Hospice Workgroup 2025
Meeting 1

July 7, 2025

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Background

- The State Health Plan should be revised every 5 years, the SHP chapter was last revised in 2013, but not put into practice until 2016
- There have been multiple recent hospice workgroups in 2018-2019 and in 2022

Recent CON History

- 2024 Affiliation agreement Gilchrist and Washington County Hospice
- Hospice of the Chesapeake affiliation agreement with Charles County in October 2020 and Calvert in June 2022 (subsequent merger)
- 2017-2018-CONs for Carroll Hospice, Costal Hospice and Joseph Ritchie (determined no CON needed-regulation change for addition of inpatient beds)
- 2016- multiple CONs Baltimore City-Bayada, PB Health and Carroll (Bayada did not finish review)
- 2016- multiple CONs PG County-Bayada, PB Health, Montgomery and Amedisys (Bayada did not finish review)

Our Workgroup Plan

Four Remote Sessions

1: General Overview/Review Standards on July 7th

2: Review of Hospice Quality Meeting on July 21

3: Review of Methodology Meeting on August 4

4: Agreement/Hospice Utilization on August 18

We have participants from across the State (Western, Eastern Shore, Southern, Central) including members experienced with analytics to work on the methodology

For our 4th meeting we have State agencies and providers across the acute and subacute continuum of care to discuss Hospice utilization in Maryland

Goals: Update and Simplify the Hospice Chapter

- Update CON references (e.g, no CON for inpatient for licensed general hospice) HB 626 *FOR the purpose of exempting an increase or decrease in bed capacity from the certificate of need requirement if the increase or decrease will occur in a certain general hospice program, under certain circumstances and certain written notice is filed with the Maryland Health Care Commission at least a certain number of days before increasing or decreasing bed capacity, April 2019*
- Solve the issue of sole provider jurisdictions
- Eliminate out of date standards
- Review and update definitions as needed
- Add additional standards as needed
- Consolidate the Hospice Survey (Removal of Part 2)
  - Still need charity care %
  - Match up language between survey and chapter

Sole Provider Jurisdictions

Resolve Sole Provider Solutions: Three Possible Solutions

Service Exemption if the sole provider is below average (3 stars) or alternatively for patient choice

In the Docketing Rules (Service Exemption) add subsection that allows a patient to elect a hospice in a contiguous county if the sole provider in the county where they live has a **below average star rating** on the Medicare Care Compare site and the elected hospice has the staff to provide care **or if the patient so chooses** and the elected hospice has the staff to provide care

Need determined by methodology

Need methodology will be designed (as part of this workgroup) to take into account sole provider jurisdictions

Regional Approach

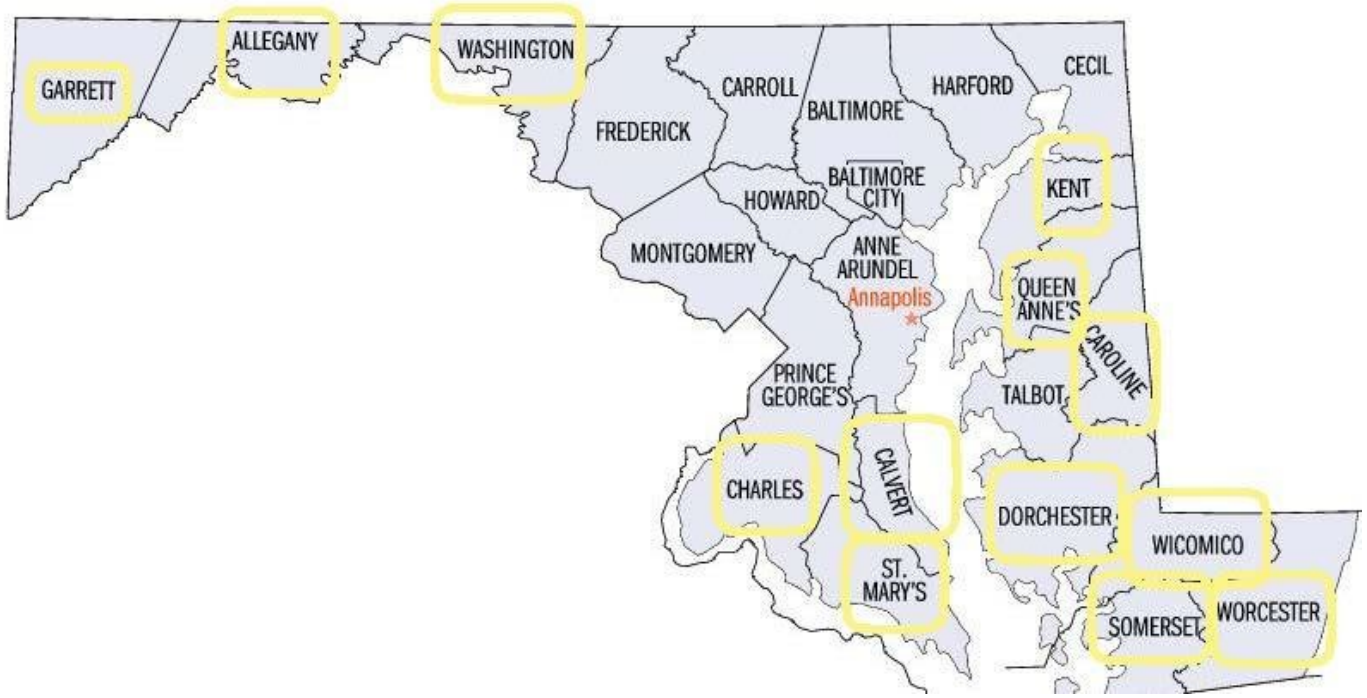
Use a regional approach in the Western, Southern and the Eastern Shore of Maryland

Maryland Sole Provider Jurisdictions

- 13 sole licensed provider jurisdictions
- Western Maryland
  - Allegany
  - Garrett
  - Washington
- Southern Maryland
  - Calvert
  - Charles
  - St. Mary's
- Eastern Shore*

Upper Shore
  - Kent
  - Queen Anne's
  - Caroline

Lower Shore
  - Dorchester
  - Wicomico
  - Somerset
  - Worcester



*The Eastern Shore can be treated as one region or separated into 2 regions: The Upper Shore and the Lower Shore.

Handout "Updated Regions for Hospice Need Determination"

Population Projections July 1st 2024

Southern Maryland		Western Maryland		Lower Eastern Shore		Upper Shore	
County	**Population Estimates**	**County**	**Population Estimates**	**County**	**Population Estimates**	**County**	**Population Estimates**
Charles	174,478	*Allegany*	67,097	*Dorchester*	33,138	*Kent*	19,557
Calvert	94,913	*Garrett*	28,393	*Somerset*	25,241	*Queen Anne's*	53,688
St. Mary's	116,469	*Washington*	157,228	*Wicomico*	106,329	*Caroline*	34,248
				Worcester	54,337	*Talbot*	38,244
Total	385,860	**Total**	252,718	**Total**	219,045	**Total**	145,737

Regional Approach

- **Southern Maryland-** Charles, Calvert and St. Mary's –*HOC/Charles, HOC/Calvert, Hospice of St. Mary's*
- **Upper Shore-**Kent, Queen Anne's, Caroline and *Talbot-Compass, Talbot Hospice Foundation*
- **Lower Shore-** Dorchester, Somerset, Wicomico and Worcester- *Coastal*
- **Western-**Allegany, Garrett, Washington- *Western Maryland Health System, Gilchrist (HOWC), Hospice of Garrett County*

Docketing Requirements/Service Exemptions

Docketing Rules (Service Exemptions)

- The Executive Director of the Commission may grant an exception to a general hospice to provide specified services to a specified resident of a jurisdiction where the hospice has not been authorized to provide hospice services, under the following circumstances:
- If a general hospice is unable to serve a patient in a jurisdiction for which it is authorized, it may request an exception from the Executive Director that permits a Maryland licensed general hospice in a contiguous Maryland jurisdiction to serve that patient.
- If a general hospice requests an exception so that it may serve a specific patient in a jurisdiction for which it is not authorized to provide services, it must demonstrate that:

It has specific service capabilities or attributes that would benefit the patient, or that there are unique circumstances regarding the patient and/or the patient's family that make it uniquely qualified to serve the patient;

It has contacted each hospice authorized to serve the jurisdiction; and

Each hospice is contacted either agreed with the requesting hospice as to the validity of the statements made in (a) above or, if an authorized hospice disagreed, the requesting hospice provided the details of any objections to the request.

An exception granted by the Executive Director is limited to the specific patient and does not permit the hospice to serve any other patient in the jurisdiction.

Changing the Need Methodology

Three Ways to Qualify (COMAR 10.24.16.04)

Home Health Agency (HHA) Chapter of the State Health Plan (COMAR 10.24.16.04) states that jurisdictions may qualify as having a need for additional HHA services based on the following

Insufficient Consumer Choice

Exists when any jurisdiction has two or fewer Medicare certified agencies that serve 10 or more clients each year during the most recent three-year period for which data is available

Insufficient Choice of Quality Performing Agencies

Exists when any jurisdiction with agencies that are serving 60% or more of its clients are not meeting the applicable quality performance requirements designated by the Commission

Concentrated Market

Exists when any jurisdiction has a Herfindahl-Hirschman Index (HHI) score of 0.25 or higher; higher market concentration may result in less competition and greater power for leading enterprises in the market

Standards

HOSPICE STANDARDS STATE HEALTH PLAN 10.24.13

Standards Staff Recommends No Changes

A. Admissions

F. Caregivers

H. Financial Accessibility

N. Public Education Programs

P. Inpatient Unit

Standards Staff Recommends Removal

C. Minimum Services-Covered in the COPs

D. Setting-Covered in the new Volume standard

G. Impact-Covered in criterion

M. Respite Care-Defined in COPs

O. Patient Rights covered in 10.07.21 (remove text but cite the COMAR)

Standards Staff Recommends Minimal Changes

B. Admissions criteria- An applicant shall identify: Any limits to the admission criteria in the COPs. ~~Its admission criteria; and Proposed limits by age, disease, or caregiver~~.(page 14)

E. Volunteer/Bereavement-An applicant shall have available sufficient trained ~~caregiving~~ volunteers to meet the needs of patients and families in the hospice program. Provide details on how a volunteer program will be implemented and maintained. An applicant shall provide bereavement services to the family for a period of at least one year following the death of the patient. Provide details on how a bereavement program will be implemented and maintained. (page 15)

I. Information to Providers and the General Public -An applicant shall document its process for informing the following entities about the program's services: hospitals, nursing homes, home health agencies, local health departments, assisted living providers, physicians, the general public, and patients/families. This information should also be made available on the applicant's website and include a schedule of fees. (page 15)

L. Linkages with Other Service Providers-An applicant shall identify how inpatient hospice care will be provided to patients, either directly, or through a contract with an inpatient provider that ensures continuity of patient care.

An applicant shall agree to document, before licensure, that it has established links with hospitals, nursing homes, home health agencies, assisted living providers, Assessments, Evaluation and Review Service ~~Adult Evaluation and Review Services~~ (AERS), Senior Information and Assistance Programs, adult day care programs, the county l~~ocal~~ Department of Social Services, and home delivered meal programs located within its proposed service area.

An applicant shall detail its plan to communicate its programs to potential referral sources in the community. (page 19)

Standards Staff Recommends Minimal Changes (continued)

J. Charity Care and Sliding Fee Scale

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

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

Notice of Charity Care Policy. Public notice and information regarding the hospice's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the population in the hospice's service area, and in a format understandable by the service area population. Notices regarding the hospice's charity care policy shall be posted in the business office of the hospice and on the hospice's website, ~~if such a site is maintained.~~ Prior to the provision of hospice services, a hospice shall address any financial concerns of patients and patient families and provide individual notice regarding the hospice's charity care policy to the patient and family along with the charity care policy and the sliding fee scale.

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

It has a specific plan for achieving the level of charity care to which it is committed. (page 17)

New Standard 1 Patient Volume

For each county listed under Standard A. Service Area, provide both three-year volume projections and historical performance data (including any assumptions) for the following metrics:

- Admissions by Level of Care
- Admissions by Setting (Home, Hospice House, Inpatient Unit)
- Admissions by Diagnosis
- Deaths and Non-Death Discharges
- Average Daily Census
- Average Length of Stay
- Median Length of Stay

New Standard 2 Late Referrals to Hospice

- An applicant shall provide its strategies to minimize late referrals to hospice (defined by the number of patients that died or discharged in less than or equal to 7 days).

New Standard 3 Long Length of Stay

- An applicant shall provide its process for managing patients who have been on hospice services for greater than 180 days.

New Standard 4 Special Populations

An applicant shall describe its programming for any special population it proposes to serve, including but not limited to:

- Patients who are Veterans
- Patients with Development Disabilities
- Patients who want to receive palliative care but are not yet eligible for hospice
- Patients who are children and adolescents

New Standard 5 Staffing

An applicant shall provide both a clinical and non- clinical staffing plan for the proposed project that includes:

- FTEs by discipline
- Full/ Part Time or PRN Status of FTEs
- Annual visits by discipline
- Caseload by discipline
- Physician and Nurse Practitioner involvement

Next Steps

- Review Quality Measures and Need Methodology
- Incorporate comments from Hospice Workgroup
- Develop draft update to Hospice Chapter and the Hospice Survey
- Distribute draft for Informal Public Comment
- Review informal comments and revise as needed
- Develop draft for promulgation of proposed permanent regulations

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Further Discussion?

END OF PRESENTATION