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STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

COMPREHENSIVE CARE FACILITY SERVICES

COMAR 10.24.20

PROPOSED PERMANENT REGULATION

Written Public Comments
Accepted Until 4:30 pm on January 7, 2019
Send To: Linda Cole
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.01 Incorporation by Reference.

This Chapter is incorporated by reference in the Code of Maryland Regulations.

.02 Introduction.

A. Purposes of the State Health Plan for Facilities and Services.

The Maryland Health Care Commission (Commission) has prepared this Chapter of the State Health Plan for Facilities and Services (State Health Plan) to ensure that actions by the Commission with respect to comprehensive care facilities, commonly known as nursing homes, are guided by the objective of meeting the current and future needs of Maryland residents.

The State Health Plan serves two purposes:

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

(2) It is the foundation for the Commission's decisions in its regulation of health care facilities and services in order to ensure that changes in health care facilities and services are appropriate and consistent with the Commission's policies. The State Health Plan articulates the policies guiding the Commission's regulation of health care facilities and services, establishes the criteria and standards that state the Commission's expectations about the facility or service development proposals it considers, and may contain methodologies that forecast need or demand for health care facilities or services, to inform the Commission and the public about appropriate considerations for Certificate of Need (CON) decisions.

The State Health Plan should provide a vision for positive change in the delivery of health care services. It should also provide useful guidance for resource allocation decisions that appropriately balance the population's need for available, accessible, affordable, and high quality health care services.

B. Legal Authority for the State Health Plan.

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

(1) The methodologies, standards, and criteria for Certificate of Need review; and

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

C. Organizational Setting of the Commission.

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

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

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

Health-General §19-110(a) provides that the Secretary of the Maryland Department of Health does not have power to disapprove or modify any regulation, decision, or determination that the Commission makes regarding or based upon the State Health Plan. The Commission has sole authority to prepare and adopt the State Health Plan and to issue Certificate of Need decisions and exemptions based on the State Health Plan. Health-General §19-118(e) provides that the Secretary shall make annual recommendations to the Commission on the State Health Plan and permits the Secretary to review and comment on the specifications used in its development. The Commission pursues effective coordination with the Secretary and State health-related agencies in its development of the State Health Plan and amendments.

D. Certificate of Need Applicability to a Comprehensive Care Facility

This Comprehensive Care Facility (CCF) Services Chapter comprises one component of the State Health Plan, which also addresses hospital, ambulatory surgery, hospice, home health agency, and other regulated health care facilities and services.

Under Health-General §19-120 and COMAR 10.24.01.02A, a Certificate of Need (CON) is required for the establishment of a CCF, the relocation of a CCF, the addition of bed capacity at a CCF, or a capital project by or on behalf of a CCF that exceeds an expenditure level established in law. Health-General §19-114(d)(2)(ii) contains an exception to Certificate of Need requirements that permits a continuing care retirement community to develop and operate a certain number of comprehensive care facility beds for subscribers to its community. Under Health-General §19-123, a continuing care retirement community is permitted to have limited direct admission to a CCF bed, provided that very specific circumstances are met.

This regulation fulfills the Commission's responsibility to adopt a State Health Plan at least every five years and to review and amend the plan annually, or as necessary, by superseding the current COMAR 10.24.08 and replacing it with this regulation.

.03 Issues and Policies.

A. Introduction.

Long term care refers to the array of medical, social, and support services needed by individuals who, because of chronic illness or disability, need help in caring for themselves over an extended period of time. Long term care services can include both institutional and community-based services for persons of all ages. This Chapter of the State Health Plan focuses on one aspect of institutional long-term care, the comprehensive care facility licensed under COMAR 10.07.02.

B. Statement of Issues and Policies.

(1) Comprehensive Care Facility Design.

Historically, comprehensive care facilities were intended to be "rest homes" or "old age homes," where persons were often sent to live out their remaining days. In the 1970s, as the importance of Medicare grew in paying for post-hospitalization rehabilitative services, comprehensive care facilities embraced a more medically-oriented model of care. As with hospitals, more patients were discharged from comprehensive care facilities "quicker and sicker," with the lighter care segment of patients migrating to home-based service delivery or assisted living facilities, and the case mix intensity of the average comprehensive care facility increasing. During the past 30 years, many comprehensive care facilities have embraced a "culture change" movement, adopting more person-centered care practices. Recent updates to the Medicare Conditions of Participation for comprehensive care facilities include a focus on person-centered care. Key elements of the culture change that have occurred are: resident direction; the provision of a more home-like environment; greater empowerment of staff and staff teams to adapt care practices, and procedures to improve residents' quality of life; and an emphasis on measuring and improving quality of care. A 2014 study found that adoption of culture change was associated with a 14.6% decline in health-related survey deficiencies. Culture change adoption, however, was not associated with changes in nurse staffing or Minimum Data Set (MDS)-based quality indicators.[1]

In addition, 2018 updates to the Facility Guidelines Institute's *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities* (FGI Guidelines) for design of health care facilities reflect the desire to move away from traditional designs considered to be overly institutional in character. This is responsive to consumer preferences. According to the 2018 FGI Guidelines, "design shall maximize opportunities for ambulation and self-care, socialization, and independence and minimize the negative aspects of a traditional environment."[2]

The most recent FGI Guidelines require no more than two residents per room with a shared toilet in new construction, and no more than four residents per room in renovations. Single resident rooms are encouraged. It also cites guidance from CMS as follows:

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[1] Grabowski, David, et.al. "Culture Changes and Nursing Home Quality of Care," *The Gerontologist*, Vol 54, Issue Supp 1, February 2014.

[2] Facility Guidelines Institute, *Guidelines for Design and Construction of Residential Health, Care, and Support Facilities*, 2018.

A3.1-2.2.2.1 (2) On October 4, 2016, the Centers for Medicare & Medicaid Services (CMS) published a final rule on the "Reform of Requirements for Long-Term Care Facilities," CMS-3260-F, in the *Federal Register*. This rule revises the requirements that long-term care facilities must meet to participate in the Medicare and Medicaid reimbursement programs. Effective November 28, 2016, each resident room must have a maximum capacity of two residents and a dedicated bathroom with at least a toilet and sink. Look for guidance on room configurations to meet CMS requirements under the Resources tab on the FGI website.[3]

Policy 1.0: The Commission will encourage comprehensive care facilities to adopt principles of person-centered care in the development of new or replacement comprehensive care facilities.

Policy 1.1: Comprehensive care facilities will be required to provide an appropriate living environment, consistent with the latest FGI Guidelines.

(2) Consumer Choice.

According to the 2016 Associated Press, National Opinion Research Center (AP-NORC) poll of adults 40 and older, 77 percent would prefer to receive care for themselves in their own home and 67 percent would prefer for their loved ones to receive care in a home setting. In the same poll, nearly four in ten (mistakenly, with respect to long-term nursing home care) expect to rely on Medicare to pay for their long-term care needs as they age."[4] Baby boomers will demand more choices for care as they age. However, public education is needed to improve the public's understanding of available options for financing their long-term care needs. Supplying up-to-date information, as described in the Commission's Consumer Guide to Long Term Care, is essential.

Another component of consumer choice is access to care. Although each jurisdiction in Maryland has at least one CCF, a small number of jurisdictions have only one or two facilities. Another issue is the quality of care provided at facilities. If residents do not have a choice of high quality providers, their access to care is limited.

The recent enhancements seen in hospitals and many physician practices for exchange of health information has not been matched in the CCF setting due, in part, to the lack of federal funding incentives. According to a report by the Office of the National Coordinator for Health Information Technology, about 64 percent of skilled nursing facilities (SNFs)[5] used electronic

[3] FGI Guidelines, 2018, Section A3.1-2.2.2.1(2).
[4] AP-NORC Poll at the University of Chicago. "Long-Term Care in America: Expectations and Preferences for Care and Caregiving." 2016.
[5] Skilled Nursing Facility (SNF) is a term used by CMS for nursing homes. These facilities are licensed in Maryland as comprehensive care facilities (CCF).

health records in 2016.[6] According to data collected from the Commission's Long Term Care Survey, 88 percent of Maryland's CCFs reported using an electronic health record in 2016.[7]

Expanding consumer choice is more than a question of geographic access. There is also the issue of financial access to care. The CCF Chapter of the State Health Plan has long required that CCFs that receive a CON participate in the Medicaid program and provide a level of Medicaid participation that is commensurate with other providers in their area, in accordance with the formula in Regulation .05A(2)(b) of this Chapter.

Policy 2.0: The Commission will continue to develop and disseminate consumer oriented information about long term providers in Maryland, including a full range of long term care services, as well as information on paying for such services.

Policy 2.1: The Commission will work with long-term care providers to assist in advancing the exchange of health information among different health care sectors in order to enhance the care of individuals in long-term care institutional and community-based settings.

Policy 2.2: The Commission will require that an applicant seeking a Certificate of Need to establish, expand, renovate, or replace a CCF serve an equitable proportion of Medicaid-eligible individuals in the jurisdiction or region. The Commission will permit a CCF holding a current Medicaid Memorandum of Understanding (MOU) to renegotiate its MOU, if requested, at the most recently published participation rates.

(3) Quality of Care.

The quality of care provided in CCFs, as well as other health care settings, has become an important focus on both the state and national level. The Center for Medicare and Medicaid Services (CMS) developed the Five-Star Quality Rating system for nursing homes in 2008. The data is posted on CMS' website, Nursing Home Compare[8], and has separate quality measures for long-stay and short-stay patients. It includes three domains: health inspections; staffing; and quality measures.

The development and use of quality measures to ascertain the performance of CCFs has evolved over time. In January 2015, CMS revamped its Star rating system for nursing homes to make it more robust and reliable. As part of this effort, CMS began verifying staffing levels with payroll data and a national auditing system under the Payroll-Based Journal (PBJ). The first mandatory reporting period began July 1, 2016. At that time, more new measures were added,

[6] Huaiquil, Amy. "Majority of Skilled Nursing Care Centers Use Electronic Health Records: Study", *Provider*, September 2017.
[7] http://mhcc.maryland.gov/mhcc/Pages/plr/plr_ltc/plr_ltc.aspx. Updates for 2016 reported by MHCC staff.
[8] Medicare.gov Nursing Home Compare: https://www.medicare.gov/nursinghomecompare/search.html?

along with changes to the methodology for development and application of such measures.[9] On November 1, 2017 CMS first posted a public use file using PBJ data.[10]

In addition, CMS announced that beginning in FY 2018, its Skilled Nursing Facility Quality Reporting Program will include a two percent reduction in SNF Prospective Payment System (PPS) payment rate that will be assigned to SNFs that fail to submit required data for quality measures.[11]

Policy 3.0: The Commission, through its Consumer Guide to Long Term Care, will report current data on comprehensive care facility services and quality of care metrics in order to assist consumers in decision-making regarding the selection of long-term care services.

Policy 3.1: The Commission will incorporate selected quality metrics from the most recent Nursing Home Compare quality measures into standards and rules used for Certificate of Need review of comprehensive care facility projects.

(4) Comprehensive Care Facilities in the Continuum of Health Care.

Comprehensive care facility services have evolved to become an integral component of a continuum of acute (hospital) and long-term care services in order to manage the care needs of many patients effectively. Federal policy initiatives, such as the IMPACT Act[12] have introduced value-based purchasing in the provision of comprehensive care facility services and requiring more cooperation and collaboration among providers to improve the quality of care.

The American Health Care Association (AHCA)[13] has set goals for 2015-2018 regarding post-acute care. These goals include: safely reducing the number of hospital readmissions within 30 days after hospital discharge during a skilled nursing center stay by an additional 15 percent; and increasing the rate of discharge back to the community by 10 percent.[14] In Maryland, the All Payer Model of hospital rate regulation has been reformed to enhance the focus on reducing avoidable hospital admissions and broadening the scope of this effort to post-acute care. The goal is to create incentives for hospitals to partner with comprehensive care facilities and other post-

[9] Design for *Nursing Home Compare* Five-Star Quality Rating System: Technical User's Guide, July 2016.
[10] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html
[11] "CMS finalizes 1% increase for SNFs FY 2018 payment rate and changes to quality programs." *Post-Acute Advisor*, August 1, 2017.
[12] The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-02-23-IMPACT.html
[13] The American Health Care Association is an association representing long term and post-acute providers.
[14] AHCA NCAL: *The Quality Initiative*, 2015-2018. https://www.ahcancal.org/quality_improvement/qualityinitiative/Documents/AHCA%20Quality%20Initiative%20Progress.pdf

acute providers to better "coordinate and optimize the use of acute care hospital services with post-acute and comprehensive care facility services. Options that may be considered include bundled payments and controlled relaxation of the three-day rule which requires a three-day hospital stay prior to comprehensive care facility admission for Medicare patients."[15]

Policy 4.0: The Commission will encourage hospitals and comprehensive care facilities to work together to reduce inappropriate and avoidable readmissions to hospitals and to provide quality care to individuals in the most appropriate and cost-effective setting.

Policy 4.1: The Commission will encourage comprehensive care facilities to work with other post-acute providers to improve overall quality of care and provide care in the most appropriate and cost-effective setting.

[15] HSCRC, *Medicare All-Payer Model Progression Plan*, December 16, 2016.

.04 Procedural Rules: Comprehensive Care Facilities.

A. Comprehensive Care Facility Home Docketing Rules.

(1) The Commission shall not docket an application involving an increase in comprehensive care facility bed capacity unless the jurisdiction in which the facility is, or will be located, has an identified need for additional comprehensive care facility beds on the date that the letter of intent for the project is filed and the proposed increase in beds does not exceed the identified need for additional beds.

(2) The Commission shall not docket an application involving establishment of a comprehensive care facility or changes to an existing comprehensive care facility unless the applicant provides an affirmation, under penalties of perjury, that, within the last ten years:

(a) No current or former owner or senior manager of the facility, of the operator, of the management organization, if any, or of any related or affiliated entity:

(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; or

(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; and

(b) Neither the facility, the operator, the management organization, if any, nor a current or former related or affiliated entity:

(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony;

(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; or

(iii) Has paid fines or penalties in excess of $10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charges relating to Medicare or Medicaid fraud or abuse.

(c) The applicant may show evidence as to why this rule should not be applied if all of the individuals involved in the fraud or abuse are no longer associated with the entity (or any of the related or affiliated entities) and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty or agreed disposition.

B. Docketing Rule Exceptions.

(1) The Commission may docket an application proposing the addition of comprehensive care facility bed capacity in a jurisdiction without an identified need for additional beds if more

than fifty percent of the comprehensive care facilities in the jurisdiction had an average overall CMS star rating of less than three stars in CMS's most recent five quarterly refreshes[16] for which CMS data is reported. In order to qualify for this docketing exception, the applicant must be:

(a) An existing comprehensive care facility in the jurisdiction that is proposing expansion of its bed capacity and had an average overall CMS star rating of at least three stars in the most recent five quarterly refreshes for which CMS data is reported, or;

(b) An applicant proposing a new comprehensive care facility in the jurisdiction that can document that all of the comprehensive care facilities it or any related entity operate had an average overall CMS star rating of at least three stars in the most recent five quarterly refreshes for which CMS data is reported.

(2) The Commission may docket an application by an existing freestanding comprehensive care facility with fewer than 100 beds that proposes a replacement facility with an appropriate expansion of bed capacity in a jurisdiction without identified need for additional beds if the applicant demonstrates that:

(a) Replacement of its physical plant is warranted, given the facility's age and condition; and

(b) The additional bed capacity proposed is needed to make the replacement facility financially feasible and viable.

(3) The Commission may docket an application proposing the addition of comprehensive care facility bed capacity in a jurisdiction without an identified need for additional beds if the applicant submits one or more acceptable signed agreements between it and one or more acute general hospitals that, at a minimum:

(a) Are approved by the Health Services Cost Review Commission;

(b) Fully detail an inter-facility partnership and an appropriate risk-sharing arrangement designed to lower the total cost of care for patients receiving comprehensive care facility services following an acute hospitalization;

(c) Will not shift costs to Medicaid for comprehensive care facility services; and

(d) Provide that:

(i) The applicant and each partnering hospital will share risks if total cost of care reductions are not achieved; and

[16] Five quarterly refreshes of CMS data includes eight consecutive quarters of data.

(ii) The applicant and each hospital will share rewards if cost reductions are achieved; or

(iii) The applicant will assume the entire risk if total cost of care reductions are not achieved.

(e) An applicant for this docketing exception shall demonstrate that a project adding additional bed capacity in the jurisdiction is necessary in order for the cost-reducing agreement between it and one or more hospitals to be effectively implemented; and that it meets all applicable standards under Regulation .05 of this Chapter.

C. Incremental Addition of Comprehensive Care Capacity.

The Commission will apply the following rules to a comprehensive care facility seeking to increase its comprehensive care facility bed capacity (commonly known as "waiver beds") pursuant to Health-General §19-120(h)(2)(i).

(1) Number of Additional Beds.

(a) The Commission will calculate the permitted maximum number of additional beds, which shall not exceed the lesser of ten beds or ten percent of the total licensed comprehensive care facility beds, based on the following:

(i) Total licensed comprehensive care facility beds at the facility; and

(ii) Documentation that the facility has the licensable, physical space to accommodate the additional beds requested consistent with the requirements of COMAR 10.24.20.05A(4).

(b) A facility shall not have at any given time more than 10 additional beds authorized pursuant to Health-General §19-120(h)(2)(i).

(c) A facility shall not request waiver beds as part of a CON application seeking to add beds.

(2) Time Period.

(a) The Commission shall only authorize additional beds pursuant to Health-General §19-120(h)(2)(i) if all of the facility's beds have been licensed and operational at the same site for at least two years and at least two years have passed since any temporarily delicensed beds were relicensed or permanently delicensed and at least two years have passed after any additional beds previously authorized under the provisions of Health-General §19-120(h)(2)(i) have been licensed.

(b) The Commission shall not authorize additional beds pursuant to Health-General §19-120(h)(2)(i) if the facility has increased or decreased its licensed bed capacity during the preceding two years or, if the facility has loaned, leased, transferred, or sold beds during the preceding two years.

(3) Use and Implementation of Comprehensive Care Facility Beds Authorized Pursuant to Health-General §19-120(h)(2)(i).

(a) Authorized beds may be implemented only at the facility for which the beds were approved and may not be loaned, leased, transferred, or sold.

(b) The Commission shall not authorize beds for a facility that has patient rooms with more than two beds unless the facility agrees to eliminate or reduce to the maximum extent possible the number of multiple bed rooms as a result of the bed addition.

(c) Bed additions shall be implemented and licensed within one year of the Commission's letter authorizing the bed addition. Any bed addition authorized but not implemented and licensed within one year will expire one year after approval and additional beds will not be authorized for the facility until two additional years have passed.

(d) A facility that has beds in the Commission's inventory as of the effective date of these regulations that were authorized more than one year before the effective date of these regulations will be considered null and void. However, the facility may seek authorization to add waiver beds without waiting two years if its licensed bed capacity has not changed in the two years preceding the request.

D. Acquisition of Comprehensive Care Facility.

The Commission shall apply the following rules to a person seeking to acquire a comprehensive care facility pursuant to Health-General §19-120. If Commission staff finds non-compliance with these rules, it shall not approve the acquisition.

(1) Notice of Acquisition. A person seeking to purchase a facility licensed entirely, or in part, as a comprehensive care facility shall provide the Commission with the notice required by COMAR 10.24.01.03A. The notice shall include:

(a) The identity of each person with an ownership interest in the acquiring entity or a related or affiliated entity;

(b) The percentage of ownership interest of each such person; and

(c) The history of each such person's experience in ownership or operation of health care facilities.

(2) Information and Disclosures Required. A person or entity subject to .04D of this Chapter shall:

(a) Affirm that the services provided will not change as a result of the proposed acquisition;

(b) Affirm that the commitment to Medicaid participation will not change as a result of the proposed acquisition and shall provide information on corporate structure and affiliations of the purchaser, purchase price, source of funds, and other relevant data as requested;

(c) Report the number and percentage of comprehensive care facility beds in the jurisdiction and planning region controlled by the person before and after the proposed purchase; and

(d) Affirm, consistent with Regulation .04A(2)(a) of this Chapter, under penalties of perjury, that within the last ten years no owner or former owner, or member of senior management or management organization, or a current or former owner or senior manager of any related or affiliated entity has been convicted of felony or crime, or pleaded guilty, nolo contendere, entered a best interest plea of guilty, received a diversionary disposition regarding a felony or crime, and that the applicant or a related or affiliated entity has not paid a civil penalty in excess of $10 million dollars that relates to the ownership or management of a health care facility.

(3) Disqualification for Acquisition. A comprehensive care facility may not be acquired, under .04D of this Chapter, by an entity with an owner or member of senior management or an owner or member of senior management of a related or affiliated entity who has been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime within the last ten years, unless all the individuals involved in the fraud or abuse are no longer associated with the entity (or any of its related or affiliated entities) and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty or agreed disposition, consistent with Regulation .04A(2)(a) of this Chapter**.**

E. Relocation of Never Licensed, CON-Approved Beds.

An application for a Certificate of Need to relocate a comprehensive care facility or a portion of a facility that includes never licensed, CON-approved beds will be reviewed for continuing need in accordance with the published bed need projections in effect when the Commission receives the letter of intent for the application.

F. Effective Date.

These regulations are effective for a Commission action or staff determination requested after the effective date of the regulations, regardless of the date on which the requesting facility received initial Commission approval or action.

.05 Comprehensive Care Facility Standards.

A. General Standards.

The Commission will use the following standards for CON review of all CCF projects.

(1) Bed Need and Average Annual Occupancy.

(a) For a relocation of existing comprehensive care facility beds currently in the inventory, an applicant shall demonstrate need for the beds at the new site in the same jurisdiction. This demonstration may include, but is not limited to, a demonstration of unmet needs by a particular patient population, high utilization of comprehensive care facility beds in the jurisdiction during the past five years, and the ways in which the relocation will improve access to needed services or improve the quality of comprehensive care facility services.

(b) An applicant proposing a project that will not add comprehensive care facility beds to a jurisdiction, but will add beds to an existing facility by relocation of existing licensed or temporarily delicensed comprehensive care facility beds within a jurisdiction, shall demonstrate that the facility being expanded operated all of its licensed beds at an occupancy rate of 90 percent or higher during the last two fiscal years for which the annual Maryland Long Term Care Survey data is available.

(2) Medical Assistance Participation.

(a) The Commission may approve a Certificate of Need for a comprehensive care facility only for an applicant that participates, or proposes to participate, in the Medicaid program, and only if the applicant submits documentation or agrees to submit documentation of a written Memorandum of Understanding (MOU) with Medicaid to maintain the proportion of Medicaid patient days required by .05A(2)(b) of this Chapter.

(b) Each applicant shall agree to serve and maintain a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other comprehensive care facilities in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus the 25th percentile value across all jurisdictions for each year[17] based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission, as published in the *Maryland Register*.

(c) An applicant for new comprehensive care facility beds has three years during which to achieve the applicable proportion of Medicaid participation from the time the facility is licensed,

[17] The required level of Medicaid participation is calculated as follows. For the most recent three years: (1) calculate the weighted mean of the proportion of Medicaid participation (defined as Medicaid patient days divided by total patient days) for each jurisdiction and region; (2) calculate the 25th percentile value for Medicaid participation in each jurisdiction; (3) subtract the 25th percentile value from the weighted mean value of Medicaid participation for each jurisdiction; (4) calculate the average difference for step 3 across all jurisdictions for each year; (5) calculate the average across all three years. The resulting proportion is subtracted from the weighted mean for each jurisdiction.

and shall show a good faith effort and reasonable progress toward achieving this goal in years one and two of its operation.

(d) An applicant that seeks to expand or replace an existing comprehensive care facility shall modify its MOU upon expansion or replacement of its facility to encompass all of the comprehensive care facility beds in the expanded or replaced facility and to include a Medicaid percentage that reflects the most recent Medicaid participation rate, unless the facility's existing MOU encompasses all beds at a percentage that is equal to or greater than the most recent Medicaid participation rate..

(e) An applicant shall agree to continue to admit Medicaid residents to maintain its required level of participation when attained and have a written policy to this effect.

(f) Prior to licensure, an applicant shall execute a written Memorandum of Understanding with the Medical Assistance Program of the Maryland Department of Health to:

(i) Achieve and maintain the level of Medicaid participation required by .05A(2)(b) of this Chapter; and

(ii) Admit residents whose primary source of payment on admission is Medicaid.

(g) An applicant may show evidence why this rule should not apply.

(3) Community-Based Services. An applicant shall demonstrate in writing its commitment to alternative community-based services and to minimizing the comprehensive care facility length of stay as appropriate for each resident and agree to:

(a) Provide information to every prospective resident about the existence of alternative community-based services, including Medicaid home and community-based waiver programs, Money Follows the Person Program, and other initiatives to promote care in the most appropriate settings;

(b) Use Section Q of Minimum Data Set (MDS) 3.0 to assess the individual's interest in and willingness to pursue community-based alternatives;

(c) Develop a discharge plan on admission with resident reassessment and plan validation at six-month intervals for the first 24 months. This plan is to be provided to the resident and/or designated representative; and

(d) Provide access to the facility for all long term care home and community-based services education and outreach efforts approved by the Maryland Department of Health and the Maryland Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.

(4) Appropriate Living Environment. An applicant shall provide to each resident an appropriate living environment that demonstrates compliance with the most recent FGI Guidelines. In addition, an applicant shall meet the following standards:

(a) In a new construction project:

(i) Develop rooms with no more than two beds for each resident room;

(ii) Provide individual temperature controls for each room;

(iii) Assure that no more than two residents share a toilet; and

(iv) Identify in detail plans to develop a comprehensive care facility that provides a cluster/neighborhood design or a connected household design, rather than an institutional design, consistent with the most recent FGI Guidelines.

(b) In a renovation or expansion project:

(i) Reduce the number of resident rooms with more than two residents per room;

(ii) Provide individual temperature controls in each newly renovated or constructed room;

(iii) Reduce the number of resident rooms where more than two residents share a toilet; and

(iv) Document that the applicant considered development of a cluster/neighborhood design or a connected household design, and, if the project includes an institutional model, document why the alternative models were not feasible.

(c) The applicant shall demonstrate compliance with Subsection .05A(4) of this Regulation by submitting an affirmation from a design architect for the project that:

(i) The project complies with applicable FGI Guidelines; and

(ii) Each design element of the project that deviates from the FGI Guidelines is justified by specific stated reasons.

(5) Specialized Unit Design. An applicant shall administer a defined model of resident-centered care for all residents and, if serving a specialized target population (such as, Alzheimer's, respiratory, post-acute rehabilitation) demonstrate that its proposed facility and unit design features will best meet the needs of that population. The applicant shall:

(a) Identify the types of residents it proposes to serve, their diagnostic groups, and their care needs;

(b) If developing a unit to serve respiratory patients, demonstrate the ability to meet Office of Health Care Quality standards in COMAR 10.07.02.14-1;

(c) If developing a unit to serve dementia patients, demonstrate the ability to meet Office of Health Care Quality standards and the most current FGI Guidelines.

(d) Demonstrate that the design of the comprehensive care facility is consistent with current FGI Guidelines and serves to maximize opportunities for ambulation and self-care, socialization, and independence. An applicant shall also demonstrate that the design of the comprehensive care facility promotes a safe and functional environment and minimizes the negative aspects of an institutional environment.

(6) Renovation or Replacement of Physical Plant. An applicant shall demonstrate how the renovation or replacement of its comprehensive care facility will:

(a) Improve the quality of care for residents in the renovated or replaced facility;

(b) Provide a physical plant design consistent with the FGI Guidelines; and

(c) If applicable, eliminate or reduce life safety code waivers from the Office of Health Care Quality and the Office of the Maryland State Fire Marshal.

(7) Public Water. Unless otherwise approved by the Commission and the Office of Health Care Quality in accordance with COMAR 10.07.02.26, an applicant for a comprehensive care facility shall demonstrate that its facility is, or will be, served by a public water system that meets the Safe Drinking Water Act standards of the Maryland Department of the Environment.

(8) Quality Rating.

(a) An applicant shall demonstrate, at the time of letter of intent submission, that at least 70 percent of all the comprehensive care facilities owned or operated by the applicant or a related or affiliated entity for three years or more had an average overall CMS star rating of three or more stars in CMS's most recent five quarterly refreshes for which CMS data is reported.

(i) If the applicant or a related or affiliated entity owns or operates one or more comprehensive care facilities in Maryland, the CMS star ratings for Maryland facilities shall be used.

(ii) If the applicant or a related or affiliated entity does not own or operate comprehensive care facilities in Maryland, CMS star ratings for such facilities in the states in which it operates shall be used.

(b) An applicant that is an existing Maryland comprehensive care facility shall document, at the time of letter of intent submission, that it had an average overall star rating of three or more stars in CMS's most recent five quarterly refreshes for which CMS data is reported, unless the facility has been owned or operated by the applicant for fewer than three years.

(c) An applicant shall demonstrate that it has an effective program of quality assurance functioning in each comprehensive care facility owned or operated by the applicant or a related or affiliated entity.

(d) An applicant that has never owned or operated a comprehensive care facility shall demonstrate its ability:

(i) To develop and implement a quality assessment and performance improvement plan, consistent with requirements of the Maryland Office of Health Care Quality; and

(ii) To produce high-level performance on CMS quality measures.

(9) Collaborative Relationships. An applicant shall document, by means of letters, for new applicants, and contracts, for existing facilities, its links with hospitals, hospice programs, home health agencies, assisted living providers, Adult Evaluation and Review Services, adult day care programs, and other community providers in the long term care continuum.

(a) An applicant shall demonstrate its commitment to effective collaboration with hospitals by documenting its successful efforts in reducing inappropriate readmissions to hospitals, improving the overall quality of care, and providing care in the most appropriate and cost effective setting. The demonstration shall include:

(i) Data showing a reduction in inappropriate hospital readmissions; and

(ii) Data showing improvements in the quality of care and provision of care in the most appropriate setting.

(b) An applicant shall demonstrate its commitment to providing an effective continuum of care by documenting its collaborative efforts with Medicare-certified home health agencies and hospices to facilitate home-based care following comprehensive care facility discharge and shall facilitate delivery of hospice services for terminally ill residents. The demonstration shall document that the applicant has:

(i) Planned for the provision of home health agency services to residents who are being discharged; and

(ii) Arranged for hospice and palliative care services, when appropriate, for residents who are being discharged.

.06 Methodology for Projecting Need for Comprehensive Care Facility Beds.

A. Geographic Area.

Comprehensive care facility bed need is projected on a jurisdictional basis.

B. Migration Assumptions.

(1) Migration into Maryland from all other states and utilization of unknown origin is taken into account in the bed need forecast, which assumes that the most recent pattern of migration from outside Maryland and unknown origin, in accordance with Regulation .06H(4), will remain the same from the base year to the target year.

(2) Out-migration from Maryland to adjacent and other states is assumed to remain constant.

(3) Migration among Maryland jurisdictions is taken into account by assuming that the most recent pattern of in- and out-migration for each jurisdiction of care, in accordance with Regulation .06H(6), will remain the same from the base year to the target year.

C. Period of Time Covered.

(1) The base year from which projections are calculated is the most recent calendar year for which all utilization and population data used in the projections are available.

(2) The target year is five years from the base year.

D. Service.

Projections are made for all nursing home beds licensed as comprehensive care facility beds.

E. Age Groups.

The following age groups are used: 0- 65, 65-74, 75-84, and 85 years and older.

F. Inventory Rules.

The following rules identify beds counted in the inventory used for calculation of jurisdictional net need for comprehensive care facility beds:

(1) Comprehensive care facility beds are counted in the jurisdiction where they are located;

(2) All licensed comprehensive care facility beds are counted;

(3) Comprehensive care facility beds that are Certificate of Need-approved but have not been implemented are counted;

(4) Waiver beds authorized under COMAR 10.24.01.03E(2) are counted; and

(5) Existing licensed beds that have been temporarily delicensed pursuant to COMAR 10.24.01.03C, are counted.

G. Data Sources.

(1) Maryland population estimates and projections by age group and jurisdiction are obtained from the most recent total population projections available from the Maryland Department of Planning.

(2) Comprehensive care facility utilization data are obtained from the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set (MDS) for Maryland.

(3) The number of licensed comprehensive care facility beds is obtained from program records of the Office of Health Care Quality and the Commission's records.

(4) The number of Certificate of Need-approved but unimplemented beds, waiver beds, and temporarily delicensed comprehensive care facility beds are obtained from the Commission's records.

H. Method of Calculation.

The Commission uses the following method to project need for comprehensive care facility beds in the target year:

(1) Base Year CCF Bed Use Rate Calculation

(a) Calculate the base year use rate by dividing base year patient days by age group and Maryland jurisdiction of residence, by the base year population by age group and jurisdiction of residence, and multiplying the result by 1,000.

(2) Forecasting Target Year CCF Bed Use Rate

(a) Calculate the target year use rate by age group and jurisdiction of residence by applying the following rules:

(i) Calculate the statewide use rate for the most recent six years by age group, by dividing statewide patient days by age group, by the corresponding year population by age group, and multiplying the result by 1,000.

(ii) Calculate average annual change in the statewide use rate by age group.

(iii) Calculate target year use rate by age group and jurisdiction of residence, by multiplying base year use rate by age group and jurisdiction of residence, by the statewide average annual use rate change by age group, year to year, from the base year to the target year.

(3) Forecasting Target Year CCF Bed Demand

(a) Calculate the target year patient days for each age group and each Maryland jurisdiction of residence, by multiplying the target year use rate for a given age group in the

jurisdiction of residence by the target year projected population for the same age group in the jurisdiction, and dividing the result by 1,000.

(b) Calculate target year total patient days for each Maryland jurisdiction of residence by summing patient days for all age groups in each jurisdiction of residence.

(4) Adjusting the Target Year CCF Bed Demand Forecast – Adjustment One: Accounting for Non-Maryland Residents and Patients of Unknown Origin

(a) Calculate the target year in-migration patient days from non-Maryland jurisdictions including patients originating outside Maryland and patients with unknown origin for each jurisdiction of care by using the following rules:

(i) Calculate the average in-migration patient days for each jurisdiction of care by summing the most recent three years of non-Maryland in-migration patient days and dividing by three.

(ii) Calculate the ratio of the average in-migration patient days in Step (4)(a)(i) to the base year patient days for each jurisdiction of residence.

(iii) Calculate the target year in-migration patient days for each jurisdiction of care by multiplying the ratio in Step (4)(a)(ii) by the target year patient days for each jurisdiction of residence in Step (3).

(b) Calculate the total target year patient days for each jurisdiction of care by adding the target year patient days originating from the same jurisdiction of care in Step (3) and the Non-Maryland patient days provided by the same jurisdiction of care in Step (4).

(5) Forecasting Target Year CCF Bed Need Using Adjustment One.

(a) Calculate the gross bed need for each jurisdiction of care by dividing the total target year patient days for the jurisdiction of care by the product of 365 and 0.95.

(b) Calculate the net bed need for each jurisdiction of care by subtracting the inventory of beds obtained using the rules in Subsections F(1)-(5) of this Regulation from the gross bed need for the jurisdiction in Step (5)(a).

(6) Adjusting the Target Year CCF Bed Need Forecast – Adjustment Two: Accounting for Inter-Jurisdictional Patient Migration in Maryland.

(a) Calculate the average net migration bed need for each jurisdiction of care by applying the following rules:

(i) Calculate the most recent three years of in-migration days from other Maryland jurisdictions for each jurisdiction of care by summing patient days from patients getting care in the jurisdiction's CCFs but originating in other Maryland jurisdictions.

(ii) Calculate the most recent three years of out-migration days for each jurisdiction of care by summing patient days from patients originating in the jurisdiction of care but getting care in another Maryland jurisdiction.

(iii) Calculate the most recent three years of net migration days for each jurisdiction of care by subtracting (6)(a)(ii) from (6)(a)(i).

(iv) Calculate the average net migration days for each jurisdiction by summing the most recent three years net migration days and dividing by three.

(v) Calculate the average net migration bed need by dividing the average net migration days by the product of 365 and 0.95.

(7) Forecasting Target Year CCF Bed Need Using Adjustments One and Two.

(a) Calculate adjusted bed need for each jurisdiction of care by summing the net bed need in Step (5) and the average net migration bed need in Step (6).

(8) Final Forecast of Target Year CCF Bed Need Adjusting for Low Jurisdictional Bed Occupancy.

(a) If a positive net bed need for a jurisdiction is projected in Step (7) but the average jurisdictional occupancy rate for the most recent 24-month period is below 90%, the bed need for that jurisdiction is adjusted to zero.

I. Mathematical Formula.

The need projection methodology described in .06H is shown here in mathematical form.

(1) Definition of Terms. Terms used in .06I(2) are defined as follows:

Term	Definition
i	Area of residence, where 1, …, 24 = 24 Maryland jurisdictions and other = non-Maryland states or unknown origin
j	Jurisdiction of care, where 1, …, 24 = 24 Maryland jurisdictions
k	Age group: under 65, 65-74, 75-84, and 85 years and over
y	Year
byr	Base year
BPD	Base year patient days
TPD	Target year patient days
BPOP	Base year population
TPOP	Target year population
BJRATE	Base year jurisdictional use rate
TJRATE	Target year jurisdictional use rate
SRATE	Statewide use rate
RATECHG	Annual change in statewide use rate
AAGR	Average annual growth rate
NONMDPD	Patient days originating outside Maryland or of unknown origin
TNONMDPD	Target year patient days originating outside Maryland or of unknown origin
GNEED	Gross bed need
INV	Inventory beds
NNEED	Net bed need
NMIGPD	Net migration patient days
NMIGNEED	Net migration bed need
ANEED	Adjusted bed need

(2) Formula. Need for comprehensive care facility beds in each jurisdiction of care is calculated as shown in the following table:

i. When i=1, …, 24, the base year jurisdictional use rate by age group $JRATE_{ki} = BPD_{ki}/BPOP_{ki}*1000$, where k=age groups: Under 65, 65-74, 75-84, and 85 years and over.

ii. Statewide use rate by age group $SRATE_{ky}=PD_{ky}/POP_{ky}*1000$, where y=byr, byr-1, …, byr-5

iii. Annual rate of change in statewide use rate by age group $RATECHG_{ky}=(SRATE_{ky}- SRATE_{k(y-1)})/ SRATE_{k(y-1)}$, where y=byr, byr-1, …, byr-4

iv. Average annual grow rate in statewide use rate by age group
$AAGR_k=(\sum_{y=(byr-4)}^{byr} RATECHG_{ky})/5$

v. Target year jurisdictional use rate by age group
$TJRATE_{ki}=JRATE_{ki}*(1+ AAGR_k)^5$

vi. Base year patient days for each jurisdiction of residence
$BPD_i=\sum_k BPD_{ki}$

vii. Target year patient days for each jurisdiction of residence
$TPD_i=\sum_k TJRATE_k*TPOP_{ki}$

viii. Ratio of average patient days originating outside Maryland or of unknown origin to the base year patient days originating in the same jurisdiction of care
$R_j=(\sum_{y=byr-2}^{byr} NONMDPD_{jy}/3)/ BPD_j$

ix. Target year patient days originating outside Maryland or of unknown origin
$TNONMDPD_j=R_j*TPD_j$

x. Gross bed need
$GNEED_j=(TPD_j+TNONMDPD_j)/(365*0.95)$

xi. Net Bed Need
$NNEED_j=GNEED_j - INV_j$

xii. Net migration patient days among Maryland jurisdictions in recent three years
$NMIGPD_{jy}= \sum_{i=1,i\neq j}^{24} PD_{jiy} - \sum_{j=1,j\neq i}^{24} PD_{ijy}$, where y=byr, byr-1, byr-2

xiii. Net migration bed need among Maryland jurisdictions
$NMIGNEED_j= (\sum_{y=byr-2}^{byr} NMIGPD_{jy}/3)/(365*0.95)$

xiv. Adjusted bed need
$ANEED_j=NNEED_j+ NMIGNEED_j$

J. Update, Correction, Publication, and Notification Rules.

(1) The Commission will update comprehensive care facility bed need projections at least every three years and publish the projections in the *Maryland Register*, including:

(a) Utilization data from the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set for Maryland; and

(b) The most recent inventory prepared by the Commission.

(2) Updates of comprehensive care facility (CCF) bed need projections will not include a jurisdiction that has an approved-but-unbuilt CCF or a jurisdiction that has a new CCF of 100 or more beds that has been in operation for less than two years.

(3) Updated projections published in the *Maryland Register* supersede any previously published projections in either the *Maryland Registe*r or in any chapter of the State Health Plan approved by the Commission.

(4) Published projections remain in effect until the Commission publishes updated comprehensive care facility bed need projections, and will not be revised during the interim other than to incorporate inventory changes or to correct errors in the data or computation.

(5) Published projections and Commission inventories in effect at the time of submission of a letter of intent will control projections of need used for that Certificate of Need review.

.07 Definitions.

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

B. Terms Defined.

(1) "Activities of daily living (ADLs)" means a major and widely used measure of physical function developed by Sidney Katz et al. in 1963; the six ADLs measured are: bathing; dressing; toileting; transferring; continence; and eating.

(2) "Adult day care" means a planned program offered in a group setting that provides services that improve or maintain health or functioning, and social activities for seniors and persons with disabilities. The services offered can vary but are designed to meet the needs of participants during the day, while allowing individuals to continue living with their families or in the community. Examples of services provided include physical and speech therapy, medication management, mental health services and support groups. Some day care programs may provide services for a specific population such as persons with Alzheimer's disease. Adult day care centers generally operate during daytime hours, Monday through Friday. A meal is typically provided as part of the program.

(3) "Adult Evaluation and Review Services (AERS)" means a Maryland Medicaid program that provides comprehensive evaluations for aged and functionally disabled adults who need long term care and are at risk for institutionalization. AERS staff are nurses and social workers. They identify services that can help individuals either remain in the community, or in the least restrictive environment where they are able to function at the highest possible level of independence.

(4) "Assisted Living Program" means a residential or facility-based program licensed under COMAR 10.07.14 that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of those services to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the individuals.

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

(6) "Certificate of Need-excluded continuing care nursing home beds" means beds in a continuing care retirement community certifiable by the Maryland Department of Aging under Title 10, Subtitle 4, of the Human Services Article, Annotated Code of Maryland, and Code of Maryland Regulations (COMAR) at 32.02.01that:

(a) Are for the exclusive use of the continuing care retirement community's subscribers who have executed continuing care agreements for the purpose of utilizing independent living units, or assisted living beds within the continuing care facility, except as provided in COMAR 10.24.01.03K;

(b) Do not exceed 20 percent of the number of independent living units at a continuing care retirement community that has 300 or more independent living units, or 24 percent of the number of independent living units at a continuing care retirement community that has fewer than 300 independent living units; and

(c) Are located on the campus of the continuing care retirement community.

(7) "Charity Care" means care for which there is no means of payment by the patient or any third-party payer.

(a) Charity care does not mean uninsured or partially insured days of care designated as deductibles or co-payments in patient insurance plans, nor that portion of charges not paid as a consequence of either a contract or agreement between a provider and an insurer, or a waiver of payment due to family relationship, friendship, or professional courtesy.

(b) Charity care does not include bad debt.

(8) "Community-based long term care services" includes a wide variety of personal care, health care, and other supportive services, provided to clients in their own homes, or in their community, to enable them to continue living at home, and to maintain as much independence as possible.

(9) "Comprehensive care facility (CCF)" means a nursing home facility licensed in accordance with COMAR 10.07.02 that admits residents requiring medical and nursing services rendered by or under the supervision of a registered nurse and who are either of advanced age or have a disease or a disability.

(10) "Continuing care" means furnishing shelter plus services consistent with the requirements COMAR 32.02.01 under all of the following conditions:

(a) Services consist of shelter plus health services;

(b) Health services provided shall include at least one of the following services:

(i) Medical and nursing services;

(ii) A formal arrangement between the provider and a nursing home by which the nursing home grants priority to subscribers for admission to the nursing home; or

(iii) Assistance with the activities of daily living other than the provision of meals.

(c) Services shall be paid for by the following method:

(i) An entrance fee in advance of receipt of services;

(ii) Regular periodic charges that guarantee health services when needed;

(iii) Purchase of services at the option of the subscriber as services are needed; or

(iv) Any combination of the arrangements in Subsection (c)(1)-(3) of this section.

(d) Services are offered to individuals who are:

(i) 60 years old or older, and

(ii) Not related to the provider by blood or marriage.

(e) Services are offered for:

(i) The life of the subscriber; or

(ii) A period in excess of one year; and

(f) Services are offered under a written agreement that may require periodic changes and shall require:

(i) A transfer of assets from the subscriber to the provider;

(ii) An entrance fee; or

(iii) Both a transfer of assets and an entrance fee.

(11) "Continuing Care Retirement Community" means a legally organized entity that provides continuing care in a facility that has been certified by the Office on Aging consistent with Human Services Article, Title 10, Subtitle 4, Parts I-V and VII-IX, Annotated Code of Maryland.

(12) "Existing beds" means licensed or CON-approved beds, but does not mean waiver beds determined not to require a Certificate of Need under COMAR 10.24.01.03 or temporarily delicensed beds under COMAR 10.24.01.03 C.

(13) "Freestanding" means a comprehensive care facility (CCF) that is not on the campus of a hospital, a continuing care retirement community, an assisted living facility, or any other health care or residential facility.

(14) "Home health agency" means a health-related organization, institution, or part of an institution that directly, or through a contractual arrangement, provides to a sick or disabled individual in the residence of that individual skilled nursing and home health aide services, and at least one other home health care service that is centrally administered, as provided under Health-General § 19-401, et seq., and as licensed by the Maryland Office of Health Care Quality under COMAR 10.07.10.

(15) "Hospice care program" means a program licensed by the Maryland Office of Health Care Quality under COMAR 10.07.21 as:

(a) "General hospice care program" means a coordinated, interdisciplinary program of hospice care services, provided in accordance with Health-General §19-901, for meeting the special physical, psychological, spiritual, and social needs of dying individuals and their families,

by providing palliative and supportive medical, nursing, and other health care services through home or inpatient care during the illness and bereavement:

(i) To individuals, who have no reasonable prospect of cure as estimated by a physician; and

(ii) To the families of those individuals; or

(b) "Limited hospice care program" means a coordinated, interdisciplinary program of hospice care services, provided in accordance with Health-General §19-901, for meeting the special physical, psychological, spiritual, and social needs of dying individuals and their families, by providing palliative and supportive non-skilled services through a home-based hospice care program during illness and bereavement:

(i) To individuals, who have no reasonable prospect of cure as estimated by a physician; and

(ii) To the families of those individuals.

(16) "Hospice house" means a residence operated by a Maryland licensed general hospice care program in accordance with COMAR 10.07.22 that provides home-based hospice services to hospice patients in a home-like environment and the care provided is not billed as general inpatient care.

(17) "Independent living unit: means a residential unit for the use of subscribers of a continuing care retirement community, but does not mean assisted living beds or comprehensive care beds.

(18) "Instrumental activities of daily living (IADLs)" means the home management activities identified as a measure of function developed by Lawton and Brody in 1969: handling personal finances; shopping; traveling; doing housework; using the telephone; and taking medications.

(19) "Jurisdiction" means any of the 23 Maryland counties or Baltimore City.

(20) "Licensed" means a facility that has received approval to operate from the Office of Health Care Quality of the Maryland Department of Health.

(21) "Long term care" means the array of medical, social, and support services needed by individuals who, because of chronic illness or disability, need another person's help in caring for themselves over an extended period of time.

(22) "Maryland Information and Assistance Program (MAP)" means a statewide program of information and assistance available for seniors through the Maryland Department of Aging. This service provides a single point of entry into the local aging network and information on services and benefits for older persons, their families, and caregivers. Staff in local offices throughout the state can help determine which services are needed and where they can be

(23) "Medicaid" means the Maryland Medical Assistance Program administered by the State under Title XIX of the Social Security Act to reimburse comprehensive medical and other health-related care for categorically eligible and medically needy persons.

(24) "Non-excluded continuing care nursing home beds" means those beds in a continuing care retirement community that do not meet all three of the provisions for exclusion from Certificate of Need found in Subsection B(7) of this Regulation, which:

(a) Are located in a continuing care retirement community certifiable by the Department of Aging under Article 70B, Annotated Code of Maryland;

(b) Require a Certificate of Need; and

(c) Shall meet all applicable rules and standards of this Chapter.

(25) "Nursing home" or "comprehensive care facility" means a health care facility licensed for comprehensive care beds under COMAR 10.07.02**.**

(26) "Nursing Home Compare" means a website developed by CMS that allows an individual to search for and compare nursing homes certified by Medicare and Medicaid. Information includes quality of care measures, staffing data, and health and fire safety inspections.

(27) "Nursing Home Compare Star Rating" means the overall CMS nursing home star rating, which is made up of three component ratings, each of which has its own star rating. The quarterly refresh of star ratings by CMS includes a combination of the three component ratings (health inspections from the past two years, staffing from the past quarter, quality measures from the past four quarters) to create an overall star rating.

(a) The first component, health inspections, is derived from annual state health inspection surveys. Results are based on the number, scope, and severity of deficiencies found during the past two most recent health inspections, and inspections due to complaints in the last two years. More weight is given to the most recent inspection(s). This component is based on comparisons within a state.

(b) The second component is staffing, which is based on registered nursing hours per resident day and on total staffing hours per resident day, each of which is case mix adjusted. Data are self-reported by nursing homes and confirmed using Payroll Based Journal reporting. The star rating is based on the most recent quarter.

(c) The third component is quality measures, which are derived from Minimum Data Set (MDS) data and Medicare claims data. Star ratings are based on performance on several long- and short-stay measures from the CMS Nursing Home Compare. The star rating is calculated based on the most recent four quarters for which data are available. Measures are risk adjusted.

(d) The overall star rating for one quarterly refresh on Nursing Home Compare is arrived at through the following steps:

(i) Step 1: begin with the health inspection rating;

(ii) Step 2: add one star to Step 1 if the staffing rating is four or five stars and greater than the health inspection rating. Subtract one star if the staffing rating is one star;

(iii) Step 3: add one star to Step 2 if the quality measure rating is five stars; subtract one star if the quality measure rating is one star. The overall rating cannot be more than five stars or less than 1 star; and

(iv) If the health inspection rating is one star, then the overall rating cannot be upgraded by more than one star based on staffing and quality.

(28) "Person" means an individual, receiver, trustee, guardian, executor, administrator, fiduciary, or representative of any kind and any partnership, firm, association, limited liability company, limited liability partnership, public corporation, or private corporation, or other entity.

(29) "Region" means one of the five areas of the State used in this Chapter for purposes of planning, for Certificate of Need review cycles, and for required Medicaid participation requirements. These areas include: Western Maryland (Allegany, Carroll, Frederick, Garrett, and Washington Counties); Montgomery County; Southern Maryland (Calvert, Charles, Prince George's, and St Mary's Counties); Central Maryland (Anne Arundel, Baltimore, Harford, Howard Counties and Baltimore City); and the Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties) .

(30) "Related entity" means any parent or subsidiary, or affiliate and includes any business, corporation, partnership, limited liability company or other entity in which the applicant, a parent or a subsidiary or affiliate holds 50% or greater ownership interest, directly or indirectly.

(31) "Residential service agency (RSA)" means an individual, partnership, firm, association, corporation, or other entity of any kind and licensed in accordance with COMAR 10.07.05 that is engaged in a nongovernmental business of employing or contracting with individuals to provide at least one home health care service, as defined in Health-General Article, §19-4A-01, Annotated Code of Maryland, for compensation to an unrelated sick or disabled individual in the residence of that individual or an agency that employs or contracts with individuals directly for hire as home health care providers

(32) "Respite Care" means formal services provided in a home, at an adult day care center, or by temporary nursing home placement, to functionally disabled or frail individuals to give informal caregivers occasional or systematic relief.

(33) "Senior Care Services Program" means a statewide program that assists residents at risk for nursing home placement in order to address their unmet needs and to allow them to remain living at home or in a caregiver's home. The program offers a variety of services and supports, such as personal care, delivered meals, and transportation assistance, all of which depends on the needs of the individual. The program is intended for individuals who have low incomes and limited assets, but too much money to qualify for Medicaid.

(34) "Senior Center" means a program supervised by the Maryland Department of Aging that provides services to seniors including but not limited to: exercise programs, health and

screening services, immunizations, health education seminars, and transportation. There are 112 senior centers in Maryland.

(35) "Subscriber" means a purchaser, or nominee, of a continuing care agreement.

(36) **"**Temporarily delicensed beds" means beds authorized by the Maryland Health Care Commission, consistent with COMAR 10.24.0103C, permitting the facility to remove beds from its license on a temporary basis that are maintained on the Commission's inventory for a period not to exceed one year.

(37) "Waiver beds" mean beds determined not to require a Certificate of Need under Health-General §19-120(h)(2)(i).