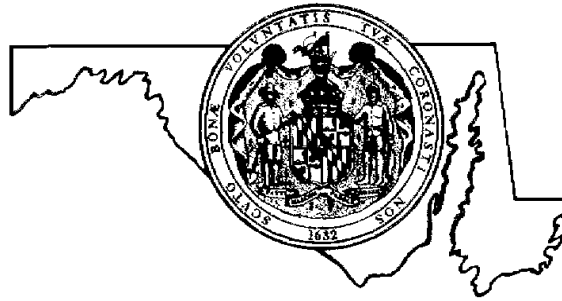


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STATE HEALTH PLAN FOR FACILITIES AND SERVICES:

NURSING HOME SERVICES

COMAR 10.24.08

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COMAR 10.24.08

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State Health Plan for Facilities and Services: Nursing Home Services

.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.

The Maryland Health Care Commission has prepared this Chapter of the State Health Plan for Facilities and Services (“State Health Plan” or “Plan”) in order to further the mission of health planning, which is to plan to meet the current and future health care system needs of all Maryland residents by assuring access, quality, and cost-effectiveness. The Commission views the State Health Plan, of which this Chapter is a part, as a policy blueprint for shaping and reshaping the health care system toward these ends, through the action of public agencies and the cooperation of private actors. Through the State Health Plan, the Commission undertakes an active role in proposing needed changes in the system, including the reallocation of resources to achieve a health care system that is cost-effective, and that balances considerations of affordability, access, and quality. In every aspect of the Plan, and in its individual Certificate of Need decisions, the Commission carefully weighs issues of quality of care and access to long term care services with considerations of quality and cost.

The State Health Plan serves two purposes:

- (1) It establishes health care policy to guide the Commission's actions and those of other health-related public agencies, and to foster specific actions in the private sector. Activities of State agencies must, by law, be consistent with the Plan.
- (2) It is the legal foundation for the Commission's decisions in its regulatory programs. These programs ensure that appropriate changes in service capacity are encouraged, and that all major expenditures for health care facilities are needed and consistent with the Commission's policies. The State Health Plan, therefore, contains policies, standards, and service-specific need projection methodologies that the Commission uses in making Certificate of Need decisions.

B. Legal Authority for the State Health Plan for Facilities and Services.

The Maryland Health Care Commission is given legal authority under Maryland Code Annotated, Health-General Article, §19-118 to develop and adopt the State Health Plan. Subsection §19-118(a)(2) states 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 Maryland Health Care Commission is an independent agency located within the Department of Health and Mental Hygiene for budgetary purposes. The purposes of the Commission, as provided under §19-103(c) are 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;
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;
3. Facilitate the public disclosure of medical claims data for the development of public policy;
4. Establish and develop a medical care data base on health care services rendered by health care practitioners;
5. Encourage the development of clinical resource management systems to permit the comparison of costs between various treatment settings and the availability of information to consumers, providers, and purchasers of health care services.
6. In accordance with Title 15, Subtitle 12 of the Insurance Article, develop a uniform set of effective benefits to be included in the Comprehensive Standard Health Benefit Plan, and a uniform set of effective benefits to be included in the Limited Health Benefit Plan;
7. Analyze the medical care data base and provide, in aggregate form, an annual report on the variations in costs associated with health care practitioners;
8. Ensure utilization of the medical care data base as a primary means to compile data and information and annually report on trends and variances regarding fees for service, cost of care, regional and national comparisons, and indications of malpractice situations;
9. Establish standards for the operation and licensing of medical electronic claims clearinghouses in Maryland;

10. Reduce the costs of claims submissions and the administration of claims for health care practitioners and payors;
11. Determine the cost of mandated health insurance services in the State in accordance with Title 15, Subtitle 15 of the Insurance Article;
12. Promote the availability of information to consumers on charges by practitioners and reimbursements from payors; and
13. Oversee and administer the Maryland Trauma Physician Services Fund in conjunction with the Health Services Cost Review Commission.

The Commission has sole authority to prepare and adopt the State Health Plan and to issue Certificate of Need decisions and exemptions therefrom.

Subsection §19-118(e) requires the Secretary of Health and Mental Hygiene to make annual recommendations to the Commission on the State Health Plan and permits the Secretary to review and comment on the specifications used in its development. However, §19-110(a) prohibits the Secretary from disapproving or modifying any determinations the Commission makes regarding the State Health Plan or other matters. The Commission pursues effective coordination with the Secretary and State health-related agencies in the course of developing its plans and plan amendments. As required by statute, the Commission coordinates its activities with the hospital rate-setting program of the Health Services Cost Review Commission to assure access to care at a reasonable cost. The Commission also coordinates its activities with the Maryland Insurance Administration. Subsection §19-117(c) empowers the Governor to notify the Commission of any intent to modify or revise the State Health Plan, or changes the Plan within 45 days of its receipt. Otherwise, the Plan becomes effective.

D. Plan Content.

This Nursing Home Services Chapter comprises one component of the overall State Health Plan for Maryland, which also addresses acute care, ambulatory surgery, obstetric, comprehensive rehabilitation, acute psychiatric, addictions, hospice, home health agency and other services.

Under §19-120 (j)(2)(iii)(4) of the Health-General Article, Annotated Code of Maryland and COMAR 10.24.01.02, a Certificate of Need is required for the establishment, or certain expansions, of a comprehensive care (nursing home) facility and chronic hospital. Commission statute, at §19-123, excludes certain comprehensive care beds in continuing care retirement communities from Certificate of Need review.

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: Nursing Homes.

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 section of the Chapter focuses on nursing homes, including facilities licensed as comprehensive care facilities (CCF). It also includes policies and standards for short-stay hospital-based skilled nursing facilities with beds licensed as comprehensive care or extended care, as well as special hospital-chronic facilities.

In Maryland, nursing homes are licensed as either comprehensive care or extended care facilities. Under regulations of the Office of Health Care Quality, a nursing home or “comprehensive care facility” is defined as “a facility which admits patients suffering from disease or disabilities or advanced age requiring medical service and nursing service rendered by or under the supervision of a registered nurse.”¹ An extended care facility license is required for “a facility which offers subacute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous hospital services.”²

This section of the Chapter addresses major issues underlying the policies developed for nursing home services in Maryland. These issues are organized into four major categories: nursing homes in the continuum of care; quality of care; consumer choice; and innovation. Supporting data on nursing homes may be found in the *Supplement to COMAR 10.24.08: Statistical Data Tables*.

B. Statement of Issues and Policies.

(1) Nursing Homes in the Continuum of Care

The aging of the baby boom generation, those born between 1946 and 1964, will increase the size of the future elderly population. This might not, however, translate into increased nursing home utilization. The use of nursing homes has declined with the development of other types of long term care services. Although the overall supply of nursing homes may be adequate, the physical stock of nursing homes is aging. Many nursing homes in Maryland are now 20 years old or older, and are in need of renovation or replacement. Data supplied by one corporate office for 28 nursing homes showed that the age of facilities ranged from 3 to 63 years with a mean facility age of 26 years.

Another corporate group with 14 Maryland facilities has nursing homes ranging in age from 2 to 46 years with a mean of 30 years.

¹ COMAR 10.07.02.01B(6)

² COMAR 10.07.02.01B (12)

The role of nursing homes is changing and evolving in response to changes in the larger health care system. Due to earlier discharges from acute care hospitals, residents of nursing homes are more acutely ill than they were ten to fifteen years ago. An analysis of data from the MDS (Minimum Data Set) shows an increase in short-stay residents and a decrease in overall lengths of stay with a concomitant increase in admissions per bed. There is now a bimodal distribution of residents, with nursing homes serving two distinct roles. One is a post-acute setting for those who need some short-term rehabilitation before they are discharged home. The other is the more traditional nursing home role of long-term residential care for persons who are increasingly frail and may be in the last months of their life. Nursing homes are also a setting for hospice care.

Consumers, however, see nursing homes as one of many options for care, and are often seeking residential care in other settings. There is increasing use of assisted living, adult day care, and enhanced services at home. This has been encouraged by *Olmstead v. L.C.*, (“Olmstead”) the 1999 Supreme Court decision which requires states to administer services, programs, and activities in the least restrictive setting appropriate to the needs of individuals with disabilities. Moreover, the Maryland Medicaid Program is seeking a waiver from the Centers for Medicare and Medicaid Services (CMS) to provide funding for more persons in community-based settings.³ All of these factors will require nursing homes to look outside of their own boundaries and form linkages to other parts of the health care system.

Policy 1.0 The Commission will assess the impact of nursing home physical plant age and design on quality of care, and encourage facilities to develop replacement facilities where needed.

Policy 1.1 The Commission will encourage nursing homes to establish transfer agreements and partner with other types of settings in order to integrate their services into the larger continuum of care.

(2) *Quality of Care.*

Along with the changes in the delivery of long term care, there is also increasing oversight from various local, state, and federal agencies responsible for assuring the quality of care provided in nursing homes. On the federal level, as Medicare is responsible for an increasing share of the cost of care provided in nursing homes, it is undertaking efforts to make sure that the dollars are spent in the most efficient and effective manner. Similarly, states, burdened by increasing costs to the Medicaid program, are looking for ways to reduce Medicaid’s share of long term care costs by the promotion of home and community-based services.

Quality oversight can be encouraged at several levels. In April 2002, CMS launched a six state test of its quality initiative; Maryland was one of the pilot states. The National Nursing Home Quality Initiative (NHQI) includes a web-based public report of quality measures called “Nursing Home Compare.” Maryland has been among the leaders in this initiative, launching its

³ Health General §15-141, effective 1/11/05.

own public report, a Nursing Home Performance Evaluation Guide in August 2001, including facility and resident characteristics, quality measures, and deficiency reports. During 2006, the Commission conducted a Nursing Home Family Satisfaction Survey, and is working on the adoption of a Resident Satisfaction Survey as well.

In addition, the Delmarva Foundation, the Quality Improvement Organization (QIO) for Maryland, has focused initiatives on four major quality measures: high-risk pressure ulcers; physical restraints; depression; and chronic pain. Delmarva works with nursing facilities to achieve improved outcomes for the initiatives and recognizes those facilities ranking in the top 5% of all nursing homes nationwide with quality excellence awards. In addition, the Office of Health Care Quality of the Maryland Department of Health and Mental Hygiene (DHMH) established a Health Care Quality Account for nursing homes in 2000. The account is funded through civil money penalties assessed to nursing homes for violation of standards. Monies in the account can then be awarded to facilities for use in training, grant awards, demonstration projects, and other projects designed to improve the quality of care in nursing homes.

Policy 2.0 The Commission will support the Department of Health and Mental Hygiene, including Medicaid and the Office of Health Care Quality, in efforts to improve and monitor the quality of care in nursing homes.

Policy 2.1 The Commission, through its Nursing Home Performance Evaluation Guide, will report current data on nursing home services and quality of care in order to assist consumers in decision-making regarding long term care services.

(3) *Consumer Choice.*

With the aging of the baby boom generation, there are increasingly more initiatives involving consumer choice. Aging baby boomers will not be content to be directed to a health care facility by their physician; they will want to have more choice in determining where they receive care. Supplying up-to-date information, as described in the Commission's Nursing Home Performance Evaluation Guide, will be essential. The Commission recently sought consumer input about the performance guides in order to be more responsive to consumer needs, and will continue to evaluate the guide on an ongoing basis.

Another component of consumer choice is access to care. Although each jurisdiction in Maryland has at least one nursing home, there are a small number of jurisdictions that have only one or two facilities. The Commission should encourage the development of services and programs to serve the residents of these jurisdictions. In addition to geographic access, there is also the issue of financial access. The State Health Plan has required that nursing homes that receive a Certificate of Need (CON) participate in the Medicaid program and provide a level of Medicaid participation that is commensurate with other providers in their area⁴. This continues to ensure access for all to needed quality long term care facilities and services.

⁴ The required level of Medicaid participation is calculated as follows. For the four years 2000-2003:

Having access to a full continuum of care is a benefit to consumers, but also raises the issue of the need to link various data from one setting to another. When a patient moves from one part of the continuum to another, data collection is often redundant and often begins again. There is a need to develop linkages, not only within the long term care system, but also between the acute and long term care systems. With almost 60% of nursing home admissions coming from acute care general hospitals, it would be a benefit to both consumers and providers to be able to share the data collected in the hospital with the nursing home.

There is a need for more consumer education about community alternatives and the ability to limit the length of stay in institutional settings. Although nursing homes will continue to provide an essential component of long term care services, the Commission encourages the development of an infrastructure in local communities to support services that can delay institutionalization.

Policy 3.0 **The Commission will work with the Department of Health and Mental Hygiene, the Health Facilities Association of Maryland (HFAM), Lifespan, the Maryland Department of Aging, and other interested groups to develop, streamline, and coordinate the necessary data and informational programs to assist consumers in selecting long term care services that include a full continuum of care, including institutional and community-based services.**

Policy 3.1 **The Commission will work with long term care providers to assist in the development of standards for the exchange of health information among different health care sectors in order to enhance the care of individuals in long term care settings.**

Policy 3.2 **The Commission will project the need for nursing home beds on a jurisdictional basis, making adjustments for the use of community-based services.**

Policy 3.3 **The Commission will require that an applicant seeking a Certificate of Need to establish, expand, renovate, or replace a nursing home serve an equitable proportion of Medicaid-eligible individuals in the jurisdiction or region. The Commission will work with Medicaid to develop a process by which providers holding a current Medicaid Memorandum of Understanding (MOU) can renegotiate their MOU, if requested, at the most recently published participation rates.**

(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 four years. The resulting proportion, 15.5%, is subtracted from the weighted mean for each jurisdiction.

(4) *Innovation.*

Just as consumers are seeking alternatives in the types of settings where care is provided, they are also demanding more options within the nursing home setting. Both in an effort to improve the quality of care, as well as to provide innovative programs for educated consumers, new models of care are emerging. There are several new models of care, such as, the Eden Alternative⁵, Wellspring⁶, and the Green House Project,⁷ that seek to restructure the way long term care services are provided. The Eden Alternative seeks to create “habitats for human beings” with an emphasis on animals, plants, and an enlivened environment. The Green House Project, an offshoot of the Eden Alternative, focuses on altering facility size, modifying interior design, and changing methods of delivering skilled professional services. This model focuses on self-contained dwellings for seven to ten people, with a large open kitchen, dining rooms, and central hearth and with each person having a private bedroom and bathroom. Wellspring integrates the concepts of resident-directed care, federal quality indicators, nationally-defined best practices, and a new leadership paradigm. These are but a few examples of types of models that have been developed both nationally and locally.

While these models of care might not be able to be developed in all nursing homes, they suggest different ways of approaching nursing home care. Features such as designing a facility to meet the clinical needs of its residents must be addressed in all nursing homes projects, and access to private bathrooms should be considered.

Policy 4.0 The Commission will work with applicants for Certificate of Need to encourage the development of innovative programs, both within nursing homes and between nursing homes and other health care providers.

⁵ www.edenalternative.com/about

⁶ www.wellspringis.org/ourstory

⁷ www.thegreenhouseproject.com

.04 Certificate of Need Procedural Rules: Nursing Homes.

A. Certificate of Need Nursing Home Merger Exemption Rules. Exemptions are permitted under this section, consistent with COMAR 10.24.01.04, to assure that merger and consolidation projects involving nursing home(s) meet statutory requirements, are not inconsistent with this or other Chapters of the State Health Plan, will result in the delivery of more efficient and effective health care services, and are in the public interest. A merged system or two or more entities proposing a merger, must satisfy the following requirements.

- (1) The project shall:
 - (a) Replace at least one obsolete physical plant, as defined in .16B(32) of this Chapter, or renovate that physical plant such that existing life safety code waivers granted by the Office of Health Care Quality and the State Fire Marshall's Office are no longer required; or
 - (b) Afford residents in each involved facility demonstrated advantages of existing or proposed special programs and services offered by one party to the merger or consolidation.
- (2) Each involved facility must attain or maintain the proportion of Medicaid participation applicable for its jurisdiction or region as required by .05A (2) of this Chapter.
- (3) The proposed merger or consolidation must be cost-effective.
- (4) Each involved facility shall provide details on the improvements to the quality of care for all affected residents that result from the proposed project.
- (5) Each involved facility must have Medicare-certified beds.
- (6) Each involved facility shall provide an appropriate living environment including, but not limited to:
 - (a) In a new construction project:
 - i. No more than two beds for each patient room;
 - ii. Individual temperature controls for each patient room; and
 - iii. No more than two residents sharing a toilet.
 - (b) In a renovation project:
 - i. Reduce the number of patient rooms with more than two residents per room;
 - ii. Provide individual temperature controls in renovated rooms; and
 - iii. Reduce the number of patient rooms where more than two residents share a toilet;

- (c) An applicant may show evidence as to why this rule should not be applied to the applicant.
- (7) Each involved facility has met all conditions of each previous Certificate of Need.
- (8) The applicant shall disclose whether any of the principals of each involved facility have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.
- (9) The applicant shall report the number and percentage of nursing home beds in the jurisdiction and planning region controlled by the applicant before and after the proposed merger.
- (10) If a facility that is included in the merger or consolidation is not a nursing home, portions of other Chapters of the State Health Plan applicable to the project shall also be met.
- (11) If the merger results in only one facility, the merged entity must meet .04A(1)-(9) of this Chapter.

B. Nursing Home Waiver Bed Rules. The Commission will apply the following rules to a facility seeking to increase or decrease its bed capacity pursuant to Health-General Article §19-120 (h)(2)(i), Annotated Code of Maryland.

(1) Calculation of Waiver Beds.

- (a) The determination of the right to obtain waiver beds is based on increases or decreases in bed capacity deriving from changes in licensed beds, Certificate of Need-approved beds, waiver beds, and temporarily delicensed beds obtained pursuant to COMAR 10.24.01.03E.
- (b) The Commission will calculate the number of allowable waiver beds based on the following:
 - (i) Total licensed capacity of the facility; and
 - (ii) Documentation that the facility has the licensable, physical space to accommodate the waiver beds consistent with the requirements of COMAR 10.24.08.05A(5).

- (c) A facility cannot have more than 10 unlicensed waiver beds at any given time.

(2) ***Time Period.***

- (a) The Commission will only authorize waiver beds if all of a facility's beds have been licensed and operational at the same site for at least two years.
- (b) The Commission will not authorize waiver beds if a facility has increased or decreased its licensed capacity during the last two years.
 - (i) The Commission will not authorize waiver beds if the facility has loaned, leased, transferred, or sold beds during the last two years.
 - (ii) The Commission will only authorize waiver beds two years after any temporarily delicensed beds are relicensed or relinquished.
 - (iii) The Commission will only authorize waiver beds two years after all previously authorized waiver beds have been licensed.

(3) ***Use and Implementation.***

- (a) Waiver beds authorized may be implemented only at the facility that applied to add the beds and may not be loaned, leased, transferred, or sold.
- (b) The Commission will not approve a Certificate of Need that includes the sale, loan, lease, or transfer of licensed beds, if the applicant has, or will receive, beds from an entity that has replaced or will replace the loaned, leased, transferred, or sold beds with waiver beds.

C. Purchase of Nursing Home. The Commission will apply the following rules to persons seeking to purchase a facility pursuant to Health General Article §19-120.

- (1) ***Notice of Purchase.*** A person seeking to purchase a facility licensed entirely, or in part, as comprehensive care, must provide the Commission with the notice required by COMAR 10.24.01.03A.
- (2) ***Information Required.*** A person subject to .04C of this Chapter must affirm that the services provided will not change as a result of the proposed acquisition, and must provide information on corporate structure and affiliations of the purchaser, purchase price, source of funds, and other relevant data as requested.

(3) ***Disclosure.***

(a) A person subject to .04C of this Chapter shall report the number and percentage of nursing home beds in the jurisdiction and planning region controlled by the person before and after the proposed purchase.

(b) A person subject to .04C of this Chapter shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

D. Relocation of Never Licensed, CON-Approved Beds. An application for a Certificate of Need to relocate a nursing home or a portion of a facility that includes never licensed, Certificate of Need-approved beds will be reviewed for continuing need in accordance with the published bed need projections in effect at the time of the letter of intent for the application.

E. Effective Date. These regulations are effective for a Commission action and 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 Nursing Home Standards.

A. General Standards. The Commission will use the following standards for review of all nursing home projects.

- (1) ***Bed Need.*** The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review.
- (2) ***Medical Assistance Participation.***
 - (a) Except for short-stay, hospital-based skilled nursing facilities required to meet .06B of this Chapter, the Commission may approve a Certificate of Need for a nursing home only for an applicant that participates, or proposes to participate, in the Medical Assistance Program, and only if the applicant documents a written Memorandum of Understanding 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 a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus 15.5%⁸ based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the ***Supplement to COMAR 10.24.08: Statistical Data Tables***, or in subsequent updates published in the *Maryland Register*.
 - (c) 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.
 - (d) Prior to licensure, an applicant shall execute a written Memorandum of Understanding with the Medical Assistance Program of the Department of Health and Mental Hygiene to:
 - (i) Achieve or maintain the level of participation required by .05A 2(b) of this Chapter; and
 - (ii) Admit residents whose primary source of payment on admission is Medicaid.

⁸ For explanation of the derivation of this percentage, see Statement of Issues and Policies, 3. Consumer Choice above.

- (iii) An applicant may show evidence why this rule should not apply.
- (3) ***Community-Based Services.*** An applicant shall demonstrate commitment to providing community-based services and to minimizing the length of stay as appropriate for each resident by:
- (a) Providing information to every prospective resident about the existence of alternative community-based services, including, but not limited to, Medicaid home and community-based waiver programs and other initiatives to promote care in the most appropriate settings;
 - (b) Initiating discharge planning on admission; and
 - (c) Permitting access to the facility for all “Olmstead” efforts approved by the Department of Health and Mental Hygiene and the Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.
- (4) ***Nonelderly Residents.*** An applicant shall address the needs of its nonelderly (<65 year old) residents by:
- (a) Training in the psychosocial problems facing nonelderly disabled residents; and
 - (b) Initiating discharge planning immediately following admission with the goal of limiting each nonelderly resident’s stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.
- (5) ***Appropriate Living Environment.*** An applicant shall provide to each resident an appropriate living environment, including, but not limited to:
- (a) In a new construction project:
 - (i) Develop rooms with no more than two beds for each patient room;
 - (ii) Provide individual temperature controls for each patient room; and
 - (iii) Assure that no more than two residents share a toilet.

- (b) In a renovation project:
 - (i) Reduce the number of patient rooms with more than two residents per room;
 - (ii) Provide individual temperature controls in renovated rooms; and
 - (iii) Reduce the number of patient rooms where more than two residents share a toilet.
 - (c) An applicant may show evidence as to why this standard should not be applied to the applicant
- (6) **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 nursing home shall demonstrate that its facility is, or will be, served by a public water system.
- (7) **Facility and Unit Design.** An applicant must identify the special care needs of the resident population it serves or intends to serve and demonstrate that its proposed facility and unit design features will best meet the needs of that population. This includes, but is not limited to:
- (a) Identification of the types of residents it proposes to serve and their diagnostic groups;
 - (b) Citation from the long term care literature, if available, on what types of design features have been shown to best serve those types of residents;
 - (c) An applicant may show evidence as to how its proposed model, which is not otherwise documented in the literature, will best serve the needs of the proposed resident population.
- (8) **Disclosure.** An applicant shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.
- (9) **Collaborative Relationships.** An applicant shall demonstrate that it has established collaborative relationships with other types of long term care providers to assure that each resident has access to the entire long term care continuum.

B. New Construction or Expansion of Beds or Services. The Commission will review proposals involving new construction or expansion of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed, using the following standards in addition to .05A(1)-(9):

(1) *Bed Need.*

- (a) An applicant for a facility involving new construction or expansion of beds or services, using beds currently in the Commission's inventory, must address in detail the need for the beds to be developed in the proposed project by submitting data including, but not limited to: demographic changes in the target population; utilization trends for the past five years; and demonstrated unmet needs of the target population.
- (b) For a relocation of existing comprehensive care facility beds, an applicant must demonstrate need for the beds at the new site, including, but not limited to: demonstrated unmet needs; utilization trends for the past five years; and how access to, and/or quality of, needed services will be improved.

(2) *Facility Occupancy.*

- (a) The Commission may approve a nursing home for expansion only if all of its beds are licensed and available for use, and it has been operating at 90 percent or higher, average occupancy for the most recent consecutive 24 months.
- (b) An applicant may show evidence why this rule should not apply.

(3) *Jurisdictional Occupancy.*

- (a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.
- (b) An applicant may show evidence why this rule should not apply.

(4) ***Medical Assistance Program Participation.***

- (a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A 2(b) of this Chapter.
- (b) 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, and must show a good faith effort and reasonable progress toward achieving this goal in years one and two of its operation.
- (c) An applicant for nursing home expansion must demonstrate either that it has a current Memorandum of Understanding (MOU) with the Medical Assistance Program or that it will sign an MOU as a condition of its Certificate of Need.
- (d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to include a Medicaid percentage that reflects the most recent Medicaid participation rate.
- (e) An applicant may show evidence as to why this standard should not be applied to the applicant.

(5) ***Quality.*** An applicant for expansion of an existing facility must demonstrate that it has no outstanding Level G or higher deficiencies, and that it maintains a demonstrated program of quality assurance.

(6) ***Location.*** An applicant for the relocation of a facility shall quantitatively demonstrate how the new site will allow the applicant to better serve residents than its present location.

C. Renovation of Facility. The Commission will review projects involving renovation of comprehensive care facilities using the following standards in addition to .05A(1)-(9).

- (1) ***Bed Status.*** The number of beds authorized to the facility is the current number of beds shown in the Commission's inventory as authorized to the facility, provided:
 - (a) That the right to operate the facility, or the beds authorized to the facility, remains in good standing; and
 - (b) That the facility provides documentation that it has no outstanding Level G or higher deficiency reported by the Office of Health Care Quality.

- (2) ***Medical Assistance Program Participation.*** An applicant for a Certificate of Need for renovation of an existing facility:
 - (a) Shall participate in the Medicaid Program;
 - (b) May show evidence as to why its level of participation should be lower than that required in .05A2(b) of this Chapter because the facility has programs that focus on discharging residents to community-based programs or an innovative nursing home model of care;
 - (c) Shall present a plan that details how the facility will increase its level of participation if its current and proposed levels of participation are below those required in .05A2(b) of this Chapter; and
 - (d) Shall agree to accept residents who are Medicaid-eligible upon admission

- (3) ***Physical Plant.*** An applicant must demonstrate how the renovation of the facility will improve the quality of care for residents in the renovated facility, and, if applicable will eliminate or reduce life safety code waivers from the Office of Health Care Quality and the State Fire Marshall's Office.

.06 Chronic Hospitals and Hospital-Based Skilled Nursing Facility Standards.

A. Chronic Hospitals. The Commission will use the standards in this section to review applications for special hospital-chronic beds:

- (1) ***Need.*** An applicant shall quantitatively demonstrate the specific unmet needs it proposes to meet in its service area, by number of patients, principal and additional diagnoses, and expected length of stay.
- (2) ***Financial Access.*** An applicant shall agree to accept patients whose primary payer source is Medicare and Medicaid.
- (3) ***Facility Occupancy.*** An applicant shall propose to serve and maintain at least an 85 percent average annual occupancy level.
- (4) ***Jurisdictional Occupancy.***
 - a. The Commission may approve a Certificate of Need application for a new chronic hospital or a new chronic hospital service at an existing health care facility only if every chronic hospital in the jurisdiction has maintained, on average, an 85 percent or higher occupancy level, for the latest 12-month period, as shown in the Health Services Cost Review Commission's Current Rates Report for the latest fiscal year. Each December, the Commission will issue a report on chronic hospital occupancy.
 - b. The applicant may show evidence why this standard should not apply.
- (5) ***Financial Viability.*** Any applicant proposing to develop a new chronic hospital or a new chronic hospital service at an existing health care facility must demonstrate that it can meet the Medicare Conditions of Participation as a Long Term Care Hospital consistent with 42 CFR Part 412.
- (6) ***Expansion.***
 - a. The Commission may approve a chronic hospital for expansion only if all of its beds are available for use and it has been operating at 85 percent or higher average occupancy for the most recent consecutive 24 months, as shown in the Health Services Cost Review Commission's Current Rates Report for the latest fiscal year.
 - b. An applicant may show evidence why of this standard should not apply.

B. Short-Stay, Hospital-Based Skilled Nursing Facilities. The Commission will use the standards in this section to review applications for short-stay hospital-based skilled nursing facilities.

- (1) ***Applicable Standards.*** The Commission shall use Subsections .05 A(1),(3-9) and the following standards, to review proposals for post-acute, hospital-based facilities that are licensed either as comprehensive care or extended care, that are Medicare-certified as hospital-based skilled nursing facilities, and that have an average length of stay of less than 30 days.
- (2) ***Financial Access.***
 - a. An applicant shall document in its Certificate of Need application that it admits or will admit patients whose primary source of payment on admission is Medicaid.
 - b. Subsection .05A (2) of this Chapter does not apply to short-stay, hospital-based skilled nursing facilities.
- (3) ***Facility Occupancy.*** An applicant shall propose to serve and maintain at least an 85 percent average annual occupancy level
- (4) ***Certification.*** An applicant shall be licensed and meet all of the requirements under COMAR 10.07.02.14-1 (Special Care Units-General) or 10.07.02.14-2 (Special Care Units-Respiratory Care Unit).

.07 Methodology for Projecting Need for Nursing Home Beds.

A. Methodology Assumptions. Need projections for nursing home beds will use the following assumptions:

(1) *Jurisdictional Need.*

- (a) Nursing home bed need includes need for both comprehensive care facilities and extended care facilities.
- (b) Except as provided in Paragraph .07A (1)(c), nursing home bed need is projected on a jurisdictional basis.
- (c) In jurisdictions for which this methodology does not project net need of 90 beds or more by the target year, the Commission may combine the projected bed need for two or more jurisdictions in the planning region, as defined in Regulation .16.

(2) *Age Adjustment.* Nursing home bed need is projected using an adjusted age-specific use rate, based on the base year use rate minus 5 percent, applied by jurisdiction, in order to account for the correlation between age and utilization.

(3) *Migration Adjustment.*

- (a) The need projection for nursing home beds reduces net out-migration from jurisdictions with retention rates less than 80 percent and use rates for the 65+ population greater than the 33rd percentile by half and allocates the reduction back to the jurisdiction.
- (b) Migration into Maryland from the adjacent states of Delaware, the District of Columbia, Pennsylvania, Virginia, and West Virginia is taken into account in estimating bed need, by assuming that the current pattern of migration from these adjacent states into Maryland will increase in the future at their projected rate of population growth.
- (c) Migration into Maryland from other than adjacent states is not taken into account in estimating need.
- (d) Out-migration from Maryland to adjacent and other states is assumed to remain constant.

- (4) **Community-Based Services Adjustment.** The utilization of community-based services, measured as patient days for those who, on admission, are light care, continent, and not cognitively impaired, is a viable substitute for a proportion of nursing home utilization, and projected nursing home bed need is reduced accordingly.

B. 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 to which projections are calculated is seven years after the base year.

C. Services. Projections are made for the following services:

- (1) Except as provided in Subsection .07C(3), need is projected for all nursing home beds licensed as either comprehensive care or extended care in Maryland.
- (2) The need for extended care beds is included with comprehensive care beds in the nursing home bed need projections.
- (3) The nursing home bed need projections exclude utilization at Charlotte Hall Veterans Home.

D. Age Groups. The following age groups are used: Under 65, 65-74, 75-84, and 85 years and over.

E. Geographic Area. Need for nursing home beds is projected by jurisdiction.

F. Inventory Rules. The following rules identify beds counted in the inventory used for nursing home bed need projections:

- (1) Nursing home beds are counted in the jurisdiction where they are located, regardless of the jurisdiction of origin of patients using the beds.
- (2) Except as provided in Subsection .07 F(4)-(5), all licensed comprehensive care and extended care beds are counted.
- (3) Comprehensive care and extended care beds which have Certificate of Need approval from the Commission are counted.

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- (4) Multiply-licensed beds, including swing beds in acute care hospitals, are not counted.
- (5) Beds in Charlotte Hall Veterans Home are not counted.
- (6) Waiver beds authorized under COMAR 10.24.01.03E(2) are counted.
- (7) Existing licensed beds, removed on a temporary basis from a facility's license, pursuant to COMAR 10.24.01.03C, are counted.
- (8) When a Certificate of Need is withdrawn or relinquished, the affected beds will be eliminated from the inventory of comprehensive care beds.

G. Data Sources.

- (1) The need for nursing home beds is based on the total noninstitutionalized civilian population, broken down by age groups, as indicated in §.07 D of this Regulation.
- (2) Maryland population estimates and projections by age group and jurisdiction are obtained from the most recent population projections available from the Maryland Department of Planning. Population estimates and projections by age group for adjacent states are obtained from the relevant planning agencies in those states and from the United States Census Bureau.
- (3) Nursing home utilization data are obtained from the Long Term Care Facility Resident Assessment Instrument's Minimum Data Set (MDS) for Maryland.

H. Nursing Home Beds.

- (1) The number of licensed comprehensive care and extended care beds is obtained from program records of the Office of Health Care Quality.
- (2) The number of Certificate of Need-approved beds, waiver beds, and temporarily delicensed comprehensive care and extended care beds are obtained from the Commission's records.

I. Method of Calculation. The Commission uses the following procedure to project need for nursing home beds in the target year:

- (1) Calculate the base year patient days by age group, area of origin, and jurisdiction of care.
- (2) Calculate the base year use rate by age group by applying the following rules:
 - (a) Calculate the use rate for the most recent year, by age group and jurisdiction of origin, by dividing the base year patient days, by age group and Maryland jurisdiction of origin, by the base year population, by age group and jurisdiction of origin, and multiplying the result by 1,000.
 - (b) Calculate an adjusted base year use rate by reducing the base year use rate calculated in Paragraph (a) above by 5 percent.
- (3) Calculate the target year patient days for each age group for each Maryland jurisdiction of residence by multiplying the adjusted base 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.
- (4) Calculate the migration-adjusted target year patient days for each jurisdiction of care by using the following rules:
 - (a) When the jurisdiction of residence is the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, add the base year patient days for a given age group, receiving care in the same jurisdiction of residence, to one half of the base year patient days for a given age group receiving care outside the jurisdiction of residence; divide the result by the base year patient days for the age group and jurisdiction of residence; multiply by the target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence in Maryland;
 - (b) When the jurisdiction of residence in Maryland is not the same as the jurisdiction of care, and the retention rate is less than 80 percent, and the base year use rate for the 65+ population is greater than the 33rd percentile, divide the base year patient days for a given age group, a given jurisdiction of residence, and a given jurisdiction of care by twice the base year patient days for the age group and the jurisdiction of residence; multiply the result by the

target year patient days for the age group and jurisdiction of residence; and sum the result over all jurisdictions of residence;

- (c) When the retention rate is greater than 80 percent, or the base year use rate for the 65+ population is less than the 33rd percentile, the target year patient days are equal to the patient days for each jurisdiction of residence as calculated in step 4(a); sum the result over all jurisdictions of residence;
 - (d) When the jurisdiction of residence is an adjacent state, sum the base year patient days for each age group and jurisdiction of residence for a given jurisdiction of care, multiply the base year patient days for each age group by the population growth rate in that age group, and sum the result over all jurisdictions of residence for a given jurisdiction of care.
- (5) Calculate the total target year patient days for each jurisdiction of care by summing the target year patient days for each age group in the jurisdiction of care over all age groups.
 - (6) Calculate the gross bed need for each jurisdiction of care by dividing the target year patient days for the jurisdiction by the product of 365 and 0.95.
 - (7) Calculate the net bed need for each jurisdiction of care by subtracting the inventory of beds obtained using the rules in .07 H (1) and (2) of this Chapter from the gross bed need for the jurisdiction.
 - (8) Calculate the number of nursing home beds for which community based services (CBS) will substitute in each jurisdiction of care.
 - (a) Calculate the proportion of total nursing home patient days represented by the patients appropriate for CBS by dividing the CBS days by the total patient days for each jurisdiction of care in the base year.
 - (b) Calculate the number of target year patient days appropriate for CBS by multiplying the target year patient days by the proportion of total nursing home patient days calculated in Step 8(a).
 - (c) Calculate the number of nursing home beds for which CBS will substitute for nursing home beds in each jurisdiction of care by dividing the target year patient days appropriate for CBS by the result of the product of 365 and 0.95.
 - (9) Calculate the adjusted net bed need for each jurisdiction of care by subtracting the number of nursing home beds for which CBS will substitute from the net bed need for each jurisdiction of care.

J. Mathematical Formula. The need projection methodology described in .07I of this Chapter is shown here in mathematical form.

(1) **Definitions of Terms.** Terms used in .07J(2) of this Chapter are defined as follows:

<u>Term</u>	<u>Definition</u>
i	area of origin, where 1, ..., 24 = 24 Maryland jurisdictions and 25, ..., 29 = specified adjacent states
j	jurisdiction of care, where 1, ..., 24 = 24 Maryland jurisdictions
k	age group
PDAYS	base year total patient days
TPD	target year patient days
BPOP	base year estimated population
TPOP	target year estimated population by age group
JRATE	base year jurisdictional use rate
ADRATE	JRATE multiplied by .95
ASPOP	adjacent state population growth rate
RRATE	base year jurisdictional retention rate
65JRATE	jurisdictional use rate for the 65+ population in the base year
TPERCENT	the 33 rd percentile of the jurisdictional use rates for the 65+ population in the base year
GNEED	gross bed need
INV	inventory beds
NNEED	net bed need
NHCBAP	number of base year nursing home days appropriate for community based services
SDAYS	projected number of target year nursing home days for which community based services will substitute
CBSBEDS	number of nursing home beds for which community based services will substitute
ANEED	net bed need adjusted for community based services

(2) **Formula.** Need for nursing home beds in each jurisdiction is calculated as shown in the following table:

- (a) When $i = 1, \dots, 24$, the Base Year $JRATE_{ki} = (1000) ((PDAYS_{ki}) / (BPOP_{ki}))$
- (b) When $i=1, \dots, 24$, then $ADRATE_{ki} = (JRATE_{ki} * .95)$
- (c) When $i = 1, \dots, 24$, then $TPD_{ki} = [ADRATE_{ki} (TPOP_{ki})] / 1000$

(d) When $i = j$, and $RRATE_i < .8$ and $65JRATE_i > TPERCENT_i$, then

$$TPD_{kj} = \sum_{i=1}^{24} \{BPD_{kij} + [0.5 (BPD_{ki} - BPD_{kij}) (TPD_{ki})] / BPD_{ki}\}$$

When $i \neq j$ and $i = 1, \dots, 24$ and $RRATE_i < .8$ and $65JRATE_i > TPERCENT_i$, then

$$TPD_{kj} = \sum_{i=1}^{24} \{[(0.5) (BPD_{kij}) (TPD_{ki})] / BPD_{ki}\}$$

When $RRATE_i \geq .8$ or $65JRATE_i < TPERCENT_i$, then $TPD_{kj} = TPD_{ki}$

When $i = 25, \dots, 29$, then

$$TPD_{kj} = \sum_{i=25}^{29} (BPD_{kij}) (ASPOP_{kj})$$

(e) $TPD_j = \sum TPD_{kj}$

(f) $GNEED_j = TPD_j / [(365) (.95)]$

(g) $NNEED_j = GNEED_j - INV_j$

(h) $SDAYS_j = (NHCBAP_j / PDAYS_j) * TPD_{kj}$

(i) $CBSBEDS_j = SDAYS_j / (365 * 0.95)$

(j) $ANEED_j = NNEED_j - CBSBEDS_j$

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

- (1) The Commission will update nursing home bed need projections at least every three years and publish them 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) Updated projections published in the *Maryland Register* supersede any previously published projections in either the *Maryland Register* or any Plan approved by the Commission.
- (3) Published projections remain in effect until the Commission publishes updated nursing home 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.
- (4) 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.

.08 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 Center* means a place licensed by the Maryland Department of Health and Mental Hygiene (DHMH) that serves elderly or medically handicapped adults during part of the day in a protective group setting. An Adult Day Care Center provides, with or without charge, care for the elderly or medically handicapped individuals, and is either designated as group care for at least four individuals or as a family home that provides care for two to three individuals. Adult Day Care Centers may be funded by the DHMH under either of two programs:
 - (a) General Funds support financially eligible adults 55 years of age or older (Health General-Article, §14-201, Annotated Code of Maryland); or
 - (b) Medical Assistance supports financially and medically eligible adults aged 16 or older (Health-General-Article, §14-301, Annotated Code of Maryland).
- (3) *Adult Evaluation and Review Services (AERS—formerly Geriatric Evaluation Services)* means a program of the Maryland Department of Health and Mental Hygiene, operated by 24 local health departments, that uses a team of professionals to provide a comprehensive medical/nursing, environmental, and psychosocial assessment. The evaluation is conducted in the individual's home or current residence.
- (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 residents.
- (5) *Case Management* means a coordinated package of services that includes, at a minimum:

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- (a) Assessment of individual client's strengths, weaknesses, needs, and resources;
 - (b) Planning of services in an effective and efficient package to enhance strengths, complement resources, and meet needs;
 - (c) Linkage of individual clients with resources in the community and insuring that clients and resources are effectively linked;
 - (d) Monitoring of services received by individual clients to determine whether or not they are effective, efficient, and needed on a continuing basis; and
 - (e) Advocacy on behalf of individual clients to ensure access to entitlement benefits and services, and to develop new resources when no service exists to meet a need.
- (6) *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.
- (7) *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 Article 70B, that meet the provisions of Health-General Article, §19-114 (d)(2)(ii), Annotated Code of Maryland, which:
- (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 10.24.01.03 K;
 - (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) Is located on the campus of the continuing care retirement community.
- (8) *Charity Care.*
- (a) Charity care means care for which there is no means of payment by the patient or any third-party payer.

- (b) 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.
- (9) *Chronic Hospital* means a facility licensed as special hospital-chronic disease in accordance with COMAR 10.07.01 that serves patients who do not need acute care or care in another kind of specialty hospital, whose needs for frequency of monitoring by a physician and for frequency and duration of nursing care exceeds the requirements of COMAR 10.07.02 for care in a comprehensive care or extended care facility, and whose expected length of stay, typically exceeds 25 days.
- (10) *Community-Based Long Term Care Services* means services delivered to functionally disabled persons in their communities to help meet their needs for health care and social support, to enable them to achieve or maintain an optimal degree of independence, and to improve their quality of life.
- (11) *Comprehensive Care Facility* means a facility licensed in accordance with COMAR 10.07.02 that admits patients suffering from disease or disabilities, or advanced age, requiring medical service and nursing service rendered by or under the supervision of a registered nurse.
- (12) *Consolidation* means a merger, as defined in this section, that results in the elimination or centralization of long term care services at one or more of the nursing homes in a merged organization.
- (13) *Continuing Care* means furnishing shelter plus health services consistent with the requirements of Article 70B, Annotated Code of Maryland. Health services include: either medical or nursing services; a formal arrangement between the provider and a nursing home by which the nursing home grants priority to the subscriber for admission; or assistance with activities of daily living other than the provision of meals. Services may be paid for by the following methods: an entrance fee in advance of receipt of services; regular periodic charges which guarantee health services whenever needed; purchase of services at the option of the subscriber as services are needed; or any combination thereof. Services are offered to an individual 60 years of age or older, not related by blood or marriage to the provider, for the life of the subscriber, or for a period in excess of one year. Services are offered under a written agreement that may require periodic charges and shall require: a transfer of assets from

the subscriber to the provider; an entrance fee, or both a transfer of assets and an entrance fee.

- (14) *Continuing Care Retirement Community* means a legally organized entity to provide continuing care in a facility that has been certified by the Office on Aging consistent with Article 70B, Annotated Code of Maryland.
- (15) *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.
- (16) *Extended Care Facility (ECF)* means a facility licensed in accordance with COMAR 10.07.02 that offers sub-acute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous acute care services, and admitting patients who require convalescent or restorative services, or rehabilitative services, or patients with terminal disease requiring maximal nursing 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 and Mental Hygiene.
- (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) *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.
- (23) *Merger* means: The combining of existing beds or services of two or more independent health care facilities, including at least one nursing home,

under a permanent arrangement of reorganization that is legally binding and that results in an entity that controls the business and programmatic functions of all the health care facilities involved.

- (24) *Non-Excluded Continuing Care Nursing Home Beds* means those beds in a continuing care retirement community which do not meet all three of the provisions for exclusion from Certificate of Need found in §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) Must meet all applicable rules and standards of this Chapter.
- (25) *Nursing Home* means a health care facility licensed for comprehensive care beds under COMAR 10.07.02.
- (26) *Obsolete Physical Plant* means a facility that:
- (a) Has been granted two or more Life Safety Code waivers by the Office of Health Care Quality;
 - (b) Maintains 100 percent of its census in a building granted life safety code waivers by the Office of Health Care Quality;
 - (c) Has more than 30 percent of its beds in rooms with three or more beds; and
 - (d) If multi-storied, does not have an elevator.
- (27) *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 or private corporation, or other entity.
- (28) *Personal Care* means assistance with those functions and activities normally associated with body hygiene, nutrition, elimination, rest, and ambulation that enable an individual to be treated at home.
- (29) *Planning Region* means one of the five areas of the State used in this Chapter for purposes of planning, bed need projections, and for Certificate of Need standards, including Medicaid percentage requirements. These

areas include: Western Maryland; Montgomery County; Southern Maryland; Central Maryland; and the Eastern Shore.

- (30) *Preadmission Screening and Resident Review (PASRR)* requires that nursing facilities cannot admit or retain an individual who has a serious mental illness, mental retardation, or a related condition unless the Developmental Disabilities Administration (DDA) or the Mental Hygiene Administration (MHA) has determined that a nursing facility placement is appropriate for the individual. PASRR applies to all new admissions to a nursing home that participates in the Medicaid program regardless of how the individual's stay is being paid.
- (31) *Respite Care* means formal services provided in a home, at a day care center, or by temporary nursing home placement, to functionally disabled or frail individuals to give informal caregivers occasional or systematic relief.
- (32) *Senior Care* means a statewide mechanism that coordinates aging services provided by major public and private agencies, in order to help persons 65 and older who are at risk of nursing home admission to remain independent in the community through assessment of needs, case management and, for low-income clients, gap filling funds.
- (33) *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, and health education seminars. There are 112 senior centers in Maryland. In addition, *Senior Center Plus* is a program of structured group activities and enhanced socialization which is designed to have a positive impact on physically frail or cognitively impaired individuals. There are 41 Senior Center Plus sites in Maryland.
- (34) *Senior Information and Assistance* means a statewide program designed to provide single point of entry centers for current information about programs, services, and, benefits for older persons and their caregivers by assisting in determining service need, processing requests, making referrals to appropriate agencies, and monitoring the outcome of requests for service or information. The information includes, but is not limited to: transportation, income and financial aid, senior centers, meals, pharmacy assistance, housing, and volunteer opportunities. There are 120 local Senior Information and Assistance offices in Maryland.
- (35) *Statewide Evaluation and Planning Service (STEPS)* means a statewide, comprehensive, multi-disciplinary long term care evaluation program for persons at risk of nursing home placement. The individual must be at risk

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of placement in a nursing home, and must be a Medicaid recipient or be eligible for Medicaid within 6 months of placement in a nursing home.

- (36) *Subscriber* means a purchaser, or nominee, of a continuing care agreement.
- (37) *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.
- (38) *Waiver Beds* mean beds determined not to require a Certificate of Need under Health-General Article, §19-120, (h)(2)(i), Annotated Code of Maryland.