

### **III. COMMENTS RECEIVED DURING FORMAL PUBLIC COMMENT PERIOD**

#### **COMAR 10.24.13**

During the Formal Public Comment Period, held July 26, 2013 – August 26, 2013, comments were received from the following individuals and organizations:

- Senate Finance Committee (Senators Thomas McLain Middleton and John C. Astle)
- Calvert Hospice (Brenda Laughhunn)
- Gilchrist Hospice (Catherine Hamel)
- Holy Cross Home Care and Hospice (Linda Maurano)
- Hospice and Palliative Care Network of Maryland (Danelle Buchman)
- Hospice of Queen Anne's, Inc. (Heather Guerieri)
- Hospice of St. Mary's (Kathryn Franzen)
- Hospice of the Chesapeake (Michael McHale)
- Joseph Richey Hospice (Charlotte Hawtin)
- LifeBridge Health, Inc. (Jonathan Montgomery)
- Montgomery Hospice (Ann Mitchell)
- Seasons Hospice (Dean Forman)
- Stella Maris (Lisa Stone)
- Western Maryland Health Systems Hospice (Linda Green)

The text of the actual comments is attached.

THOMAS M. MIDDLETON  
CHAIR

JOHN C. ASTLE  
VICE CHAIR



ROB GARAGIOLA  
BARRY GLASSMAN  
DELORES G. KELLEY  
ALLAN H. KITTLEMAN  
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JAMES N. MATHIAS, JR.  
E. J. PIPKIN  
CATHERINE E. PUGH  
VICTOR R. RAMIREZ

## THE SENATE OF MARYLAND

FINANCE COMMITTEE  
August 23, 2013

Dr. Craig Tanio, Chairman  
Maryland Health Care Commission

Mr. Garret A. Falcone, Vice Chairman  
Maryland Health Care Commission

Members of the Maryland Health Care Commission

Ladies and Gentlemen:

After a recent meeting with the Executive Director of the Maryland Health Care Commission (MHCC) on the hospice regulations proposed by MHCC, we still have concerns regarding these regulations. Last September, I, on behalf of the Senate Finance Committee, sent a letter to you and the members of the commission detailing the concerns, priorities, and preferences of the Senate Finance Committee regarding updating the hospice CON regulations. As a result of the August 6 meeting with Mr. Steffen, we want to reiterate that:

1. The Senate Finance Committee supports enhanced educational outreach by MHCC and the Hospice Network to meet the potential unmet need for hospice services in Maryland.
2. The Senate Finance Committee encourages MHCC to work with the Hospice Network to develop measures of quality assessment regarding the provision of hospice services.
3. The Senate Finance Committee has significant concerns regarding the methodology that was used to determine the need for additional hospice CONs in several Maryland jurisdictions, most recently Prince George's County and Baltimore City.

We believe that there may be potential unmet need for hospice services; however, there is no evidence that people are being denied hospice services in Maryland because of inadequate supply.

In the formal comment period on these proposed regulations, which ends on August 26, the Hospice Network has formally opposed the promulgation of the MHCC's hospice regulations because there is "no final agreement among interested parties regarding the procedural rules and standards" embodied by the proposed regulations. The lack of an agreement is contrary to the direction of the Senate Finance Committee that all parties must be in agreement before the regulations are proposed. We also do not feel that MHCC has fully engaged all of the stakeholders to the fullest extent to move forward. **We fully support the comments of the Hospice Network on the promulgated regulations.**

Dr. Craig Tanio, Chairman  
Mr. Garret A. Falcone, Vice Chairman  
August 23, 2013  
Page 2

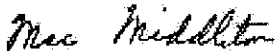
Last September, the Senate Finance Committee suggested that MHCC impose a three to five-year moratorium on expanding CON requirements until the following conditions occur:

- MHCC should work with the Hospice Network and other interested parties to agree to a methodology to determine "unmet" need;
- this agreed to methodology would then be used to assess the current hospice structure in the State; and
- if after an analysis it is determined that additional capacity is warranted and the current infrastructure cannot meet the additional need, and if MHCC is permitted to allow for additional hospice CONs, a process must be in place to avoid adverse selection of incoming hospice patients.

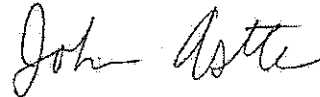
Finally, based on national data, the length of stay in Maryland hospice programs is less than the national average. The shorter length of stay may stem from hospice-eligible patients staying longer in hospitals and nursing facilities. During the moratorium, MHCC should review this trend and consider developing possible incentives for hospitals and nursing facilities to make earlier referrals to licensed hospice programs.

At this point we see no reason to alter or amend the Senate Finance Committee's position. We remain unconvinced that the methodology to determine the need for additional hospice CONs requires updating. We also believe that the "need-based" model proposed in the regulations based on national average utilization rates for hospice services is not nearly as relevant as a strictly "demand-based" approach for determining the need for additional hospice CONs. Thank you for your attention to this extremely important matter.

Very truly yours,



Thomas McLain Middleton, Chairman



John C. Astle, Vice Chairman

TMM:JCA/DAS/ncs

cc: Members of the Senate Finance Committee  
Mr. Ben Steffen, Executive Director, MHCC  
Ms. Linda Cole, MHCC

RECEIVED

AUG 13 2013

MARYLAND HEALTH  
CARE COMMISSION



August 13, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Cc: Senate Thomas "Mac" Middleton, Chair, Senate Finance Committee

Senator John Astle, Vice Chair, Senate Finance Committee

Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services: Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of Proposed Action [13-198-P-1] [State Health Plan for Facilities and Services: Hospice Services]

Dear Ms. Cole:

On behalf of Calvert Hospice as Executive Director, I am writing in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13). This action was considered by the Commission at an open meeting held on June 20, 2013 and there was no opportunity for public comment.

I must oppose the promulgation of these regulations until such time as the interested parties can reach agreement on certain aspects of the state health plan incorporated in the proposed regulations by reference.

Since the purpose of these regulations is intended to provide a policy blueprint for the Commission and affected industries to address issues related to the provision of hospice services, it is premature for these regulations to go forward. There has been no final agreement among interested parties regarding the procedural rules and standards. A Hospice Education Workgroup is still underway and there remain issues that have not been resolved. The Network values the opportunity to offer expertise on hospice care and appreciates initial collaborations with the Maryland Health Care Commission (MHCC), both in revising the methodology used to update the draft of the State Health Plan and in working on the newly formed Hospice Education Workgroup. However, these collaborations have not resulted in agreement regarding the opening of Baltimore City and Prince Georges County for docketing additional hospice providers for the following reasons:

1. The plan as prematurely drafted does not reflect or consider that the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients.

*Care, Comfort, Compassion*

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[www.calverthospice.org](http://www.calverthospice.org)

2. The proposed regulations state that they will have "minimal or no economic impact on small businesses." The opening up of additional hospices in two regions which currently have ten and nine hospice respectively will create hardship for those existing hospices which manage care under a fragile but slim economy of scale, making it more difficult for any of these hospices to reach those citizens who have need.

3. It was the understanding of the legislature and I that no regulations would be proposed until the Hospice Education Workgroup conducted its business and developed a mechanism to account for existing hospices abilities to meet need among diverse populations.

4. During Hospice Chapter Workgroup meetings last fall and in testimony given at the Senate Finance Committee hearing on January 24, 2013, the Maryland Hospice Network's representatives spoke to the low utilization of hospice services in Baltimore City and Prince George's County not as a matter of access but one of utilization and acceptance. There is adequate access and capacity for hospice care given by the ten providers in Baltimore City and nine providers in Prince George's County.

5. In spring 2010, MHCC decided that a Certificate of Need was required for in-patient hospice units (IPU). IPU is inextricably tied to the Hospice Chapter, yet MHCC has voted to expand capacity for IPU without addressing a need methodology for this costly service. In light of the recent MHCC action of July 2013, I urge MHCC to collaborate with the Maryland Network on an IPU Workgroup to determine need criteria and formula for in-patient hospice units. **Given this new development, the Hospice regulations should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan.**

Many complex factors determine a patient's choice to enter hospice. They sometimes involve the patient's or family's individual cultural, ethnic, spiritual, or psycho-social perceptions. Other specific patient-related factors as well as the patient's family situation can influence hospice choice. Research<sup>1</sup> indicates that diverse populations tend to under-utilize hospice. This may be due to inadequate education on the benefits of hospice or to cultural factors. I believe that we shared consensus with MHCC on this issue thus the formation of the Hospice Education Workgroup. The workgroup is charged to increase hospice "Geographic Variations in Black-White Differences in End-of-Life Care for Patients with ESRD." *Clinical Journal of the American Society of Nephrology* – April 11, 2013. Bernadette A. Thomas, Rudolph A. Rodriguez, Edward J. Boyko, Cassianne Robinson-Cohen, Annette L. Fitzpatrick, and Ann M. O'Hare. "Barriers in Hospice Use Among African Americans." *Journal of Hospice & Palliative Nursing* – May 2013. Angela D. Spruill, MSN, ANP-BC, OCN, Deborah K. Mayer, PhD, RN, AOCN, FAAN, Jill B. Hamilton, PhD, RN. awareness and utilization in demographically diverse communities through educational endeavors. With this workgroup intact there is no reason to introduce new providers in these two jurisdictions.

I am disappointed that the Commissioners voted to promulgate the regulations after the informal comment period without waiting for the Hospice Education Workgroup to thoroughly research and formulate its plan on how to increase hospice use among diverse populations. As stated previously the Maryland Network believes that all the parties agreed earlier in the year to wait on promulgating regulations until the workgroup finished its work.

**The workgroup needs time to gain substance, definition, measurement, momentum, and implementation of strategies to determine if educational outreach makes a true difference in our communities and increases hospice utilization**

Consistent with the position we articulated in our letter of May 3 and the recommendations of the Senate Finance Committee, the Network further proposes that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point: an application to establish a new general hospice in Maryland, or to expand the services of an existing general Maryland hospice to a new jurisdiction will only be docketed if, and only if, analysis determines that the current infrastructure cannot meet the additional need.

**The Network is confident the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients and offer them and their families high quality care. We believe the Commissioners should reconsider their action on adopting the health plan, as written, and take time to amend the plan in light of our comments and objections outlined here.**

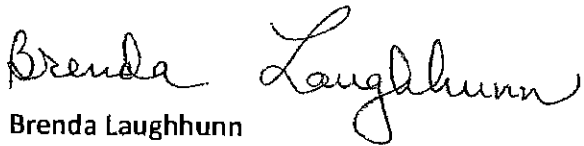
As noted above, of equal concern is the fact that the MHCC has voted to expand capacity for in-patient hospice units (IPU) **without addressing a need methodology for this costly service.** We urge MHCC to establish IPU Workgroup comprised of representatives from the hospice provider community and MHCC staff members to determine need criteria and formula for in-patient hospice units. Given this new development the Hospice regulations **should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan.**

In summary, the Hospice and Palliative Care Network of Maryland and I as a member of this group oppose these regulations and requests that regulations not be promulgated until the **following has occurred:**

- All interested parties reach a consensus on these important issues.
- The Hospice Education Workgroup finalizes an educational plan which is put in place and operational with enough time to be able to measure its degree of success in Prince Georges County and Baltimore City.

• An IPU Workgroup is convened to create and *agree* on an objective need determination for hospice inpatient units. As hospice experts, we take pride both in providing high quality care and in operating regulatory-compliant programs. The Network will continue to strive for fruitful collaboration with MHCC on educational endeavors, quality initiatives, and innovative strategies to enhance care for Maryland's patients and their families. Together, we must do further work on outreach and education. We sincerely believe that education, and not additional providers, is the most effective solution to hospice under-utilization.

Sincerely,



Brenda Laughunn  
Executive Director



August 26, 2013

**SENT VIA EMAIL AND FAX**

Ms. Linda Cole  
Chief, Policy and Planning, Center for Long Term Care and Community-Based Services  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services: Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of Proposed Action [13-198-P-I] [10.24.13 State Health Plan for Facilities and Services: Hospice Services]

Dear Ms. Cole:

On behalf of Gilchrist Hospice Care, Inc. ("Gilchrist"), I respectfully submit this letter in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13) (the "Regulations"), which the Maryland Health Care Commission (the "Commission") considered at its June 20, 2013 meeting. Gilchrist agrees with and incorporates the comments submitted on behalf of the Board of Directors of the Hospice & Palliative Care Network of Maryland (the "Network") regarding this matter. **Gilchrist opposes the adoption of the Regulations until the Commission and the hospice community agree on how to resolve the following two important issues: the opening of Baltimore City and Prince George's County for docketing and the lack of an objective need criteria for inpatient hospice units.**

It has been noted several times<sup>1</sup> that adding additional hospice providers will not resolve the low utilization of hospice services in Baltimore City and Prince George's County. Rather, given the diverse cultural make-up of these jurisdictions, the hospice community believes that the ten providers in Baltimore City and nine providers in Prince George's County should have the opportunity to address this issue through educational outreach. For example, as noted in its letter of May 10, 2013 responding to the informal public comment period of the Regulations,

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<sup>1</sup> For example, this issue was discussed at length in Gilchrist's letter of May 10, 2013 responding to the informal public comment period of the Regulations, in the Network's letters regarding the Regulations, during Hospice Chapter Workgroup meetings last fall, and in testimony given at the Senate Finance Committee hearing on January 24, 2013.

Ms. Linda Cole  
August 26, 2013  
Page 2

Gilchrist has instituted volunteer training programs and educational sessions on the importance of advanced care planning in Baltimore City, which is already increasing African American use rates at Gilchrist. In addition, Gilchrist plans for its cultural diversity and inclusion council to begin operations this fall, and it plans to add an annual cultural competency program for all staff as well. Gilchrist believes that the implementation of education and community outreach programs such as these can allow existing providers to provide adequate access to hospice care in Baltimore City and Prince George's County without needing to open the door to new providers, which will lead to increased government and provider costs associated with the certificate of need process. Although the Hospice Education Workgroup was established to work on this issue, it has not completed its tasks, which Gilchrist understood was to occur before the Regulations were finalized. Therefore, Gilchrist respectfully requests that the Commission wait to promulgate the Regulations until the Hospice Education Workgroup completes an educational plan, such plan has been implemented long enough to analyze its success in Baltimore City and Prince George's County, and the Commission considers whether and how to incorporate this analysis into the Regulations.

As the Commission knows, it has decided that inpatient hospice units (IPUs) require a Certificate of Need. Although the Regulations add standards for the Commission to use when reviewing applications to establish or increase inpatient bed capacity, it does not include an objective need methodology to guide such reviews, which would otherwise occur on an ad-hoc basis. Gilchrist believes that the Commission should work with the Network in creating an IPU Workgroup to develop and incorporate an objective need criteria and formula for IPUs into the Regulations.

Gilchrist appreciates the Commission's initial collaboration with the hospice community regarding the Regulations. It respectfully requests that the Commission continue this collaboration so that all interested parties can reach a consensus on each of the above-mentioned issues before the Regulations are adopted. Please let me know if Gilchrist can provide additional information to assist with this effort.

Very truly yours,



Catherine Hamel

cc: Danelle Buchman, Executive Director, Hospice & Palliative Care Network of Maryland



**HOLY CROSS  
HOME CARE & HOSPICE**

11800 Tech Road-Suite #240  
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(301) 754-7743 Fax

VIA EMAIL AND US MAIL

August 16, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Cc: Senate Thomas "Mac" Middleton, Chair, Senate Finance Committee  
Senator John Astle, Vice Chair, Senate Finance Committee

Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities  
and Services: Hospice Services. Authority: Health-General Article,  
§§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of  
Proposed Action [13-198-P-I] [State Health Plan for Facilities  
and Services: Hospice Services]

Dear Ms. Cole:

As the Executive Director of Holy Cross Home Care and Hospice, I represent one of the first hospices to be certified in Maryland by Medicare and Medicaid thereby delivering Hospice services to Montgomery, Prince George's and Howard County since 1983. I am writing in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13). To my dismay, I witnessed this action being presented and considered by the Commission at an open meeting held on June 20, 2013 with no opportunity for public comment.

We at Holy Cross must oppose the promulgation of these regulations until such time as the interested parties can reach agreement on certain aspects of the state health plan incorporated in the proposed regulations by reference.

Since the purpose of these regulations is intended to provide a policy blueprint for the Commission and affected industries to address issues related to the provision of hospice services, it is premature for these regulations to go forward. There has been no final agreement among interested parties regarding the procedural rules and standards. A Hospice Education workgroup, which I am participating in, is still underway and there remain issues that have not been resolved.

Page 1

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ACCREDITED BY COMMUNITY HEALTH ACCREDITATION PROGRAM (CHAP)

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Those of us who provide service to the residents of Maryland value the opportunity to offer expertise on hospice care and appreciate initial collaborations with the Maryland Health Care Commission (MHCC), both in revising the methodology used to update the draft of the State Health Plan and in working on the newly formed Hospice Education Workgroup. However, these collaborations have not resulted in an agreement regarding the opening of Baltimore City and Prince Georges County for docketing additional hospice providers for the following reasons:

1. The plan, as prematurely drafted, does not reflect or consider that the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients.

2. The proposed regulations state that they will have "minimal or no economic impact on small businesses." The opening up of additional hospices in two regions which currently have ten and nine hospice respectively will create hardship for those existing hospices which manage care under a fragile but slim economy of scale, making it more difficult for any of these hospices to reach those citizens who have need.

3. It was the understanding of the legislature and the Network that no regulations would be proposed until the Hospice Education workgroup conducted its business and developed a mechanism to account for existing hospices abilities to meet need among diverse populations.

4. During Hospice Chapter Workgroup meetings last fall and in testimony given at the Senate Finance Committee hearing on January 24, 2013, the Network's representatives spoke to the low utilization of hospice services in Baltimore City and Prince George's County not as a matter of access but one of utilization and acceptance. There is adequate access and capacity for hospice care given by the ten providers in Baltimore City and nine providers in Prince George's County.

Many complex factors determine a patient's choice to enter hospice. They sometimes involve the patient's or family's individual cultural, ethnic, spiritual, or psycho-social perceptions. Other specific patient-related factors as well as the patient's family situation can influence hospice choice. Research indicates that diverse populations tend to under-utilize hospice. This may be due to inadequate education on the benefits of hospice or to cultural factors. The Network believes that we shared consensus with MHCC on this issue thus the formation of the Hospice Education Workgroup. The workgroup is charged to increase hospice awareness and utilization in demographically diverse communities through educational endeavors. With this workgroup intact there is no reason to introduce new providers in these two jurisdictions.

I am disappointed and surprised that the commissioners voted to promulgate the regulations after the informal comment period without waiting for the Hospice Education Workgroup to thoroughly research and formulate its plan on how to increase hospice use among diverse populations. As stated previously the Network believes that all the parties agreed earlier in the year to wait on promulgating regulations until the workgroup finished its work.

The workgroup needs time to gain substance, definition, measurement, momentum, and implementation of strategies to determine if educational outreach makes a true difference in our communities and increases hospice utilization. Without this educational outreach, the Commission will be adding new Hospices, increasing the cost of care and diluting the existing competent clinical staff serving that area, and the intended outcome of increasing the number of residents who are receiving hospice services will not be realized.

Consistent with the position the Hospice Network, articulated in their letter of May 3, and the recommendations of the Senate Finance Committee, Holy Cross

Home care and Hospice support that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point: an application to establish a new general hospice in Maryland, or to expand the services of an existing general Maryland hospice to a new jurisdiction will only be docketed if, and only if, analysis determines that the current infrastructure cannot meet the additional need. We at Holy Cross are confident the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients and offer them and their families high quality care. We believe the Commissioners should reconsider their action on adopting the health plan, as written, and take time to amend the plan in light of these comments and objections outlined here.

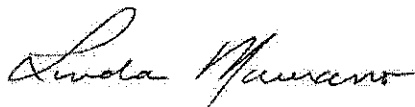
In summary, Holy Cross Home Care and Hospice opposes these regulations and requests that regulations not be promulgated until the following has occurred:

- All interested parties reach a consensus on these important issues.
- The Hospice Education Workgroup finalizes an educational plan which is put in place and operational with enough time to be able to measure its degree of success in Prince Georges County and Baltimore City.
- An IPU workgroup is convened to create and agree on an objective need determination for hospice inpatient units.

At Holy cross Home Care and Hospice, we take pride both in providing high quality care and in operating regulatory-compliant programs. We support the Hospice Network and will continue to strive for fruitful collaboration with MHCC on educational endeavors, quality initiatives, and innovative strategies to enhance care for Maryland's patients and their families.

Together, we must do further work on outreach and education. We sincerely believe that education, and not additional providers, is the most effective solution to hospice under-utilization.

Sincerely,



Linda Maurano, RN, BSN, MSN  
Executive Director



Hospice & Palliative Care Network  
OF MARYLAND

VIA EMAIL AND US MAIL

August 16, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Cc: Senate Thomas "Mac" Middleton, Chair, Senate Finance Committee  
Senator John Astle, Vice Chair, Senate Finance Committee

Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services: Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of Proposed Action [13-198-P-I] [State Health Plan for Facilities and Services: Hospice Services]

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We must oppose the promulgation of these regulations until such time as the interested parties can reach agreement on certain aspects of the state health plan incorporated in the proposed regulations by reference.

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The Network values the opportunity to offer expertise on hospice care and appreciates initial collaborations with the Maryland Health Care Commission (MHCC), both in revising the methodology used to update the draft of the State Health Plan and in working on the newly formed Hospice Education Workgroup. However, these collaborations have not resulted in agreement regarding the opening of Baltimore City and Prince Georges County for docketing additional hospice providers for the following reasons:



Hospice & Palliative Care Network  
OF MARYLAND

1. The plan as prematurely drafted does not reflect or consider that the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients.
2. The proposed regulations state that they will have “minimal or no economic impact on small businesses.” The opening up of additional hospices in two regions which currently have ten and nine hospice respectively will create hardship for those existing hospices which manage care under a fragile but slim economy of scale, making it more difficult for any of these hospices to reach those citizens who have need.
3. It was the understanding of the legislature and the Network that no regulations would be proposed until the Hospice Education Workgroup conducted its business and developed a mechanism to account for existing hospices abilities to meet need among diverse populations.
4. During Hospice Chapter Workgroup meetings last fall and in testimony given at the Senate Finance Committee hearing on January 24, 2013, the Network’s representatives spoke to the low utilization of hospice services in Baltimore City and Prince George’s County not as a matter of access but one of utilization and acceptance. There is adequate access and capacity for hospice care given by the ten providers in Baltimore City and nine providers in Prince George’s County.
5. In spring 2010, MHCC decided that a Certificate of Need was required for in-patient hospice units (IPU). IPU is inextricably tied to the Hospice Chapter. The Network urges MHCC to collaborate with the Network on an IPU Workgroup to determine need criteria and formula for in-patient hospice units. **The Hospice regulations should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan.**

Many complex factors determine a patient’s choice to enter hospice. They sometimes involve the patient’s or family’s individual cultural, ethnic, spiritual, or psycho-social perceptions. Other specific patient-related factors as well as the patient’s family situation can influence hospice choice. Research<sup>1</sup> indicates that diverse populations tend to under-utilize hospice. This may be due to inadequate education on the benefits of hospice or to cultural factors. The Network believes that we shared consensus with MHCC on this issue thus the formation of the Hospice Education Workgroup. The workgroup is charged to increase hospice awareness and utilization in demographically diverse communities through educational

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Hospice & Palliative Care Network  
OF MARYLAND

endeavors. With this workgroup intact there is no reason to introduce new providers in these two jurisdictions.

We are disappointed that the Commissioners voted to promulgate the regulations after the informal comment period without waiting for the Hospice Education Workgroup to thoroughly research and formulate its plan on how to increase hospice use among diverse populations. As stated previously the Network believes that all the parties agreed earlier in the year to wait on promulgating regulations until the workgroup finished its work.

**The workgroup needs time to gain substance, definition, measurement, momentum, and implementation of strategies to determine if educational outreach makes a true difference in our communities and increases hospice utilization**

Consistent with the position we articulated in our letter of May 3 and the recommendations of the Senate Finance Committee, the Network further proposes that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point: an application to establish a new general hospice in Maryland, or to expand the services of an existing general Maryland hospice to a new jurisdiction will only be docketed if, and only if, analysis determines that the current infrastructure cannot meet the additional need.

**The Network is confident the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients and offer them and their families high quality care. We believe the Commissioners should reconsider their action on adopting the health plan, as written, and take time to amend the plan in light of our comments and objections outlined here.**

As noted above, of equal concern is the fact that the MHCC has voted to expand capacity for in-patient hospice units (IPU) **without addressing a need methodology**. The Network urges MHCC to establish IPU Workgroup comprised of representatives from the hospice provider community and MHCC staff members to determine need criteria and formula for in-patient hospice units. The Hospice regulations **should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan**.

In summary, the Hospice and Palliative Care Network of Maryland opposes these regulations and requests that regulations not be promulgated until the following has occurred:

- All interested parties reach a consensus on these important issues.
- The Hospice Education Workgroup finalizes an educational plan which is put in place and operational with enough time to be able to measure its degree of success in Prince Georges County and Baltimore City.



Hospice & Palliative Care Network  
OF MARYLAND

- An IPU Workgroup is convened to create and *agree* on an objective need determination for hospice inpatient units.

As hospice experts, we take pride both in providing high quality care and in operating regulatory-compliant programs. The Network will continue to strive for fruitful collaboration with MHCC on educational endeavors, quality initiatives, and innovative strategies to enhance care for Maryland's patients and their families. Together, we must do further work on outreach and education. We sincerely believe that education, and not additional providers, is the most effective solution to hospice under-utilization.

Sincerely,

Danelle Buchman  
Executive Director

August 16, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services:

Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated

Code of Maryland. Notice of Proposed Action [13-198-P-I] [State Health Plan for Facilities and Services: Hospice Services]

Dear Ms. Cole:

As one of the Board of Directors of the Hospice & Palliative Care Network of Maryland (the "Network"), I write in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13). This action was considered by the Commission at an open meeting held on June 20, 2013 and there was no opportunity for public comment.

I must oppose the promulgation of these regulations until such time as the interested parties can reach agreement on certain aspects of the state health plan incorporated in the proposed regulations by reference.

Since the purpose of these regulations is intended to provide a policy blueprint for the Commission and affected industries to address issues related to the provision of hospice services, it is premature for these regulations to go forward. There has been no final agreement among interested parties regarding the procedural rules and standards. A Hospice Education Workgroup is still underway and there remain issues that have not been resolved. The Network values the opportunity to offer expertise on hospice care and appreciates initial collaborations with the Maryland Health Care Commission (MHCC), both in revising the methodology used to update the draft of the State Health Plan and in working on the newly formed Hospice Education Workgroup. However, these collaborations have not resulted in agreement regarding the opening of Baltimore City and Prince Georges County for docketing additional hospice providers for the following reasons:

The plan as prematurely drafted does not reflect or consider that the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients.

The proposed regulations state that they will have "minimal or no economic impact on small businesses." The opening up of additional hospices in two regions which currently have ten and nine hospice respectively will create hardship for those existing hospices which manage care under a fragile but slim economy of scale, making it more difficult

for any of these hospices to reach those citizens who have need.

It was the understanding of the legislature and the Network that no regulations would be proposed until the Hospice Education Workgroup conducted its business and developed a mechanism to account for existing hospices abilities to meet need among diverse populations.

During Hospice Chapter Workgroup meetings last fall and in testimony given at the Senate Finance Committee hearing on January 24, 2013, the Network's representatives spoke to the low utilization of hospice services in Baltimore City and Prince George's County not as a matter of access but one of utilization and acceptance. There is adequate access and capacity for hospice care given by the ten providers in Baltimore City and nine providers in Prince George's County.

In spring 2010, MHCC decided that a Certificate of Need was required for in-patient hospice units (IPU). IPU is inextricably tied to the Hospice Chapter. The Network urges MHCC to collaborate with the Network on an IPU Workgroup to determine need criteria and formula for in-patient hospice units. **The Hospice regulations should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan.**

Many complex factors determine a patient's choice to enter hospice. They sometimes involve the patient's or family's individual cultural, ethnic, spiritual, or psycho-social perceptions. Other specific patient-related factors as well as the patient's family situation can influence hospice choice. Research<sup>1</sup> indicates that diverse populations tend to under-utilize hospice. This may be due to inadequate education on the benefits of hospice or to cultural factors. The Network believes that we shared consensus with MHCC on this issue thus the formation of the Hospice Education Workgroup. The workgroup is charged to increase hospice awareness and utilization in demographically diverse communities through educational endeavors.

With this workgroup intact there is no reason to introduce new providers in these two jurisdictions. I am concerned that the Commissioners voted to promulgate the regulations after the informal comment period without waiting for the Hospice Education Workgroup to thoroughly research and formulate its plan on how to increase hospice use among diverse populations. As stated previously the Network believes that all the parties agreed earlier in the year to wait on promulgating regulations until the workgroup finished its work.

**The workgroup needs time to gain substance, definition, measurement, momentum, and implementation of strategies to determine if educational outreach makes a true difference in our communities and increases hospice utilization**

Consistent with the position we articulated in our letter of May 3 and the recommendations of the Senate Finance Committee, the Network further proposes that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point: an application to establish a new general hospice in Maryland, or to

expand the services of an existing general Maryland hospice to a new jurisdiction will only be docketed if, and only if, analysis determines that the current infrastructure cannot meet the additional need.

**The Network is confident the current providers in these jurisdictions have the Infrastructure, capacity, and scale to serve additional patients and offer them and their families high quality care. We believe the Commissioners should reconsider their action on adopting the health plan, as written, and take time to amend the plan in light of our comments and objections outlined here.**

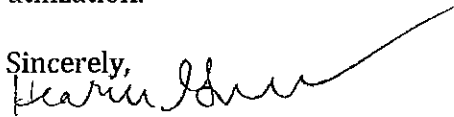
As noted above, of equal concern is the fact that the MHCC has voted to expand capacity for in-patient hospice units (IPU) **without addressing a need methodology**. The Network urges MHCC to establish IPU Workgroup comprised of representatives from the hospice provider community and MHCC staff members to determine need criteria and formula for in-patient hospice units. The Hospice regulations **should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan.**

In summary, I oppose these regulations and requests that regulations not be promulgated until the following has occurred:

- All interested parties reach a consensus on these important issues.
- The Hospice Education Workgroup finalizes an educational plan which is put in place and operational with enough time to be able to measure its degree of success in Prince Georges County and Baltimore City.
- An IPU Workgroup is convened to create and *agree* on an objective need determination for hospice inpatient units.

As a hospice expert, I take pride both in providing high quality care and in operating regulatory-compliant programs. I know I as well as the entire Network will continue to strive for fruitful collaboration with MHCC on educational endeavors, quality initiatives, and innovative strategies to enhance care for Maryland's patients and their families. Together, we must do further work on outreach and education. I sincerely believe that education, and not additional providers, is the most effective solution to hospice under-utilization.

Sincerely,

  
Heather Guerieri RN, MSN, CHPN  
Executive Director



MedStar St. Mary's  
Hospital  
*Hospice*

P.O. Box 625  
Leonardtown, Maryland 20650  
301-994-3023 PHONE  
301-994-3318 FAX  
hospiceofstmarys.org

August 26, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Ms. Cole:

On behalf of Hospice of St Mary's I am writing in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13).

As the Southern representative on the board of the Hospice and Palliative Care Network of Maryland I must echo the Network's concerns regarding the finalization of these regulations. MHCC has welcomed the Hospice Network to the table on several occasions and has worked collaboratively with us in addressing end of life issues. We were hoping that MHCC would not move forward on these regulations until the Education Work group had completed its review. The workgroup is charged to increase hospice awareness and utilization in culturally diverse communities through educational endeavors. The underutilization of hospice in minority populations is a very complex issue. While I believe education will help- I am not convinced it alone will drive utilization up. To this end there needs to be specific measures established to determine if public outreach efforts actually do increase utilization. The workgroup needs more time to develop these measures.

With regard to Baltimore City and PG County, the issue of underutilization has nothing to do with the lack of availability of services. To open these areas up to docketing will absolutely create a hardship for the existing hospices. Even a small hospice like us has the ability to flex up and down as census dictates. All of operate on the principle that no one in need is ever turned away.

---

Thank you for your thoughtful consideration of the above. Hospice of St. Mary's is thankful to be a member of the Hospice and Palliative Network of Maryland. All of us strive to provide excellence in end of life services for our communities.

Sincerely,



Kathryn Franzen  
Director

Knowledge and Compassion  
**Focused on You**



Anne Arundel County  
90 Ritchie Highway • Pasadena, MD 21122  
phone: 410.987.2003 • fax: 443.837.1505  
Prince George's County  
9500 Arena Drive • Suite 250 • Largo, MD 20774  
phone: 301.499.4500 • fax: 240.487.1081  
hospicechesapeake.org

August 23, 2013

Ms. Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Cc: Senate Thomas "Mac" Middleton, Chair, Senate Finance Committee  
Senator John Astle, Vice Chair, Senate Finance Committee

**Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services: Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of Proposed Action [13-198-P-1] [State Health Plan for Facilities and Services: Hospice Services]**

Dear Ms. Cole:

On behalf of Hospice of the Chesapeake, I write in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13).

Our organization must oppose the promulgation of these regulations until such time as the interested parties can reach agreement on certain aspects of the state health plan incorporated in the proposed regulations by reference.

Since the purpose of these regulations is intended to provide a policy blueprint for the Commission and affected industries to address issues related to the provision of hospice services, it is premature for these regulations to go forward. There has been no final agreement among interested parties regarding the procedural rules and standards. A Hospice Education Workgroup (HEW) is still underway and there remain issues that have not been resolved.

Hospice of the Chesapeake appreciates the collaborations with the Hospice and Palliative Care Network of Maryland (Network) and the Maryland Health Care Commission (MHCC), both in revising the methodology used to update the draft of the State Health Plan and in working on the newly formed HEW. However, these collaborations have not resulted in agreement regarding the opening of Baltimore City and Prince Georges County for docketing additional hospice providers for the following reasons:

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1. The plan as prematurely drafted does not reflect or consider that the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients.
2. The proposed regulations state that they will have "minimal or no economic impact on small businesses." The opening up of additional hospices in two regions which currently have ten and nine hospice respectively will create hardship for those existing hospices which manage care under a fragile but slim economy of scale, making it more difficult for any of these hospices to reach those citizens who have need.
3. It was the understanding of the legislature and the Network that no regulations would be proposed until the HEW conducted its business and developed a mechanism to account for existing hospices abilities to meet need among diverse populations.
4. During Hospice Chapter Workgroup meetings last fall and in testimony given at the Senate Finance Committee hearing on January 24, 2013, the Network's representatives spoke to the low utilization of hospice services in Baltimore City and Prince George's County not as a matter of access but one of utilization and acceptance. There is adequate access and capacity for hospice care given by the ten providers in Baltimore City and nine providers in Prince George's County.
5. In spring 2010, MHCC decided that a Certificate of Need was required for in-patient hospice units (IPU). IPU is inextricably tied to the Hospice Chapter. The Network urges MHCC to collaborate with the Network on an IPU Workgroup to determine need criteria and formula for *future* (not currently approved) in-patient hospice units. **The Hospice regulations should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan.**

Many complex factors determine a patient's choice to enter hospice. They sometimes involve the patient's or family's individual cultural, ethnic, spiritual, or psycho-social perceptions. Other specific patient-related factors as well as the patient's family situation can influence hospice choice. Hospice of the Chesapeake believes that we shared consensus with the Network and MHCC on this issue thus the formation of the HEW and our participation in this work. The HEW is charged to increase hospice awareness and utilization in demographically diverse communities through educational endeavors. With this workgroup intact there is no reason to introduce new providers in these two jurisdictions.

Hospice of the Chesapeake is disappointed that the Commissioners voted to promulgate the regulations after the informal comment period without waiting for the HEW to thoroughly research and formulate its plan on how to increase hospice use among diverse populations. As stated previously the Network believes that all the parties agreed earlier in the year to wait on promulgating regulations until the HEW finished its work.

**The HEW needs time to gain substance, definition, measurement, momentum, and implementation of strategies to determine if educational outreach makes a true difference in our communities and increases hospice utilization.**

Consistent with the position the Network articulated in a letter dated May 3 and the recommendations of the Senate Finance Committee, the Network has further proposed that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point:

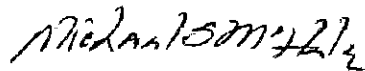
an application to establish a new general hospice in Maryland, or to expand the services of an existing general Maryland hospice to a new jurisdiction will only be docketed if, and only if, analysis determines that the current infrastructure cannot meet the additional need.

**Hospice of the Chesapeake is confident that we and other providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients and offer them and their families high quality care. We believe the Commissioners should reconsider their action on adopting the health plan, as written, and take time to amend the plan in light of our comments and objections outlined here.**

As noted above, of equal concern is the fact that the MHCC has voted to expand capacity for in-patient hospice units (IPU) **without addressing a need methodology**. The Network urges MHCC to establish IPU Workgroup comprised of representatives from the hospice provider community and MHCC staff members to determine *future* (not currently approved) need criteria and formula for in-patient hospice units. The Hospice regulations **should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan**.

As a hospice provider, Hospice of the Chesapeake will continue to strive for productive collaboration with the Network and MHCC on educational endeavors, quality initiatives, and innovative strategies to enhance care for Maryland's patients and their families. Together, we must do further work on outreach and education. We sincerely believe that education, and not additional providers, is the most effective solution to hospice under-utilization.

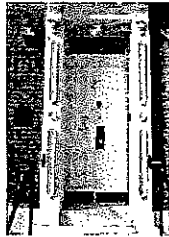
Sincerely,

A handwritten signature in black ink that reads "Michael S. McHale". The signature is written in a cursive, slightly slanted style.

Michael S. McHale  
President and CEO

June 28, 2113

Craig Tanio MD, MPH, Chair  
The Maryland Health Care Commission:  
201 West Preston Street  
Baltimore, MD 21201



# Joseph Richey Hospice



#### Officers

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The Rev. Frederick Thomas, Jr.  
William P. Young, Jr. Esquire

Dear Dr. Tanio:

Regarding: Changes to the State Health Plan for hospice care.

Comment submitted by: Charlotte Hawtin Executive Director,  
Joseph Richey Hospice and Dr. Bob's Place

Joseph Richey Hospice operates the only freestanding hospice facilities and services in the city of Baltimore and serves the community with hospice homecare. Over 74% of the people we serve are African American. This has been a consistent picture. Our facilities are located on bus and light rail lines.

There are a number of reasons there is lower use of hospice by African Americans in Baltimore City and Prince Georges County. Many African Americans do not engage or utilize a primary care physician. They use services such as Patient First and hospital emergency rooms. The immediacy of treatment at a Patient First and the emergency room is compelling. They are often unaware of the role of a primary care doctor in terms of keeping a longitudinal record on their health care. African Americans are often diagnosed later with terminal illness due to the venue they choose for care. We often serve people with hospice care who were only very recently diagnosed. We have built a trust relationship with the community. The final reason African Americans use hospice less often is the family. Usually in the extended family there are several people who are employed as health care RN's, aides or workers. These people often provide care to a family member without accessing hospice services.

Our staff includes an African American Medical Director, several African American RN's, African American hospice aides, social worker, cooks, housekeepers and security personnel. JRH staff is frequently acquainted with the people who come to us for care or with their families. Over time this builds trust. We do not limit stays at our 20-bed adult inpatient unit to only those days billable at the inpatient level of care. We provide a place for care especially to those who have no able caregiver regardless of reimbursement. We usually operate our inpatient adult unit with a waiting list. Over the past 25 years we have served terminally ill people who are blind, physically, developmentally and mentally disabled and those recently released from prison. We accept patients with no insurance and those who are MA pending. All of these elements help to serve our city. JRH is the only hospice in Maryland that is funded by Ryan White and Housing Opportunities for People with AIDS.

The Centers for Medicare and Medicaid Services have designated JRH as an 'Essential Care Organization' due to our services to the disadvantaged and minorities.

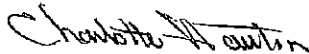
Adding additional hospices to the mix will not change the picture in Baltimore or Prince Georges County.

We are slowly expanding our services. I have hired marketers to build our homecare census. Over a third of those we serve each year are insured by Medicaid managed care organizations. We know the city. We do not use security personnel to accompany our nurses. Our nurses call before going to a home. Usually the neighborhood knows about someone who is terminally ill on the block and welcomes us. Suburban hospice providers do not know the city.

We also operate Dr. Bob's Place, a hospice for children providing end of life care to kids at home and at our inpatient unit. We recently submitted an application to the state to provide respite care to medically fragile children, who have a life limiting diagnosis outside the hospice criteria. Dr Bob's Place like JRH also serves predominantly African American patients.

I am not per se opposed to adding more hospices to the city mix. We have always operated in a competitive environment. But I do not think expanding the number of hospices will yield the result you seek. I am happy to talk to the members of the Maryland Health Care Commission about my observations and to give you a tour. We are just across the street!

Sincerely,



Charlotte Hawtin  
Executive Director

GORDON • FEINBLATT<sup>LLC</sup>  
ATTORNEYS AT LAW

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August 26, 2013

**VIA FAX: 410-358-8811**  
**VIA EMAIL: linda.cole@maryland.gov**

Ms. Linda Cole, Chief  
Long Term Care Policy and Planning  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD 21215-2299

Re: Proposed Revisions to the State Health Plan for Facilities  
and Services - Hospice Services

Dear Ms. Cole:

This letter is written on behalf of LifeBridge Health, Inc. ("**LifeBridge**") to comment on the proposed permanent regulations (the "**Proposed Regulations**") reenacting the State Health Plan for Facilities and Services: Hospice Services (the "**State Health Plan**") at COMAR 10.24.13. Please accept this letter as LifeBridge's response to the notice published in the July 26, 2013 Maryland Register inviting comment on the Proposed Regulations to the Maryland Health Care Commission (the "**Commission**").

LifeBridge applauds the Commission's decision to revise the State Health Plan to keep pace with the growing demand for hospice in Maryland as patients, their families, and health care practitioners become more aware of the value of hospice as a holistic approach to end-of-life care.<sup>1</sup> In particular, hospice has grown in importance in institutional settings. The Proposed Regulation recognizes that "in recent years, hospice utilization in locations other than the patient's home as increased....Additional locations, such as residential hospices and inpatient units, have been developed for individuals needing care."<sup>2</sup>

This is a welcome development. Hospice at the hospital offers another hospice delivery mechanism for patients who traditionally do not have adequate access to hospice, such as

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<sup>1</sup> Supplement to COMAR 10.24.13: Statistical Data Tables (MHCC 4.10.13) (Table 2) (showing over 60% growth in total hospice admissions in Maryland between 2003 and 2011).

<sup>2</sup> Proposed Regulations, p. 3 (proposed COMAR 10.24.13.03(A)).

Baltimore City residents.<sup>3</sup> As recognized by the Commission's new need projections, Baltimore City residents' use rate for hospice services is less than 60% of the target use rate.<sup>4</sup> Outreach and education may mitigate this disparity, but the Proposed Regulations recognize that even traditional growth in capacity by existing hospice providers will not be enough<sup>5</sup>; providers need the flexibility to meet the challenge of a higher use rate.

With these comments in mind, LifeBridge offers two suggestions to the Proposed Chapter to secure flexibility in providing hospice services, without overturning the carefully tailored regulatory structure created by the Proposed Regulations.

*First*, the Commission should add a new sentence to the end of proposed COMAR 10.24.13.04(C):

“A Certificate of Need is not required to relocate the inpatient capacity of an existing licensed general hospice program to another site within the same jurisdiction, such as when a hospice relocates after being acquired by another health care facility.”

Under the current Certificate of Need rules, a licensed general hospice may relocate its existing inpatient capacity to another site within the same “primary service area” – whether pursuant to an acquisition or otherwise – without requiring a Certificate of Need, so long as the relocation does not involve a capital expenditure or a change in capacity or health care services offered.<sup>6</sup> However, the Proposed Regulations do not confirm that the primary service area of a licensed general hospice is the jurisdiction in which the general hospice is licensed to provide services.<sup>7</sup> This change would confirm that the relocation of existing inpatient capacity does not require a certificate of need application pursuant to proposed COMAR 10.24.13.06(P).

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<sup>3</sup> LifeBridge wholeheartedly agrees with the Commission that Baltimore City has a need for additional hospice capacity. Baltimore City is currently underserved. The Commission's recognition of the need in Baltimore City furthers the Commission's task to maintain “a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services” (HG § 19-109(c)(2)) and advances the Commission's mandate to achieve the “elimination of health care services disparities of minority populations” throughout Maryland's health care delivery system. *See* HG §§ 20-901, 19-134; *see also* Maryland Plan to Eliminate Minority Health Disparities: Plan of Action 2010-2014 (DHMH 2010).

<sup>4</sup> Supplement to COMAR 10.24.13: Statistical Data Tables (MHCC 4.10.13) (Table 8).

<sup>5</sup> Proposed Regulations, p. 6 (proposed COMAR 10.24.13.03(B)(3) (noting that the Proposed Regulations' need calculation methodology takes into account the growth potential of existing hospice providers; a finding of need in Baltimore City means that at current growth rates, current Baltimore City providers will not be able to meet gross need in the target year).

<sup>6</sup> *See* COMAR 10.24.01.03(D); *see also* COMAR 10.24.01.02(A)(2)(b), COMAR 10.24.01.03(A)(6).

<sup>7</sup> COMAR 10.24.13.05(A) is unclear on this point, for instance.

*Second*, the Commission should add a new subsection “E” to COMAR 10.24.13.04 to read as follows:

**“E. Institutional Care Exception.** A Certificate of Need is not required for a licensed general hospice program to provide inpatient hospice services to inpatients located at another health care facility, such as an acute general hospital or comprehensive care facility, so long as (1) the program has a Certificate of Need to operate in the jurisdiction in which the health care facility is located; and (2) the hospice services are provided to patients in the health care facility’s licensed and approved beds, whether or not such beds are ‘clustered’ into a single unit.”

This change confirms the Commission’s preference that hospice services be delivered to patients in existing non-hospice inpatient capacity. For instance, The Proposed Regulations state that before new inpatient hospice capacity is approved, it must be demonstrated that adding such capacity “is the most cost-effective alternative for providing care to hospice patients” in light of “other options for the provision of inpatient hospice care....including...contracts with...licensed facilities, including hospitals and comprehensive care facilities[.]”<sup>8</sup> Despite the recent controversy regarding “clustered” beds, the Commission has always maintained that a hospice program may provide “unclustered” hospice services at inpatient facilities within a jurisdiction for which the hospice program has a Certificate of Need.<sup>9</sup> The Commission has recognized that in this situation, no Certificate of Need is required because no new beds have been added, and thus no one has expanded the capacity of Maryland’s health care delivery system.

LifeBridge’s suggestion would, however, reverse a recent shift by Commission staff to treat the “clustering” of hospice services within an inpatient facility as the “establishment of a health care facility” for Certificate of Need purposes.

This reversal would be salutary. Hospitals, hospices, and, most importantly, patients, need hospice services at the hospital to be provided in an organized and efficient manner. For patients near death and unable to leave a hospital or intermediate facility (a growing share of the hospice population, according to the Commission), hospice offers inpatient services (such as psychological support and bereavement counseling to the patient’s family) throughout the patient’s final days and beyond. Hospital patients transitioning “in place” to hospice services can benefit from a “home-like atmosphere” with designated “patient areas...designed to preserve the

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<sup>8</sup> Proposed Regulation, p. 14 (COMAR 10.24.13.05(P)(3)).

<sup>9</sup> See, e.g., Letter of Paul Parker to Howard Sollins Regarding Northwest Hospital (3.29.13).

dignity, comfort, and privacy of patients” and families, even in hospital settings.<sup>10</sup> As summarized by the hospice workgroup report, “[h]ospice care and palliative care programs provide valuable services to our dying patients and their families in Maryland to maximize their quality of life in their final days and to support their families....”<sup>11</sup>

It should not be correct that the Certificate of Need law requires the Commission to docket “clustered” beds receiving hospice services, while taking no notice when a hospice offers services to hospital or nursing home inpatients in beds identified on a random, ad hoc basis, and in areas that do not best permit the “home-like atmosphere” hospices strive to create. The Commission should recognize that no Certificate of Need is required to provide hospice services to inpatients when the hospice already has a Certificate of Need to operate, when no one is adding new inpatient beds to the health care delivery system, and when existing rules already prevent overutilization of hospice services in the beds that are being used.<sup>12</sup>

Your attention to these comments is very much appreciated. To discuss these comments or request their elaboration or clarification, please feel free to contact me.

Sincerely,



Jonathan Montgomery

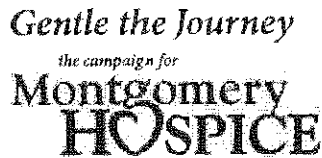
cc: Joel Suldan  
Barry F. Rosen

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<sup>10</sup> 42 C.F.R. § 418.100(e) (Medicare rules for hospices’ physical environment); *see also id* at § 418.108(a)(2) (making physical environment rules applicable to contractual arrangements with hospitals).

<sup>11</sup> “Workgroup Report on Hospice Care, Palliative Care, and End of Life Counseling: Executive Summary, p.1.

<sup>12</sup> Medicare rules state that “[t]he total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.” 42 C.F.R., §418.108(d).



<b>Hospice at Home</b>	<b>Casey House</b>
1355 Piccard Drive, Suite 100	6001 Muncaster Mill Road
Rockville MD 20850	Rockville MD 20855
phone 301 921 4400	240 631 6800 phone
fax 301 921 4433	240 631 6809 fax

[www.montgomeryhospice.org](http://www.montgomeryhospice.org)

VIA EMAIL AND US MAIL

August 23, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Cc: Senate Thomas "Mac" Middleton, Chair, Senate Finance Committee  
Senator John Astle, Vice Chair, Senate Finance Committee

Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services: Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of Proposed Action [13-198-P-I] [State Health Plan for Facilities and Services: Hospice Services]

Dear Ms. Cole:

On behalf of Montgomery Hospice, I write in response to the formal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13). This action was considered by the Commission at an open meeting held on June 20, 2013 and there was no opportunity for public comment.

I oppose the promulgation of these regulations until such time as the interested parties can reach agreement on certain aspects of the state health plan incorporated in the proposed regulations by reference.

Since the purpose of these regulations is intended to provide a policy blueprint for the Commission and affected industries to address issues related to the provision of hospice services, it is premature for these regulations to go forward. There has been no final agreement among interested parties regarding the procedural rules and standards. A Hospice Education Workgroup is still underway and there remain issues that have not been resolved.

Montgomery Hospice appreciates the collaboration with the Maryland Health Care Commission (MHCC), both in revising the methodology used to update the draft of the State Health Plan and in working on the newly formed Hospice Education Workgroup. However, these collaborations have not resulted in agreement regarding the opening of Baltimore City and Prince Georges County for docketing additional hospice providers for the following reasons:

1. The proposed regulations state that they will have “minimal or no economic impact on small businesses.” On the contrary, the opening up of additional hospices in two regions which currently have ten and nine hospice respectively will create hardship for the existing hospices that are small businesses. Having another competitor will divert resources from patient care to marketing, making it more difficult to care for those citizens who have need.
2. It was the understanding of the legislature and the Network that no regulations would be proposed until the Hospice Education Workgroup conducted its business and developed a mechanism to account for existing hospices abilities to meet need among diverse populations.
3. During Hospice Chapter Workgroup meetings last fall and in testimony given at the Senate Finance Committee hearing on January 24, 2013, the Network’s representatives spoke to the low utilization of hospice services in Baltimore City and Prince George’s County not as a matter of access but one of utilization and acceptance.
4. In the spring of 2010, MHCC decided that a Certificate of Need was required for hospice in-patient units (IPU). IPU is inextricably tied to the Hospice Chapter. The Network urges MHCC to collaborate with the Network on an IPU Workgroup to determine need criteria and formula for in-patient hospice units. **The Hospice regulations should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan, especially in light of the July 2013 MHCC decision to open IPU beds in a hospital that is already well-served by other IPUs.**

Many complex factors determine a patient’s choice to enter hospice. They sometimes involve the patient’s or family’s individual cultural, ethnic, spiritual, or psycho-social perceptions. Other specific patient-related factors as well as the patient’s family situation can influence hospice choice. Research indicates that diverse populations tend to under-utilize hospice. This may be due to inadequate education on the benefits of hospice or to cultural factors. The Network believes that we shared consensus with MHCC on this issue, resulting in the formation of the Hospice Education Workgroup. The workgroup is charged to increase hospice awareness and utilization in demographically diverse communities through educational endeavors. With this workgroup still functioning, there is no reason to introduce new providers in these two jurisdictions.

We are disappointed that the Commissioners voted to promulgate the regulations after the informal comment period without waiting for the Hospice Education Workgroup to thoroughly research and formulate its plan on how to increase hospice use among diverse populations. As stated previously the Network believes that all the parties agreed earlier in the year to wait on promulgating regulations until the workgroup finished its work.

**The workgroup needs time to gain substance, definition, measurement, momentum, and implementation of strategies to determine if educational outreach makes a true difference in our communities and increases hospice utilization.**

Consistent with the recommendations of the Senate Finance Committee, the Network further proposes that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point: an application to establish a new general hospice in Maryland, or to expand the services of an existing general Maryland hospice to

a new jurisdiction will only be docketed if, and only if, analysis determines that the current infrastructure cannot meet the additional need.

**The Network is confident the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients and offer them and their families high quality care. We believe the Commissioners should reconsider their action on adopting the health plan, as written, and take time to amend the plan in light of our comments and objections outlined here.**

As noted above, of equal concern is the fact that the MHCC has voted to expand capacity for hospice in-patient units (IPU) **without addressing a need methodology**. Montgomery Hospice urges MHCC to establish an IPU Workgroup comprised of representatives from the hospice provider community and MHCC staff members to determine need criteria and formula for hospice in-patient units. The Hospice regulations **should not move forward until an IPU need formula is collaboratively developed and incorporated into the State Health Plan**.

In summary, Montgomery Hospice opposes these regulations and requests that regulations not be promulgated until the following has occurred:

- All interested parties reach a consensus on these important issues.
- The Hospice Education Workgroup finalizes an educational plan which is put in place and operational with enough time to be able to measure its degree of success in Prince Georges County and Baltimore City.
- An IPU Workgroup is convened to create and *agree* on an objective need determination for hospice inpatient units.

I sincerely believe that education, and not additional providers, is the most effective solution to hospice under-utilization. I also believe that adding more hospice IPUs without regard to a need methodology will result in fewer hospice transfers from hospitals to home and more Marylanders dying in hospitals. It is contrary to the philosophy adopted by Maryland in its Balancing Incentive Program (BIP), which promotes the use of Home and Community Based Services (HCBS).

Sincerely,



Ann Mitchell  
President & CEO

**VIA EMAIL, FAX AND US MAIL**

August 26, 2013

Linda Cole  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

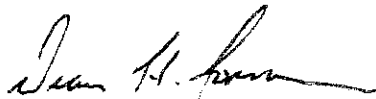
Re: Regulation .01 under COMAR 10.24.13 State Health Plan for Facilities and Services: Hospice Services. Authority: Health-General Article, §§19-109(a)(1) and 19-118, Annotated Code of Maryland. Notice of Proposed Action [13-198-P-1] [State Health Plan for Facilities and Services: Hospice Services]

Dear Mrs. Cole:

As a member of the Hospice & Palliative Care Network of Maryland I am writing in support of the August 16th letter you received from the Networks Executive Director, Ms. Danelle Buchman on behalf of the Board of Directors, of which Seasons holds a seat. We were fully involved in the writing of this letter and support it in its entirety.

One item in the Networks letter I would like to emphasize is Seasons desire to be part of an in-patient hospice units (IPU) workgroup to determine need criteria and formula for IPUs. Seasons currently operates 12 IPUs around the country and has substantial experience in assessing need for these services for our patients as well as for hospitals and the community at large. We look forward to working with the MHCC on this important part of the State Health Plan for Hospice Services.

Sincerely,



Dean Forman  
Executive Director





*Stella Maris*

60 YEARS OF CARE  
30 YEARS OF HOSPICE

August 23, 2013

Linda Cole  
Chief, Long-Term Care  
Policy & Planning  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Ms. Cole:

I am writing in response to the formal public comment period regarding the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13). This action was considered by the Commission at an open meeting held on June 20, 2013.

Stella Maris, Inc. opposes the promulgation of these regulations and we are requesting that MHCC continue to collaborate with Maryland Hospices to reach a mutual agreement on certain aspects of the State Health Plan that have the potential to negatively affect Maryland Hospices.

On January 24, 2013, testimony was provided to the Senate Finance Committee by hospice representatives based on the low utilization of hospice services in Baltimore City and Prince George's County. Based on an open dialog between the Senate Finance Committee, hospice representatives and MHCC, it was concluded that hospice use in Baltimore City and Prince George's County was not due to access, but one of utilization and acceptance. There are currently 10 providers of hospice care in Baltimore City and 9 providers in Prince George's County. Certainly, there is adequate access and capacity with the current number of providers.

What evolved from this dialog was a commitment to develop educational outreach to increase awareness and utilization in demographically diverse communities. A Hospice Education Workgroup was developed to discuss how to increase awareness of hospice in diverse communities. This Workgroup is still underway and has not yet had the opportunity to implement and evaluate the effectiveness of the existing hospices to meet the needs of the diverse populations.

I believe this Workgroup will be beneficial in determining additional outreach/educational opportunities. I also believe the Workgroup needs additional time to implement and evaluate the effectiveness of their efforts prior to opening Baltimore City and Prince George's County for additional hospices. It does not make sense to add more hospices when the consensus was for increased educational outreach. Opening these areas will only create a hardship for the existing hospices.

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Mercy Health Services  
sponsored by  
The Sisters of Mercy*

Ms. Linda Cole  
August 23, 2013  
Page 2

Certificate of Need for inpatient hospice units is tied to the Hospice Chapter. Stella Maris supports collaboration with MHCC and the Hospice Network to develop a need criteria and formula for in-patient hospice units prior to allowing an existing/new general Maryland hospice to docket for in-patient beds. The decision to create new in-patient beds or add a general hospice should only be allowed if the analysis determines that the current hospices cannot meet the additional need.

We are currently challenged with an additional 16 inpatient beds in Baltimore County that were approved by MHCC. The approval was based on what was a good business plan/venture and not on demonstrated need. The current hospice providers have demonstrated there was no need to add in-patient beds. This decision by MHCC will severely impact the existing hospices in Baltimore County. A need methodology for in-patient units must be developed. Stella Maris requests that the Hospice regulations are not approved until an IPU formula is collaboratively developed and incorporated in the State Health Plan.

In conclusion, Stella Maris opposes these regulations and requests that the regulations not be promulgated until the following has occurred:

- The Hospice Education Workgroup finalizes an educational plan which is implemented and operational with sufficient time to be able to measure its success in Baltimore City and Prince George's County prior to opening these areas for additional hospices.
- An IPU Workgroup is established to create and agree upon a need methodology for inpatient units.

I thank you for this opportunity to comment on the State Health Plan and look forward to collaborating with MHCC to resolve our concerns.

Sincerely,



Lisa Stone

Sr VP Outreach Services

cc: Senator Thomas "Mac" Middleton, Chair Senate Finance Committee  
Senator John Astle, Vice-Chair, Senate Finance Committee

WMHS Hospice Service  
1050 W. Industrial Blvd  
Ste 19  
Cumberland, Md 21502

August 26,2013

Linda Green/Clinical Director Hospice

ATTENTION:

Linda Cole

Chief,Policy& Planning Center for LTC & Community-Based Svcs

Ms Cole:

I am aware of the feedback to you re: COMAR 12 24 13: Health Plan Hospice Services from the Hospice and Palliative Care Network of Maryland. I support the work and respect the knowledge of this group. Here in Western Maryland, we have felt our small program to be protected by the current CON requirements for Hospice licensure. It is a stormy sea these days and for small programs a very threatening financial environment. We constantly strive to provide the best quality End of Life Care. This is difficult in the face of shorter lengths of stay and rising costs to provide what is needed. In addition we compete for a valuable and required volunteer force. While the philosophy of a free market is appealing, in our corner of the state it is daunting to consider the potential for additional providers of specialized End of Life Care dividing a small pie and shrinking a limited revenue source.

I have been the Clinical Director of our program for 17 years. Never at any time have I made a decision r/t patient/ family care with the thought that I did not need to worry "because we are the only Hospice in the county".In fact this has been an impetus to provide the best to our patients/families because they do not have choice in provider. We strive to be as good as the best in our state and our benchmarking surveys seem to support that we are meeting this goal.

Thank you in advance for hearing our concerns.

If you wish to speak with me or need further information, I can be reached at 240-964-9002.

Thank You

Linda Green RN/ Clinical Director Hospice