,533	324,458	367,336	387,000	355,706	329,797	329,578
70-74	159,761	200,922	256,163	287,344	327,635	346,894	320,075	296,160
75-79	124,579	135,754	171,835	220,756	248,925	284,590	302,963	279,449
80-84	98,580	96,743	106,729	136,756	176,720	199,905	229,734	243,937
85+	98,126	113,544	123,487	139,274	170,154	217,422	265,566	316,652
Total	5,773,552	5,988,400	6,141,808	6,336,587	6,518,798	6,676,995	6,834,512	6,968,618

APPENDIX 3

BAYADA HOSPICE, CARROLL HOSPICE, AND P-B HEALTH HOSPICE
PROJECTED UTILIZATION AND
PROJECTED REVENUE AND EXPENSE STATEMENTS

T.__.E 2b

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2018	2019	2020	2021
Admissions	39	167	238	278
Deaths	24	128	186	223
Non-death discharges	5	27	41	49
Patients served	39	177	250	290
Patient days	1,755	8,346	13,099	16,692
Average length of stay	45	50	55	60
Average daily hospice census	10	23	36	46
Visits by discipline				
Skilled nursing	904	4,047	5,523	6,452
Social work	222	992	1,354	1,581
Hospice aides	990	4,431	6,047	7,064
Physicians - paid	18	80	109	128
Physicians - volunteer	N/A	N/A	N/A	N/A
Chaplain	136	608	830	969
Other clinical	25	112	153	179
Licensed beds				
Number of licensed GIP beds	N/A	N/A	N/A	N/A
Number of licensed Hospice House beds	N/A	N/A	N/A	N/A
Occupancy %	N/A	N/A	N/A	N/A
GIP(inpatient unit)	N/A	N/A	N/A	N/A
Hospice House	N/A	N/A	N/A	N/A

Assumptions

		1.50	3.21	4.58	5.35

FOR Reference only

		AVG Weekly Admits		
		Year 2	Year 3	Year 4
New Admits		1.48	1.91	2.13
New + Readmission	PA	3.21	4.58	5.35
New Admits		3.62	4.1	4.1
New + Readmission	VT	4.6	4.89	4.6
Average		3.21	4.58	5.35

REVISED TABLE 4 Part 1

		Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)		20_18_	20_19	20_20	20__21_
1. Revenue					
a. Inpatient services		$ 55,826	$ 238,041	$ 419,005	$ 516,726
b. Hospice House services		N/A	N/A	N/A	N/A
c. Home care services		$ 310,890	$ 1,328,808	$ 2,215,080	$ 2,711,166
d. Gross Patient Service Revenue		$ 366,816	$ 1,567,849	$ 2,634,085	$ 3,227,892
e. Allowance for Bad Debt[3]		$ -	$ 20,386	$ 30,460	$ 37,677
f. Contractual Allowance		$ 7,483	$ 31,984	$ 53,999	$ 66,496
g. Charity Care		$ 77,546	$ 20,386	$ 30,460	$ 37,677
h. Net Patient Services Revenue		$ 281,888	$ 1,495,093	$ 2,518,167	$ 3,086,044
i. Other Operating Revenues		$ 104,776	$ 502,717	$ 466,902	$ 606,297
	Medicaid Room and Board Pass Through Income				$ 516,817
	Service Intensity Add On Revenue				$ 89,480
j. Net Operating Revenue		$ 386,764	$ 1,997,810	$ 2,985,069	$ 3,692,340
2. Expenses					
a. Salaries, Wages, and Professional Fees, (including fringe benefits)		$ 305,057	$ 811,004	$ 1,360,569	$ 1,618,845
b. Contractual Services		$ 155,442	$ 722,017	$ 818,108	$ 1,025,823
	Medicaid Room and Board Expenses				$ 534,933
	GIP Expenses at 4.1% utilization (Baltimore City Average Rate)				$ 465,920
	Respite Expenses				$ 24,970
c. Interest on Current Debt		$0	$0	$0	$0
d. Interest on Project Debt		$0	$0	$0	$0
e. Current Depreciation		$ 3,500	$ 5,000	$ 7,500	$ 8,000
f. Project Depreciation		N/A	N/A	N/A	N/A
g. Current Amortization		N/A	N/A	N/A	N/A
h. Project Amortization		N/A	N/A	N/A	N/A
i. Supplies		$ 4,176	$ 17,712	$ 28,670	$ 35,964
j. Other Expenses (Specify)		$ 142,031	$ 450,217	$ 677,036	$ 820,527
k. Total Operating Expenses		$ 610,206	$ 2,006,950	$ 2,891,872	$ 3,509,158
3. Income					
a. Income from Operation		$471,592	$2,070,566	$3,089,988	$3,634,189
b. Non-Operating Income		$0	$0	$0	$0
c. Subtotal		$471,592	$2,070,566	$3,089,988	$3,634,189
d. Income Taxes		See footnote	See footnote	See footnote	See footnote
e. Net Income (Loss)		$ (223,442.08)	$ (8,140.19)	$ 93,197	$ 183,182

Modifications to this Table 4 Part 1 have been highlighted for ease of reference.

Carroll Hospice (DI #C3, Table 2B, p. 70 and Table 4, pp. 74-75)

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT

	Projected years – ending with first year at full utilization			
FISCAL YEAR	2017	2018	2019	2020
Admissions-unduplicated		123	290	482
Deaths		105	255	434
Non-death discharges		6	15	24
Patients served		123	302	515
Patient days		4,305	10,150	16,870
Average length of stay		35.0	35.0	35.0
Average daily hospice census		11.8	27.8	46.2
Visits by discipline				
Skilled nursing		1,446	3,426	5,690
Social work		203	481	799
Hospice aides		1,204	2,853	4,738
Physicians - paid		28	67	110
Physicians - volunteer		0	0	0
Chaplain		313	741	1,230
Other clinical-therapy		33	77	128
Licensed beds				
Number of licensed GIP beds		0	0	0
Number of licensed Hospice House beds		0	0	0
Occupancy %				
GIP(inpatient unit)		0%	0%	0%
Hospice House		0%	0%	0%

Carroll Hospice

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)

	Projected Years (ending with first full year at full utilization)			
FISCAL YEAR	2017	2018	2019	2020
1. Revenue				
a. Inpatient services		0	0	0
b. Hospice House services		0	0	0
c. Home care services		696,789	1,650,479	2,741,319
d. Gross Patient Service Revenue		696,789	1,650,479	2,741,319
e. Allowance for Bad Debt		(6,271)	(14,854)	(24,672)
f. Contractual Allowance		(22,459)	(52,953)	(87,549)
g. Charity Care		(6,109)	(14,716)	(24,845)
h. Net Patient Services Revenue		661,947	1,567,955	2,604,253
i. Other Operating Revenues (Specify)		0	0	0
j. Net Operating Revenue		661,950	1,567,955	2,604,253
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)		635,917	1,131,272	1,576,487
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies		68,648	162,607	270,078
j. Other Expenses (Specify)		248,646	435,193	648,560
k. Total Operating Expenses		953,211	1,729,072	2,495,125
3. Income				

a. Income from Operation		(291,265)	(161,117)	109,128
b. Non-Operating Income		0	0	0
c. Subtotal		(291,265)	(161,117)	109,128
d. Income Taxes		0	0	0
e. Net Income (Loss)		(291,265)	(161,117)	109,128

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
FISCAL YEAR	2017	2018	2019	2020
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare		90%	90%	90%
2. Medicaid		5%	5%	5%
3. Blue Cross		3%	3%	3%
4. Other Commercial Insurance		2%	2%	2%
6. Other (Specify)		0%	0%	0%
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare		90%	90%	90%
2. Medicaid		5%	5%	5%
3. Blue Cross		3%	3%	3%
4. Other Commercial Insurance		2%	2%	2%
5. Self-Pay		0%	0%	0%
6. Other (Specify)		0%	0%	0%
7. TOTAL	100%	100%	100%	100%

TABLE 2B: STATISTICAL PROJECTIONS – PROPOSED PROJECT
P-B HEALTH'S RESPONSE:

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2018	2019	2020	2021
Admissions	50	75	133	169
Deaths	40	68	102	151
Non-death discharges	4	6	10	14
Patients served	50	82	120	177
Patient days*	2,600	4,264	6,240	9,204
Average length of stay *	52	52	52	52
Average daily hospice census*	7	12	17	25
Visits by discipline				
Skilled nursing	990	1,624	2,376	3,505
Social work	170	277	408	603
Hospice aides	930	1,525	2,232	3,292
Physicians – paid	102	166	245	362
Physicians – volunteer	-	-	-	-
Chaplain	136	221	327	483
Other clinical	34	56	82	120
Licensed beds				
Number of licensed GIP beds	0	0	0	0
Number of licensed Hospice House beds	0	0	0	0
Occupancy %	0	0	0	0
GIP(inpatient unit)	0	0	0	0
Hospice House	0	0	0	0

Note The number of Patient Days equals the number of patients served (177) times the average number of days (52) or 9,204. (Table 2B (2).

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT
P-B HEALTH'S RESPONSE:

(INSTRUCTIONS: Each applicant should complete this table for the proposed project only)

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	2021—
1. Revenue				
a. Inpatient services **(Respite)**	63,692	103,606	152,860	225,894
b. Hospice House services	0	0	0	0
c. Home care services	501,228	822,014	1,202,947	1,774,347
d. Gross Patient Service Revenue	564,920	925,620	1,355,807	2,000,241
e. Allowance for Bad Debt	-4,700	-7,701	-11,280	-16,642
f. Contractual Allowance	-50,001	-81,927	-120,002	-177,041
g. Charity Care	-18,902	-30,971	-45,365	-66,928
h. Net Patient Services Revenue	491,317	805,021	1,179,159	1,739,630
i. Other Operating Revenues (Specify)	0	0	0	0
j. Net Operating Revenue	491,317	805,021	1,179,159	1,739,630
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	276,960	454,214	664,704	922,148
b. Contractual Services*	53,331	87,463	127,995	143,000
	0	0	0	0
d. Interest on Project Debt*	1,783	23,396	34,237	49,870
e. Current Depreciation	0	0	0	0
f. Project Depreciation	0	0	0	0
g. Current Amortization	0	0	0	0
h. Project Amortization*	5,355	8,782	12,852	18,720
i. Supplies*	35,664	58,489	85,594	124,674
j. Other Expenses (Specify)**rent, comm.,ins., and taxes***	26,748	43,867	64,195	93,506

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	2021
k. Total Operating Expenses*	384,132	650,447	951,674	1,351,917
3. Income				
a. Income from Operation*	107,185	154,574	227,285	387,712
b. Non-Operating Income	0	0	0	0
c. Subtotal*	107,185	154,574	227,285	387,712
d. Income Taxes*	-30,548	-44,053	-64,776	-110,498
e. Net Income (Loss)*	76,637	110,520	162,509	277,214

Table 4 Cont.	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	2021
4. Patient Mix				
A. As Percent of Total Revenue				
1. Medicare	70%	73%	75%	76%
2. Medicaid	10%	10%	12%	12%
3. Blue Cross	5%	4%	4%	3%
4. Other Commercial Insurance	13%	11%	7%	7%
6. Other (Specify)	2%	2%	2%	2%
7. TOTAL	100%	100%	100%	100%
B. As Percent of Patient Days/Visits/Procedures (as applicable)				
1. Medicare	60%	62%	64%	65%
2. Medicaid	18%	18%	20%	20%
3. Blue Cross	5%	4%	4%	3%
4. Other Commercial Insurance	14%	13%	9%	9%
5. Self-Pay	3%	3%	3%	3%
6. Other (Specify)	0	0	0	0
7. TOTAL	100%	100%	100%	100%