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MEMORANDUM

TO: Commissioners

FROM: Linda Cole
Chief, Long Term Care Policy and Planning

DATE: June 13, 2013

RE: **Action on Proposed Permanent Regulations:**
COMAR 10.24.13: State Health Plan for Facilities and Services - Hospice Services

Repeal of Part of COMAR 10.24.08: State Health Plan for Facilities and Services - Nursing Home, Home Health Agency, and Hospice Services

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A revised draft Hospice Services Chapter of the State Health Plan for Facilities and Services was presented to you at the April 2013 Commission meeting. The draft Chapter was released for a 30-day informal public comment period that ended on May 10, 2013. Comments were received from 12 organizations and individuals. Attached are the following documents for your consideration:

1. ***Analysis of Informal Public Comments and Staff Recommendations – Draft State Health Plan for Facilities and Services: Hospice Services COMAR 10.24.13.*** The comments are grouped by category, followed by Staff's analysis and recommendation. Copies of the original comments are attached in Section III.

2. ***State Health Plan for Facilities and Services: Hospice Services, COMAR 10.24.13:*** Staff will recommend that the Commission adopt this Chapter to replace the Commission's current regulation of hospices services, which is contained in COMAR 10.24.08.

3. ***State Health Plan for Facilities and Services: Nursing Home, Home Health Agency, and Hospice Services, COMAR 10.24.08.*** This is the current Chapter that includes hospice services (in addition to nursing home and home health agency services). Staff will ask you to repeal the portion of this Chapter that deals with hospice services (found at pages 49-62), contingent on the new Chapter becoming effective.

At the Commission meeting, Staff will make a presentation regarding the comments received and Staff's recommendations.

MARYLAND
HEALTH CARE
COMMISSION

Analysis of Informal Public Comments and Staff Recommendations

Draft State Health Plan for Facilities and Services:

Hospice Services

COMAR 10.24.13

June 20, 2013

I. STATE HEALTH PLAN FOR FACILITIES AND SERVICES: HOSPICE SERVICES (COMAR 10.24.13)

Introduction:

The current Chapter of the State Health Plan (“Plan”), COMAR 10.24.08, includes nursing home, home health agency, and hospice services. These services will be updated in separate Plan Chapters. This is the first Chapter to be updated to address hospice services. This Chapter (COMAR 10.24.13) was developed by Commission staff with the assistance of a Hospice Work Group, composed of representatives of hospices, Medicaid, Centers for Medicare and Medicaid Services, the Office of Health Care Quality, and others. The draft Chapter was sent out for Informal Public Comment in April, 2012. Due to the volume of comments received, the Plan Chapter, including the need methodology was revised.

The revised Hospice Plan Chapter was sent out for another Informal Public Comment period from April 10- May 10, 2013. Comments were received from a total of 12 organizations:

- Erickson Living (Adam Kane)
- Gilchrist Hospice (Catherine Hamel)
- Hospice and Palliative Care Network of Maryland (Danelle Buchman) –“Hospice Network”
- Hospice of St. Mary’s (Christine Wray)
- Lifespan Network (Danna Kauffman)
- MedChi (Gene Ransom)
- Montgomery Hospice (Ann Mitchell)
- Office of Health Care Quality (Patricia Nay)
- Seasons Hospice (Dean Forman)
- Stella Maris (Lisa Stone)
- Talbot Hospice (J T Smith II)
- Worcester County Health Planning Advisory Council (Mary Stevens)-“Worcester County”

The remainder of this document provides a summary of the written comments received and staff analysis and recommendations. A complete set of the written comments received on the draft Plan Chapter is attached.

II. SUMMARY AND ANALYSIS OF PUBLIC COMMENTS

Section .02: Introduction

- OHCQ:

  "Currently (March, 2013), hospice houses are not licensed by the Office of Health Care Quality (OHCQ), which is in the process of developing regulations for such entities."

  Suggested language: "The Office of Health Care Quality (OHCQ) will begin licensing and regulating hospice houses on January 1, 2014."

  Staff Analysis and Recommendation:

  Staff agrees to insert the suggested updated wording.

Section .03: Issues and Policies: Hospice Services

Section .03B(1): Availability and Accessibility of Hospice Services.

- Hospice Network:

  "The Network appreciates the collaboration with MHCC in the development of the Hospice Education Workgroup and is hopeful that the group will be able to develop meaningful solutions to educate more people about the benefits of hospice for patients and their family members."

- Stella Maris:

  "Stella Maris also commends the Commission for its collaboration with the Hospice and Palliative Care Network of Maryland with the development of the Hospice Education Workgroup."

- Hospice of St. Mary's:

  "We commend Commission staff for establishing the Hospice Education Workgroup and look forward to contributing to this effort."

- MedChi:

  "On behalf of MedChi, I appreciate the MHCC reaching out to our organization to discuss ways in which state policy can assist in promoting greater diversity in doing outreach to underserved communities that have historically had less hospice utilization."

- Worcester County:

  “The Council appreciates the MHCC concern for improving patient choice, which is introduced on page 4 in Section .03B. It translates to regulations about jurisdictions with only one hospice provider in .04B. Docketing Sole Provider Jurisdictions and in .04D Service Exception. Taken together these two alternatives show willingness to balance viability of service providers with fostering of patient choices.

  On page 4, Section .03B (1) first paragraph refers to “increased by 75% from 12,247 to 21.834. The last number should use a comma and be ’21,834’.”

  Staff Analysis and Recommendation:

  Staff appreciates the participation and support of all of the Hospice Education Workgroup members. No change is needed in the draft. The typographical error will be corrected.

Section .03B(3): Data Collection and Need Projection.

- Worcester County:

  “On page 5 into page 6 the document identifies the increase in the numbers of patients with live discharges as conditions improve. It is not clear in the standards where this is reflected as the calculation of need only uses death data. Can you add a note on page 6 that hospice agency capacity uses all discharges in calculation of services provided, but as yet the impact of the increasing number of live discharges is not sufficient to impact need calculations.”

  Staff Analysis and Recommendation:

  While there has been a clear rise in live discharges, the literature related to hospice services has consistently used deaths as the metric of choice for calculating use rates, demand, and ultimately need. For the sake of simplicity and understandability, as discussed and recommended by the Hospice Work Group, the methodology for calculation of hospice need has been restricted to hospice deaths alone, and does not include live discharges.

  Staff recommends replacing the sentence on the top of page 6 with the following sentence: “Although the growth in live discharges is reflected in the growth in both hospice patients and hospice patient days, the methodology, for consistency with the literature, internal consistency, and ease of understanding, uses hospice deaths for its forecast.”

- OHCQ:

  “Seventh page: ‘Furthermore, since some hospice care is provided by home health agencies, the impact of the prospective payment system on home health care may also have an impact on hospice services.' Comment: Home health agencies do not provide hospice care, though they provide home health services, including palliative care."

Staff Analysis and Recommendation:

For clarity, remove: "Furthermore, since some hospice care is provided by home health agencies, the impact of the prospective payment system on home health care may also have an impact on hospice services."

- Montgomery Hospice/ Hospice Network:

  In 5th paragraph, second sentence reads: "By October 2013, the Centers for Medicare and Medicaid Services (CMS) is required to implement revisions to the methodology for determining payment rates for routine home care and other services included in hospices." Comment: "Finally, although CMS must change the hospice reimbursement methodologies by October 1, 2013, it is not required to do so at that time."

  Staff Analysis and Recommendation:

  Revise the sentence as follows: *No earlier than* October 1, 2013, the Centers for Medicare and Medicaid Services (CMS) is required to *begin* implementation to…" (new language in italics)

Section .04: Certificate of Need Docketing and Exception Rules: Hospice

Section .04A General Docketing

- Seasons Hospice:

  "The Docketing Rules should be conformed to each other in relation to inpatient bed capacity. On page 8 of the draft Chapter, under Regulation .04A(1), the introductory language should state: 'Except as noted in .04B(1), (2), *or C below*…' (emphasis added) It is apparent that .04C is a specific rule for inpatient capacity applications."

- Hospice Network:

  "The Network proposes, consistent with the recommendations of the Senate Finance Committee, that Section .04A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point that 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, after an analysis, it is determined that the current infrastructure cannot meet the additional need."

- MedChi:

  "Unlike many other states, Maryland continues to restrict providers from entering the hospice market and the draft update continues that policy….Further, the methodology to calculate volumes and capacities leaves few opportunities to expand the market….In general, the restrictions have served Maryland well by protecting our strong hospice community and limiting the involvement of out of state companies that have been found to engage in questionable business practices. However, these restrictions may also result in a significant lack of new providers that may have a different approach and more success in connecting with underserved populations."

Staff Analysis and Recommendation:

Seasons' comments refer to the introductory language which states, "Except as noted in .04B(1) and (2) below, the Commission will only consider an application for docketing to establish a new general hospice in the jurisdiction or to expand the general hospice services of an existing hospice to that jurisdiction if the net need…." The introductory language to Section .04C states: "A Certificate of Need application by an existing general hospice to establish inpatient capacity or to change the inpatient bed capacity operated by the hospice under its general hospice license may be docketed without regard to need projections generated…." This language lays out the different scenarios and indicates that bed need governs the development of a new general hospice or expansion into a new jurisdiction, but not the development of inpatient capacity for an existing general hospice. For clarification, and in response to Seasons' comment, staff recommends adding to.04A. General Docketing: *Establishment of a General Hospice or Expansion into a New Jurisdiction.* "(italics indicate new wording)

With respect to MedChi's comments, the docketing rules identify types of facilities that have experience in providing hospice services; these include: existing Maryland general and limited license hospices; hospice providers in other states; hospitals; comprehensive care facilities; and home health agencies. These health care facilities are most closely linked to the experience of providing hospice care. Staff believes that health care facilities comprise an appropriate pool of potential applicants and does not recommend expansion at this time.

With respect to the Hospice Network's recommendation, the need methodology (which was proposed by the Hospice Network), explicitly accounts for capacity of the existing infrastructure in identifying unmet need. The capacity of existing providers to meet future demand is calculated using the compound annual growth rate based on five years of data and projecting the capacity of providers forward to the target year. Unmet need is calculated by subtracting the future capacity of existing providers from the target year gross need, which is calculated by multiplying the target year hospice use rate by the expected deaths in the target year. This approach to accounting for the capacity of the existing infrastructure to meet future demand was proposed by the Hospice Network on August 17, 2012.

Section .04B Docketing: Sole Provider Jurisdictions.

- Talbot Hospice:

  "Proposed Section 10.24.13.04B(2) allows docketing of an application by an existing limited license hospice in a "sole provider" jurisdiction to allow that limited license hospice to become a general hospice, notwithstanding volume criteria that would otherwise apply. THF strongly endorses this proposal. However, informal discussions with your office have suggested that the proposed amendment to the docketing rule may not take effect until after the expiration of THF's limited license in December of 2013, and that application by THF after that date could not be docketed… THF proposes a change in the language: 'the Commission may docket an application by a hospice provider that operated a limited license in 2013 in the jurisdiction to become a general hospice in that jurisdiction…This small change will perfect the evident intent of the proposed rule and not make it hostage to the timing of completion of the rulemaking effort.'"

  Staff Analysis and Recommendation:

  Staff has checked with OHCQ and THF can extend its limited license after its expiration in December, 2013. An application could be docketed by the Commission after the Hospice Plan Chapter regulations become effective. Therefore, no change is recommended.

Section .04C Docketing: Inpatient Capacity

See comments by Seasons Hospice under .05P below.

Section .04D Service Exception

- Erickson Living:

  "Erickson Living proposes a new subsection that empowers the consumer to request a Service Exception and discretion to the Executive Director to grant such a request:

  .04D(4): A consumer may request an exception from the Executive Director that permits a Maryland licensed general hospice to provide services outside of its service area."

  Staff Analysis and Recommendation:

  The Service Exception is set up as a rare occurrence, under exceptional circumstances, for when a hospice authorized in the service area cannot provide the needed services. These requests are usually of an emergent nature and require the affected parties to confer and resolve it as quickly as possible. Consumers do have a choice, which they can express to a provider when an authorized hospice cannot be found to provide desired hospice services. For example, there have been cases where Jewish Social Services Agency Hospice was granted permission to serve clients whose preference was to have a hospice to meet their religious needs. Hospice patients and their families are under a great deal of stress and should not have to deal with navigating the state exceptions processes. No change is recommended.

Section .05: Hospice Standards

Section .05A Service Area

- Erickson Living:

  "The State Health Plan should consider allowing specialized hospices that target unique populations or integrate with different health care models. 'An applicant may select a subset of a service area that targets a specialized population or a specialized care model.'"

- Lifespan:

  "In reviewing this State Health Plan, Lifespan would like to recommend inclusion of language that would allow continuing care retirement communities to provide hospice to residents similar to the current requirements governing specialty home health agencies in CCRCs. "

  Staff Analysis and Recommendation:

  Many continuing care retirement communities (CCRCs) contract with community hospices to provide hospice care in the residence (independent living, assisted living, nursing home bed) of the subscriber. This proposal, if made part of the Chapter, may create multiple new hospice programs in jurisdictions where the methodology does not show need for even a single new hospice program. The suggested change would give CCRC residents special access to a new provider whose services would not be available to members of the general public when no evidence has been presented that CCRC residents have problems with access to needed hospice services different from any member of the general public. No change is recommended.

Section .05C Minimum Services

- OHCQ:

  "An applicant shall provide the following services directly: (a) physician services and medical direction; (b) skilled nursing care; (c) medical social services; (d) counseling (including dietary counseling): (e) hospice aide and homemaker services; (f) spiritual services; and (g) on-call nursing response." Comment: "We believe that a, e, f, and g may be contracted rather than directly provided. Please see the federal hospice regulations. “

Staff Analysis and Recommendation:

OHCQ is correct that services that must be provided directly are: nursing, medical social services, and all counseling services (including bereavement and nutrition). Services that may be contracted include: physician, hospice aide, and physical, occupational, speech therapies. All licensed professionals, whether direct employees or contract must participate in the hospice’s in-service training program. All individuals must also receive orientation about the hospice philosophy.

Staff recommends rewriting this standard as follows:

C. Minimum Services.

(1) An applicant shall provide the following services directly:

(a) Skilled nursing care;

(b) Medical social services;

(c) Counseling (including bereavement and nutrition counseling)

(2) An applicant shall provide the following services, either directly or through contractual arrangements:

(a) Physician services and medical direction;

(b) Hospice aide and homemaker services;

(c) Spiritual services;

(d) On-call nursing response:

(e) Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management);

(f) Personal care;

(g) Volunteer services;

(h) Bereavement services;

(i) Pharmacy services;

(j) Laboratory, radiology, and chemotherapy services as needed for palliative care;

(k) Medical supplies and equipment; and

(l) Special therapies, such as physical therapy, occupational therapy, speech therapy, and dietary services.

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

Section .05 N Public Education Programs

- Worcester County:

  "Though the section on public education programs is excellent, our concern is that the word 'disparity' is not used in any of these sections and should appear at least in .05 Standard N."

  Staff Analysis and Recommendation:

  Suggested rewording: "An applicant shall document its plan to provide public education programs designed to increase awareness of the needs of dying individuals and their caregivers, *to increase the provision of hospice services to minorities and the underserved and to reduce the disparities in hospice utilization*. Such a plan shall detail the appropriate methods it will use to reach and educate diverse racial, religious, and ethnic groups *that have used hospice services at a lower rate than the overall population* in the proposed hospice's service area." (new language in italics).

Section .05P Inpatient Unit

- Seasons Hospice:

  "There should be only one Impact Standard for inpatient bed capacity. This Standard should recognize the need of general hospices to have the capacity to provide services to patients in need of inpatient services. The Hospice Standards under Regulation .05G, which is a general Impact Standard, states that it applies, in part, to a 'change in inpatient bed capacity.' However, in addition to this general Hospice Standard, there are specific standards applicable to an 'Inpatient Unit', under Regulation .05P. It is advisable that this duplicate reference…should be eliminated…"

  Staff Analysis and Recommendation:

  For purposes of clarity, staff recommends that applicable language in .05G regarding establishment or expansion of an inpatient hospice unit be moved to .05P as follows: "An applicant shall project the impact of its inpatient unit on future demand for hospice services provided by existing general hospices authorized to serve each jurisdiction affected by the project."

- Seasons Hospice:

  "Also, Impact should not be judged based on prospective future demand that might be forecast. It has not been the case that the CON process, administered by the Commission or its predecessor, the former Health Resources Planning Commission, makes CON decisions based on a regulation or projection of future 'demand' versus 'need'.'"

  Staff Analysis and Recommendation:

  The standard asks the applicant to "quantitatively demonstrate the impact of the establishment or expansion of the inpatient hospice capacity on hospices in the jurisdiction…." This is a standard assessment that has been included in Chapters of the State Health Plan and in COMAR 10.24.01 CON review criteria by both the current and predecessor Commissions. No change is recommended.

- Seasons Hospice:

  "Finally, Regulation .05P(2) should be removed or revised. It requires an Applicant to meet a quantitative standard for which it may have no access to information about other hospices and their capacity. This language should state that the Applicant's evaluation should be based on 'publicly available data.'"

  Staff Analysis and Recommendation:

  This standard requires the applicant to quantitatively demonstrate the impact of its project on other hospice programs. The applicant can use any publicly available data. However, since an applicant may also want to use its own data or data compiled by consultants, academics, or others, staff does not want to restrict the data sources. No change is recommended.

- Seasons Hospice:

  "A revision to the Cost-Effectiveness Standard is warranted. In evaluating options, the Applicant…is asked to demonstrate that its project is the 'best' alternative for providing care to patients. Rather than using this standard, the Chapter would better provide for a comprehensive evaluation of a CON applicant if it required the Applicant to demonstrate that the bed capacity is a cost-effective option. 'Best' is a relative term and, while cost-effectiveness is important, it is one standard among several."

  Staff Analysis and Recommendation:

  Staff agrees that the CON review process should be comprehensive and that the cost effectiveness standard is one among many. The Commission also requires that in proposing a project, an applicant would have considered multiple options in developing the approach that it considers the best. Therefore the applicant should be able to address this standard, which is a standard used in SHP and CON review criteria. For clarity, staff recommends changing the word “best” to “most cost-effective.”

Section .06 Methodology for Projecting Need for General Hospice Services

Typographical Error

- Worcester County:

  “On page 15, the sentence is .06C Services (1) is not clear with respect to the use of the word ‘both.’ Please consider moving it to before ‘general and limited’ or before ‘need projections and inventory’, whichever is appropriate.”

  Staff Analysis and Recommendation:

  Revise as follows: “General and limited hospice programs are included in *both* the need projections and inventory.” (Italics indicate changed wording)

Development of Methodology

- Stella Maris:

  “As a member of the Hospice Work Group, I am appreciative of the collaborative efforts that the MHCC has afforded our industry in revising the methodology to update the state health plan.”

- Montgomery Hospice:

  “First of all, Montgomery Hospice greatly appreciates the collaborative work in December 2012 and January 2013 between the MHCC staff and Sue Lyn Schramm, consultant for the Hospice and Palliative Care Network of Maryland.”

- Hospice Network:

  “Over the past year, the Network has appreciated the collaborative approach that the Maryland Health Care Commission (MHCC) has demonstrated in revising the methodology used to update the draft of the state health plan.”

  Staff Analysis and Recommendation:

  Staff appreciates the willingness of the hospice industry and their consultant to work with staff in a collaborative manner to amend and update the need methodology for hospice services. Staff spent time during Hospice Work Group meetings reviewing each variable and component of this methodology, as well as its outcome, in achieving consensus.

Number of Existing Providers

- Hospice Network:

  “During the Hospice Work Group meetings and testimony given at the Senate Finance Committee hearing, the Network’s representatives articulated the low utilization of hospice services in Baltimore City and Prince George’s County was not 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.”

- Montgomery Hospice:

  “I also would argue that the existing 9 or 10 hospices in Baltimore City and Prince George’s have the infrastructure, capacity and scale to admit and care for additional patients.”

- Stella Maris:

  “The testimony that was provided during the Senate Finance Committee indicated that there is low utilization of hospice services in Baltimore City and Prince George’s County, despite the fact that there are ten (10) providers in Baltimore City and nine (9) providers in Prince George’s County.”

Staff Analysis and Recommendation:

The draft Chapter’s approach explicitly accounts for the capacity of existing providers to grow and meet future demand. In fact, the proposed alternative approach to account for this capacity was recommended on August 17, 2012 by the Hospice Network, which suggested this alternative methodology.

The Hospice Network methodology proposed the following steps (emphasis added):

> 3. To accurately estimate future <u>unmet</u> need based upon raw hospice need (i.e., the number of people needing hospice care), the state should recognize that current providers are capable of growth. Our proposed formula accounts for future growth among existing providers and assumes that they will be able to continue growing as they have during the five-year baseline period by hiring additional hospice clinicians to meet increased hospice need in their jurisdictions.
>
> 6. Calculate the compound annual growth rate exhibited by hospice providers during the five year period from 2006-2010. (See Step 6: Supplemental Table C.)
>
> 7. Forecast hospice volume that will be delivered by existing providers in the target year 2015 by using the rate of compound annual growth exhibited in each jurisdiction during the five year baseline period, 2006-2010. This results in ***Estimated Hospice Maximum Volume*** during the target year.

As noted by the Hospice Network, the proposed approach accepted by staff explicitly accounts for the capacity of all existing providers to serve future demand for services. Commission staff recommends no change be made to the need methodology or the docketing rule.

As far as the number of providers in these jurisdictions, the numbers are a bit misleading. In Baltimore City, there are 9 authorized providers. Of these, in 2011, one served 50% of patients, one served 22% of patients and the rest served 11% or less. In Prince George's County, there are also 9 authorized providers. Of these, in 2011, one served 32%, one served 25%, one served 21%, and the rest served less than 10% each. This pattern has been consistent in these counties over the past five years. Notably, during the past decade, when no applications for new general hospices were accepted, providers had the opportunity to expand and serve additional patients.

***Low Utilization Factor*s**

- Gilchrist:

  "Despite increased availability and payment coverage of hospice services, studies have shown that African Americans and members of other ethnic minority groups consistently underutilize hospice….Researchers believe that several factors may contribute to this effect, including the following: *Cultural or religious beliefs*….*Preferences for aggressive treatment*….*Lack of discussion and planning for end of life care*….*Lack of trust in the health care system*…."

- Stella Maris:

  "Many factors come into play when a patient and family are choosing hospice care. Cultural, ethnic, spiritual, and psycho-social all determine whether a patient/family are understanding and accepting of end of life care."

Staff Analysis and Recommendation:

Staff agrees and, for this reason, is now working with the Hospice Education Initiative Work Group on opportunities within the community for greater outreach and education of minorities and underserved members of the community. The CON process presents an opportunity for a new provider to try an innovative approach to education and outreach to minority communities. An applicant must detail its plans for education and outreach to minority and underserved in the communities in which it seeks to provide services.

Need Projections/CON Reviews

- Gilchrist:

  "However, given the known disparity in hospice use by African Americans and other racial and ethnic groups, it is Gilchrist's position that additional study and outreach is required before the Commission relies on this methodology to accept new provider applications in jurisdictions that have predominantly African-American populations….For the reasons set forth above, Gilchrist urges the Commission to consider a moratorium on certificate of need for new hospice providers until the newly created work group has completed a study on how to increase utilization of end of life services among all racial groups. This will also allow additional time for existing providers to implement outreach programs targeted at increasing utilization of hospice services by African Americans and other racial and ethnic groups."

- MedChi:

  "Unlike many other states, Maryland continues to restrict providers from entering the hospice market and the draft update continues that policy….Further, the methodology to calculate volumes and capacities leaves few opportunities to expand the market….In general, the restrictions have served Maryland well by protecting our strong hospice community and limiting the involvement of out of state companies that have been found to engage in questionable business practices. However, these restrictions may also result in a significant lack of new providers that may have a different approach and more success in connecting with underserved populations."

- Montgomery:

  "I would argue that 2013 is not the time to adhere strictly to the need methodology. There is enormous change going on in the hospice field, and prudent policy would be to wait until there is an atmosphere of stability."

  Staff Analysis and Recommendation:

  Staff worked collaboratively with the Hospice Network to produce consensus on the methodology that is included in this regulation. The purpose of need projections in the State Health Plan is to guide CON reviews and Commission policy.

  The concept of a moratorium was presented at the Senate Finance Committee and rejected by leadership and members of the Committee. It must be noted that while some commenters find the possibility of docketing CON applications in two jurisdictions to be too expansive, others find it restrictive of any new development. No change is recommended.

Components of Methodology

- Gilchrist:

  "Nevertheless, the proposed need methodology uses a target use rate based on hospice use by all races, which may not accurately reflect the true need for additional access to hospice programs in counties where the population is majority African American."

- Seasons Hospice:

  "The MedPac national average use rate applied as a benchmark for hospice demand/utilization should be adjusted for the demographic characteristics of each county."

  "As currently proposed, volume threshold does not reflect differences in program sizes and differences in the percentage of deaths to hospice admissions among jurisdictions…. An adjustment factor should be used based on the average death numbers by jurisdiction, as compared to the median death numbers for the state, which the median rate served is then adjusted by jurisdiction. Alternatively, the Volume Threshold should be based on a percentage of deaths in that jurisdiction."

  Staff Analysis and Recommendation:

  Each component and variable of the methodology was discussed and voted on by the Hospice Work Group before staff released the draft Chapter. There was consensus on these components and on the appropriateness of the methodology.

  Seasons Hospice correctly notes that use rates vary by race, as evidenced in the referenced MedPAC report. Similar to race, there are variations in use rate when comparing urban and rural counties. During the Hospice Work Group meetings, members discussed variable use rates by region. The Work Group favored a single national use rate as the appropriate target for identifying need. It should be noted that the jurisdictions identified with need (Baltimore City and Prince George's County) have significantly lower utilization rates than the Maryland hospice utilization rate; furthermore, the use of hospice among Maryland Medicare beneficiaries is below the national average. This indicates that demographics alone do not explain the lower use rate in these jurisdictions. Furthermore, there is evidence to indicate that with adequate education and awareness, the use rates in different demographic groups do change with time. This is seen in the MedPAC table referenced by Seasons Hospice. The African American use rate has increased to 34% in 2010 from 17% in 2000. For this reason, the Commission and the Hospice Network have collaborated to create a Hospice Education Initiative that includes: Maryland Hospital Association, Maryland State Medical Society, Baltimore City Department of Aging, Prince George's County Departments of Health and Family Services, DHMH Office of Health Care Quality, DHMH Office of Minority Health and Health Disparities, Baltimore City Central Maryland Ecumenical Council, and a consumer/social worker representative from the University of Maryland. These groups are working together in order to improve education and awareness of hospice services in Maryland. Commission staff recommends no changes

  During the development of the hospice need methodology, several approaches to the calculation of the volume threshold were considered. The Hospice Work Group and the Hospice Network consistently rejected the notion of a jurisdiction-based volume threshold in favor of a statewide volume threshold. One challenge is that in Baltimore City and Prince George's County, where need is identified, the provision of hospice services is dominated by one or two providers who serve most of the patient volume, even though there are nine hospices licensed to serve each of those jurisdictions. For example, the median number of patients served by a provider is 54 in Baltimore City, and 106 in Prince George's County. A uniform jurisdiction-level median size was also discussed, but ultimately rejected, as the Hospice Work Group concluded that it was too low a threshold. Ultimately, the goal of a CON assessment of need is to identify the level of additional need that can support an additional provider. The statewide median number of deaths served, which is the current volume threshold, also represents the average patient volume of a provider in the state and is a reasonable threshold for adding a new provider. Commission staff recommends no changes.

CON Regulatory Issues

- Seasons Hospice:

"The importance of general hospices having the capability to meet the inpatient hospice service needs of patients should be recognized. …the draft Chapter disrupts the ability of terminally ill patients to exercise their right to choose which hospice provides care and support to them. The Chapter does so by imposing limits on the ability of hospices to have sufficient inpatient capacity to meet this requirement."

"The Chapter should recognized [sic] and support the various ways in which inpatient hospice services can be made available by general hospices."

"The Chapter does not need to provide an additional limitation on the availability of inpatient hospice services from a particular hospice. Federal law already operates as a control on the amount of inpatient hospice services a hospice provides."

"The Chapter should restore the Commission's historical approach to the treatment of inpatient hospice services as a service, and not regulate inpatient hospice services as subject to rules governing 'bed capacity'."

"If inpatient hospice services are considered a form of 'bed capacity', page 3 of the Chapter should recognize that the 'waiver rules' apply to changes in bed capacity."

"Where inpatient hospice services are provided under a contractual arrangement complying with 42 CFR, Sections 418.108 and .110, using existing, licensed hospital bed capacity as the hospital designates its beds, this should not be considered hospice 'bed capacity'."

Staff Analysis and Recommendation:

Staff agrees that hospices, as a condition of Medicare certification, must provide their patients access to a full range of services, including general inpatient (GIP) care. In Maryland 27 general license hospices have in place contracts, facilities, or other systems to provide GIP care for their patients. All of the hospices in Maryland meet their obligation to provide access to GIP and most do not operate their own inpatient facilities.

Since, as Seasons acknowledges, hospice is defined under both licensing regulations and CON regulations as a “health care facility”, changes that would increase a hospice’s bed capacity require a CON. This capacity is outside of the general hospice program need projections and is not limited to a specific number of beds. If a general hospice wishes to create its own bed capacity to provide GIP services or to add beds to existing bed capacity that it operates under its general hospice license, it can apply for a CON and is not limited in the number of beds it may seek as long as a project is consistent with the SHP standards and CON criteria. In addition, because the CON review schedule does not provide filing dates for projects to increase inpatient hospice bed capacity, applications for such projects may be submitted at any time.

Hospices, as health care facilities, may add waiver beds to their existing inpatient bed capacity, as long as they meet the requirements of COMAR 10.24.01.

Definitions Section

- OHCQ:

“Twenty-third page: ‘(11) Hospice House means a residence operated by a Maryland licensed general hospice care program (defined in proposed regulations, COMAR 10.07.22) that provides care to hospice patients in a home-like environment. The care provided is routine and continuous home care and it cannot be billed as general inpatient services.’

Comment: We recommend that you directly quote rather than paraphrase this definition in regulations.”

Staff Analysis and Recommendation:

As recommended by OHCQ, change the definition to be consistent with hospice house regulations as follows: “Hospice House means a residence operated by a Maryland licensed general hospice care program that provides home-based hospice services to hospice patients in a home-like environment and the care is not billed as general inpatient care.”

Other Comments

- MedChi:

  ”[T]he MHCC and the hospice community could consider some measures that will encourage diversity among providers and place responsibilities on providers to address health disparities:

  When taking new applications for hospice services, the MHCC could give preference to providers owned and operated by underrepresented racial and ethnic minorities….

  The MHCC should consider requirements on existing hospice providers to initiate and place resources into underserved communities. For example, each hospice provider could be required to develop and fund a minority outreach program as a condition of maintaining the CON….

  The MHCC should consider requiring existing providers to support and engage local minority owned businesses….”

  Staff Analysis and Recommendation:

  Staff notes that the MHCC can only take action when reviewing an application for a CON. Once the CON is awarded and the program is licensed, new conditions cannot be imposed by the Commission. OHCQ has the authority to require, during the licensure or license renewal process, that hospice programs meet additional requirements that were not imposed by the Commission.

  Staff believes that the draft Chapter, as well as the Commission’s hospice education initiative, address the importance of providing culturally sensitive hospice services, and seeking to educate minority and underserved populations about the many benefits that patients and families receive from hospice programs. We recommend that the Hospice Education Work Group consider MedChi’s suggestions when arriving at the elements that are appropriate for education and outreach. Staff does not believe that a preference should be awarded based on ownership, but instead, encourages all qualified applicants to apply. Under the draft Chapter, each applicant is required to provide a specific plan for education and outreach to underserved and minority communities.

III. COMMENTS RECEIVED DURING INFORMAL PUBLIC COMMENT PERIOD

COMAR 10.24.13

During the Informal Public Comment Period, held April 10, 2013- May 10, 2013, comments were received from the following individuals and organizations:

- Erickson Living (Adam Kane)
- Gilchrist Hospice (Catherine Hamel)
- Hospice and Palliative Care Network of Maryland (Danelle Buchman) –"Hospice Network"
- Hospice of St. Mary's (Christine Wray)
- Lifespan Network (Danna Kauffman)
- MedChi (Gene Ransom)
- Montgomery Hospice (Ann Mitchell)
- Office of Health Care Quality (Patricia Nay)
- Seasons Hospice (Dean Forman)
- Stella Maris (Lisa Stone)
- Talbot Hospice (J T Smith II)
- Worcester County Health Planning Advisory Council (Mary Stevens)-"Worcester County"

The text of the actual comments is attached.

III: INFORMAL PUBLIC COMMENTS SUBMITTED

Erickson LIVING
Add more Living to your Life™

May 10, 2013

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

Dear Ms. Cole:

Thank you for the opportunity to comment on the draft State Health Plan update for hospice services. Please accept these comments on behalf of Erickson Living.

.04 Certificate of Need Docketing and Exception Rules: Hospice

D. Service Exception.

Erickson Livings proposes a new subsection that empowers the consumer to request a Service Exception and discretion to the Executive Director to grant such a request.

<u>(4) A consumer may request an exception from the Executive Director that permits a Maryland licensed general hospice to provide services outside of its service area.</u>

Rationale:

The proposed language does not provide a consumer any opportunity to petition the Executive of the Commission to be served by a hospice of his or her choice. Subsection (a) does not ask a hospice to submit a consumer preference to justify a Service Exception and Subsection (c) provides other hospices consent rights to grant a Service Exception. Consumer preferences and needs are absent from any discussion of Service Exceptions.

.05 Hospice Standards.

A. Service Area.

The State Health Plan should consider allowing specialized hospices that target unique populations or integrate with different health care models.

<u>An applicant may select a subset of a service area that targets a specialized population or a specialized care model.</u>

Rationale:

The significant barriers to entry proposed by the proposed State Health Plan may preclude Maryland consumers from having the benefits of different care models that focus on integration, specialized populations, or that are uniquely designed to service traditionally under served communities. If these barriers remain in place, the MHCC should have the authority to approve new limited models for demonstration purposes.

The MHCC may consider using such authority in service areas in which there is a lack of competition among hospice providers and in service areas in which it is accepting new applications to docket a new hospice program.

Again, thank you for the opportunity to comment on the draft update. If you should have any further questions or concerns, please contact me at 410-402-2211 or via electronic mail at adam.kane@erickson.com.

Sincerely,

Adam Kane

Senior Vice President

Gilchrist
HOSPICE CARE
Guiding the way.

May 10, 2013

VIA EMAIL

TO: Linda Cole
Chief, Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2299
lcole@mhcc.state.md.us

Re: Comments to Draft State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13)

Dear Ms. Cole:

Attached please find written comments being filed on behalf of Gilchrist Hospice Care, Inc. regarding the Draft State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13)

Sincerely,

Catherine Y. Hamel
Executive Director

11311 McCormick Road, Suite 350 • Hunt Valley, MD 21031 • 443-849-8200 • gilchristhospice.org

Gilchrist
HOSPICE CARE
Guiding the way.

May 10, 2013

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

Re: Draft State Health Plan for Facilities and Services: Hospice Services
COMAR 10.24.13

Dear Ms. Cole:

On behalf of Gilchrist Hospice Care, Inc. ("Gilchrist"), I respectfully submit for your consideration the following comments to the draft State Health Plan for Facilities and Services: Hospice Services that was issued by the Maryland Health Care Commission (the "Commission") for public comment on April 10, 2013 (with comments due May 10, 2013).

Gilchrist commends the Commission for its collaboration with the Hospice & Palliative Care Network of Maryland with respect to the update of the State Health Plan. Overall, we are pleased with the new methodology proposed for Certificate of Need review for hospice programs. However, given the known disparity in hospice use by African Americans and other racial and ethnic groups, it is Gilchrist's position that additional study and outreach is required before the Commission relies on this methodology to accept new provider applications in jurisdictions that have predominantly African-American populations.

Based on the need methodology proposed in the draft State Health Plan, Baltimore City and Prince George's County are currently the only two jurisdictions showing need for additional hospice services. According to the most recent U.S. Census Reports, Baltimore City and Prince George's County are also the only two jurisdictions in Maryland having a majority African American population (63% and 65% respectively).[1]

Despite increased availability and payment coverage of hospice services, studies have shown that African Americans and members of other ethnic minority groups consistently

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[1] www.census.gov

11311 McCormick Road, Suite 350 • Hunt Valley, MD 21031 • 443-849-8200 • gilchristhospice.org

underutilize hospice.[2] The 2013 Medicare Payment Advisory Commission ("MedPac") Report to Congress recognized that this disparity exists but is not fully understood.[3] Researchers believe that several factors may contribute to this effect, including the following:

- *Cultural or religious beliefs* – Research has shown that African Americans believe much more strongly than whites that God should control the timing of one's death.[4]
- *Preferences for aggressive treatment* – Studies have suggested that African Americans are more likely than whites to prefer aggressive life-sustaining therapies rather than palliative care at end of life.[5]
- *Lack of discussion and planning for end of life care* - End of life care is often "under-discussed" and "under-planned" by African Americans. In one 2011 study, 85% of whites, as compared to 59% of African Americans, had discussed end of life preferences and 2/3 of whites, as compared to 1/4 of African Americans, had a living will.[6]
- *Lack of trust in the health care system* – Historical experiences such as the Tuskegee syphilis clinical study, in which African American men were deprived of treatment of syphilis as an experiment, may have led to a mistrust of medical professionals among African Americans.[7]

The Commission has acknowledged that certain racial groups are reluctant to access hospice services. Nevertheless, the proposed need methodology uses a target use rate based on hospice use by *all races*, which may not accurately reflect the true need for additional access to hospice programs in counties where the population is majority African American. In addition, as stated in the 2012 MedPac Report to Congress, the presence of more hospice providers does not necessarily translate into more access to care. MedPac reported that the percentage of Medicare decedents who used hospice was unrelated to a state's supply of hospice providers.[8]

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[2] Rhodes, Ramona L., *Racial Disparities in Hospice: Moving from Analysis to Intervention*, AMA Journal of Ethics, Virtual Mentor, Sept. 2006, Vol. 8, No. 9: 613-616 (and studies cited therein).

[3] MedPac Report to Congress, March 2013, pp. 269-271.

[4] Carr, D, *Racial Differences in End-of-life Planning: Why Don't Blacks and Latinos Prepare for the Inevitable?* OMEGA, 2011, Vol. 63, p. 10.

[5] Rhodes (2006).

[6] Carr at p. 10.

[7] Volandes, A, Paasche-Orlow, M, Gillick, M, Cook, E.F., Shaykevich, S, Abbo, E, Lehmann, L., *Health Literacy Not Race Predicts End-of-life Care Preferences*, Journal of Palliative Care Medicine. Vol. 11 November 2008, p. 755.

[8] 2012 MedPac Report to Congress: Medicare Payment Policy at 291.

The evidence suggests that simply adding new hospice providers will not increase hospice utilization in Baltimore City and Prince George's County. Instead, research has shown that health literacy and a heightened commitment to patient education leads to more preferences for end-of-life comfort care.[9] To this end, in Baltimore City, Gilchrist has instituted volunteer training programs and educational sessions on the importance of advanced care planning. African American use rates at Gilchrist have increased from 14% in 2007 to a projected 22% for FY 2013. In addition, our cultural diversity and inclusion council will begin operations this summer, and we will add an annual cultural competency program for all staff this fall. By implementing education and community outreach programs, existing providers may provide adequate access to hospice care in Baltimore City and Prince George's County without the need to open the doors for new provider applications, which will lead to increased government and provider costs associated with the certificate of need process.

For the reasons set forth above, Gilchrist urges the Commission to consider a moratorium on certificate of need for new hospice providers until the newly created work group has completed a study on how to increase utilization of end of life services among all racial groups. This will also allow for additional time for existing providers to implement outreach programs targeted at increasing utilization of hospice service by African Americans and other racial and ethnic groups.

Thank you for your continued support of Maryland hospice programs. Please let me know if we can provide any additional information.

Very truly yours,

Catherine Y. Hamel
Executive Director

C: Peter Parvis, Esq. (via electronic mail)
Molly Ferraioli, Esq. (via electronic mail)
Regina Bodnar (via electronic mail)
Danelle Buchman (via electronic mail)
Ann Mitchell (via electronic mail)

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[9] Volandes at p. 758.

Hospice & Palliative Care Network
OF MARYLAND

MAY 8 2013 PM 2:54

May 3, 2013

VIA EMAIL & US MAIL

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

Re: State Health Plan for Facilities and Services: Hospice Services

Dear Ms. Cole:

On behalf of the Board of Directors of the Hospice & Palliative Care Network of Maryland (the "Network"), we write in response to the informal public comment period for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13)

Over the past year, the Network has appreciated the collaborative approach that the Maryland Health Care Commission (MHCC) has demonstrated in revising the methodology used to update the draft of the state health plan.

During the Hospice Work Group meetings and testimony given at the Senate Finance Committee hearing, the Network's representatives articulated the low utilization of hospice services in Baltimore City and Prince George's County was not 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.

There are many factors that determine a patient's choice to enter hospice. Often it is complicated and involves the patient's individual cultural, ethnic, spiritual, psycho-social, or other factors related to the patient or their family situation. There is no easy answer, but research [1]shows us that diverse populations tend to under-utilize hospice, and that may be due to cultural factors – or due to the fact that they simply are unaware of the benefits hospice may have for their families.

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[1] "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

The Network appreciates the collaboration with MHCC in the development of the Hospice Education Workgroup and is hopeful that the group will be able to develop meaningful solutions to educate more people about the benefits of hospice for patients and their family members.

The Network proposes, consistent with the recommendations of the Senate Finance Committee, that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point that 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, after an analysis, it is determined 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 handle additional patients.

In addition, page six states "By October 2013, the Centers for Medicare and Medicaid Services (CMS) is required to implement revisions to the methodology for determining payment rates for routine home care and other services included in hospices." Our understanding is that CMS may introduce a revised rate as early as FY 2014, but is not required to do so by that date.

Finally, as the experts in our field, our members pride ourselves in providing high quality and compliant care to patients and families in Maryland. The Network appreciates the opportunity to collaborate with MHCC on educational endeavors, quality initiatives, and innovative strategies that affect the patients and families we serve. We know there is work to be done in terms of outreach and education, and believe those efforts provide the solution to under-utilization of hospice services as opposed to adding additional providers.

Sincerely,
Danelle A. Buchman

Danelle Buchman
Executive Director

MedStar St. Mary's
Hospital

25500 Point Lookout Road
P.O. Box 527
Leonardtown, Maryland 20650
301-475-8981 **PHONE**
medstarstmarys.org

A Century of Caring
1912-2012

100 Years

May 9, 2013

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

RE: Request for Informal Public Comments on Draft Hospice Regulations

Dear Ms. Cole:

Hospice of St. Mary's supports the draft State Health Plan chapter governing certificate of need coverage for hospice services in Maryland. We strongly believe education, particularly at the local level, is one of the best mechanisms to address under-utilization of hospice services and end-of-life care. In the case of hospice services in our area, under-utilization, particularly by minority populations, is not a function of lack of capacity, lack of competition, or sub-standard quality of existing service providers. We commend Commission staff for establishing the Hospice Education Workgroup and look forward to contributing to this effort.

Hospice of St. Mary's, a wholly owned subsidiary of MedStar St. Mary's Hospital, offers hospice services to St. Mary's County residents. We are continually reaching out to all segments of our community with the goal of educating our community about hospice and end-of-life care. We believe these efforts have resulted in use rates in St. Mary's County slightly higher than the draft Plan's target use rate, higher than other Southern Maryland counties, and higher than most other rural counties. Last quarter, about 19% of our clients were people of color. This is only one or two percentage points less than the percentage of the same population in St Mary's County.

Hospice of St. Mary's has no problem meeting the need of our existing patients even as our numbers are growing. No one has ever been turned away or had to wait to get into hospice service. And, we have the infrastructure, capacity and scale to handle additional patients. Hospice of St. Mary's is confident that the Commission's targeted policies on outreach and education to promote utilization will go a long way towards solving the problem of under-utilization. We are also exploring the development of an outpatient palliative care program to provide a more robust continuum of end-of-life care to better serve our community and we look forward to incorporating this and educational activities in our new HEZ initiative.

We appreciate the opportunity to provide these comments, and welcome any questions you may have.

Sincerely,

Christine Wray
President, St. Mary's Hospital

LIFESPAN
NETWORK

May 9, 2013

Sent Via E-Mail: Email: linda.cole@maryland.gov

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

RE: DRAFT - State Health Plan For Facilities And Services: Hospice Services COMAR 10.24.13

Dear Ms. Cole:

On behalf of LifeSpan Network, thank you for the opportunity to comment on the above-referenced proposed State Health Plan. In reviewing this State Health Plan, LifeSpan would like to recommend the inclusion of language that would allow continuing care retirement communities (CCRCs) to provide hospice to residents similar to the current requirements governing specialty home health agencies in CCRCs.

The delivery of health care services is rapidly changing both nationally and in Maryland, with growing emphasis on meeting the medical needs of individuals in their homes. CCRCs already satisfy this goal by not only providing the continuum of care to residents but, in essence, serving as the resident's medical home. However, under Maryland's current regulatory laws, CCRCs are unable to provide hospice care to their residents without obtaining a full CON, a task which can be difficult when considering the limited population the CCRC desires to serve.

Over the years, the State has continued to recognize the importance of end of life care, i.e., the development and implementation of MOLST, the creation of an Advance Directive Registry, etc. For many residents, hospice becomes a crucial component in their care and it seems only appropriate that the CCRC should be able to continue providing care to that resident at such an emotional time for the resident and the resident's family.

To the best of our knowledge, there is no data to suggest that the exception which currently exists for CCRCs in the context of home health agencies has been detrimental to service or quality of care. On the contrary, the exception services to advance the principles of continuing care which again is to provide seniors with the continuum of services. Therefore, LifeSpan respectfully requests that the Commission include similar language for hospice services by CCRCs as is currently allowed for specialty home health agencies.

Sincerely,

Danna L. Kauffman

Danna Kauffman
Senior Vice President of Public Policy

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

May 10, 2013

MAY 16 2013 AM 9:39

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

RE: Draft State Health Plan for Facilities and Services: Hospice Services

Dear Ms. Cole:

Thank you for the opportunity to review the draft public comments for the State Health Plan update for hospice services. On behalf of MedChi, I appreciate the MHCC reaching out to our organization to discuss ways in which state policy can assist in promoting greater diversity in doing outreach to underserved communities that have historically have less hospice utilization. MedChi General Counsel Stephen Johnson gave a detailed report at the last work group on the things MedChi has done on this issue, and he will continue to attend and participate. We are willing to work on this issue, however, any request for CMEs or practitioner outreach will require a funding source. We are also reaching out to local chapters of the National Medical Association regarding this issue pursuant to your request. The Prince George's Chapter has expressed an interest in helping, and we will forward you a contact once we have it available.

MedChi applauds the MHCC and the hospice community for recognizing the need for hospice to do greater outreach and penetrate more successfully in underserved populations as stated in *Section B. (1) Availability and Accessibility of Hospice Services.* Such a focus is consistent with the Governor's priority to address racial and ethnic health disparities throughout Maryland. MedChi is strongly supportive of the Governor's efforts.

Unlike many other states, Maryland continues to restrict providers from entering the hospice market and the draft update continues that policy. The draft update limits new hospice providers to only those that are existing hospices or have experience in operating health facilities (.04(A.)(2)). Further, the methodology to calculate volumes and capacities leaves few opportunities to expand the market. These restrictions undoubtedly support our existing providers and many of our strong non-profit organizations. In general, the restrictions have served Maryland well by protecting our strong hospice community and limiting the involvement of out of state companies that have been found to engage in questionable business practices.

However, these restrictions may also result in a significant lack of new providers that may have a different approach and more success in connecting with underserved populations. The restriction on new providers referenced above will almost certainly discourage providers owned by racial or ethnic minorities from becoming hospice providers in Maryland. Given these restrictions, the MHCC and the

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hospice community could consider some measures that will encourage diversity among providers and place responsibilities on providers to address health disparities.

- When taking new applications for hospice services, the MHCC could give preference to providers owned and operated by underrepresented racial and ethnic minorities. Given the projection for additional need in Baltimore City and Prince George's County, the MHCC should try to encourage qualified providers that are members of underserved communities.

- The restriction on the background of new providers (.04(A.)(2)), should not be limited to current owners and operators of health facilities. For example, board certified physicians should be eligible, by nature of their education and experience, to apply. The proposed restriction will prevent physicians from making an application to the MHCC.

- The MHCC should consider requirements on existing hospice providers to initiate and place resources into underserved communities. For example, each hospice provider could be required to develop and fund a minority outreach program as a condition of maintaining the CON. The MHCC, or another entity, should collect and monitor compliance. In the alternative, the MHCC could assess each hospice provider and centrally develop and manage a statewide minority outreach program.

- The MHCC should consider requiring existing providers to support and engage local minority owned businesses. The Governor has recently raised the MBE goals for state contracts. The purpose of the MBE program is to address the significant barriers to entry for MBEs and encourage diversity among owners and operators of businesses. A CON is a significant barrier to entry. The MHCC may consider applying an MBE requirement as a condition of maintaining a CON to achieve similar purposes of the state MBE program.

Again, thank you for soliciting our ideas for addressing health disparities in hospice services. MedChi welcomes the opportunity to assist the Administration in achieving these important policy aims.

Sincerely,

Gene M Ransom III

Gene M. Ransom, III
Chief Executive Officer

Gentle the Journey
the campaign for
Montgomery
HOSPICE

Hospice at Home
1355 Piccard Drive, Suite 100
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May 9, 2013

VIA EMAIL

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

Re: State Health Plan for Facilities and Services: Hospice Services
COMAR 10.24.13

Dear Ms. Cole:

On behalf of Montgomery Hospice, I am writing an informal public comment about the draft Hospice Services section of the State Health Plan. First of all, Montgomery Hospice greatly appreciates the collaborative work in December 2012 and January 2013 between the MHCC staff and Sue Lyn Schramm, consultant for the Hospice and Palliative Care Network of Maryland.

In this year of escalating health care reform and Medicare sequester cuts, hospices nationwide are undergoing dramatic changes. Medicare reimbursement is being cut while hospice lengths of stay are shortening.

In addition, hospices nationally are being scrutinized by Medicare for adherence to regulations. In fact, three mega-hospices have been accused by the federal government of billing for patients who have a prognosis greater than 6 months. Non-profit Hospice of San Diego went out of business earlier in 2013 because of these allegations and VITAS, the largest for-profit hospice in the country, was sued in May 2013 under the False Claims Act by the U.S. Department of Justice. Additionally, in March 2013 the U.S. Department of Justice announced the following:

> **Hospice of Arizona and Related Entities Pay $12 Million to Resolve False Claims Act Allegations**
>
> *Hospice of Arizona L.C., along with a related entity, American Hospice Management LLC, and their parent corporation, American Hospice Management Holdings LLC, have agreed to pay $12 million to resolve allegations that they violated the False Claims Act*

by submitting or causing the submission of false claims to the Medicare program for ineligible hospice services, the Justice Department announced today.

During this turbulent time in 2013, the state of Maryland should be pleased that its strong healthcare policy endorsement of hospice Certificate of Need has created an environment where quality community based hospices can compete honestly. In April 2013 CMS published its annual *Program for Evaluating Payment Patterns Electronic Report (PEPPER).* The state of Maryland is notable for exhibiting lower percentages of live discharges within 25 days and lower percentages of hospice patients with long lengths of stay when compared to the national average.

I would argue that 2013 is not the time to adhere strictly to the need methodology. There is enormous change going on in the hospice field, and prudent policy would be to wait until there is an atmosphere of stability. Since hospice saves the Maryland healthcare system money*, it makes sense not to disrupt a compliant, quality group of providers.

I also would argue that the existing 9 or 10 hospices in Baltimore City and Prince Georges have the infrastructure, capacity and scale to admit and care for additional patients. These two jurisdictions, with a high percentage of minority citizens, will be the beneficiaries of a targeted and comprehensive awareness campaign to educate the citizens residing in Baltimore City and Prince Georges about the benefits of hospice. The campaign is currently being developed by the Maryland Health Care Commission and the Hospice Education Workgroup.

Therefore, I agree with the Network's proposal, which is consistent with the recommendation of the Senate Finance Committee, that section 0.4 A(2) Certificate of Need Docketing and Exception Rules: Hospice General Docketing be amended to include a third point that 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, after an analysis, it is determined that the current infrastructure cannot meet the additional need.

Finally, although CMS may change the hospice reimbursement methodologies by October 1, 2013, it is not required to do so at that time. This is in reference to page 6, paragraph 2, sentence 2.

Thank you for considering my comments.

Sincerely,
Ann Mitchell
Ann Mitchell MPH
President & CEO

* Please see attached research study published in Health Affairs in March 2013.

By Amy S. Kelley, Partha Deb, Qingling Du, Melissa D. Aldridge Carlson, and R. Sean Morrison

DOI: 10.1377/hlthaff.2012.0851
HEALTH AFFAIRS 32,
NO. 3 (2013): -

THE CARE SPAN

Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay

ABSTRACT **Despite its demonstrated potential to both improve quality of care and lower costs, the Medicare hospice benefit has been seen as producing savings only for patients enrolled 53–105 days before death. Using data from the Health and Retirement Study, 2002–08, and individual Medicare claims, and overcoming limitations of previous work, we found $2,561 in savings to Medicare for each patient enrolled in hospice 53–105 days before death, compared to a matched, nonhospice control. Even higher savings were seen, however, with more common, shorter enrollment periods: $2,650, $5,040, and $6,430 per patient enrolled 1–7, 8–14, and 15–30 days prior to death, respectively. Within all periods examined, hospice patients also had significantly lower rates of hospital service use and in-hospital death than matched controls. Instead of attempting to limit Medicare hospice participation, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.**

Amy S. Kelley (amy.kelley@mssm.edu) is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, in New York City.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College and a professor at the Graduate Center, City University of New York.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Melissa D. Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and the director of research methods training for the Mount Sinai Medical Student Training in Aging Research Program.

R. Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai; the director of the school's Hertzberg Palliative Care Institute; and the Herman Merkin Professor of Palliative Care.

As of 2012, 5 percent of the most seriously ill Americans accounted for more than 50 percent of health care spending, with most costs incurred in the last year of life as a result of hospital-based treatment.[1–3] Despite those high and escalating health care costs, numerous studies demonstrate that seriously ill patients and their families receive suboptimal care, characterized by untreated pain and physical symptoms, spiritual and emotional distress, high family caregiving burdens, and unnecessary or unwanted treatments inconsistent with their previously stated wishes and goals for care.[4–11]

Hospice has been shown to greatly improve the quality of care for patients and their families near the end of life. Under Medicare Part A, the hospice benefit covers palliative care services delivered by a team of professionals, including physicians, nurses, social workers, chaplains, home health aides, and volunteers, to dying patients—that is, patients with a life expectancy of six months or less—who are willing to forgo curative treatments.[12]

Studies have consistently demonstrated that hospice is associated with reductions in symptom distress, improved outcomes for caregivers, and high patient and family satisfaction.[8,13–15] Recent evidence also indicates that continuous hospice use reduces the use of hospital-based services—including emergency department visits and intensive care unit stays—and the likelihood of death in the hospital.[16]

The number of hospices has increased rapidly over the past twenty years, making hospice programs available to almost all eligible Americans.[17] Medicare hospice spending has risen considerably with the growth and development of new hospice programs, particularly in the for-profit sector, and the resulting rise in the number of patients accessing the hospice benefit.[18,19]

This increase in spending has led the Centers for Medicare and Medicaid Services to explore methods of containing Medicare hospice spending, such as through payment reform or investigation of hospices with long lengths-of-stay.[20] What is not known, however, is how the length of hospice enrollment relates to overall Medicare spending at the end of life—including what periods of enrollment might decrease net Medicare costs as compared to usual care and, if they do, by how much.

The length of hospice enrollment that might achieve the greatest cost savings to Medicare is the subject of considerable debate. Some scholars have argued that beneficiaries must be enrolled in hospice longer than current practice to achieve financial savings under Medicare.[21-23] Others have found that longer hospice length-of-stay is associated with higher Medicare spending—particularly for those with noncancer diagnoses.[24]

In the largest and most rigorous study to date, Donald Taylor and colleagues observed that hospice enrollment 53–105 days before death maximized Medicare savings compared to usual nonhospice care.[23] However, this study has been criticized for its inability to control for factors not present in Medicare claims that are known to be associated with higher costs, such as patients' functional status.[25]

Another criticism cited notable differences between the hospice and control groups: Hospice users had greater costs in the period preceding hospice enrollment compared with their matched controls.[25] Such limitations cast doubt on the validity of the reported findings regarding both the timing of hospice enrollment to maximize savings and the magnitude of those savings.

Health care reform in the past decade has sharpened the focus on increasing the value of health care and on forging effective policy to guide that process. A clearer understanding of the value of existing Medicare programs thus is required. In this study we aimed to better understand the value of Medicare hospice by examining the relationship between length of hospice enrollment and overall Medicare costs.

Specifically, we compared Medicare costs for patients receiving hospice care to those of patients not receiving hospice care across four different periods of hospice enrollment: 1–7, 8–14, and 15 30 days before death, the most common enrollment periods, and 53–105 days before death. In addition, we investigated both the source of hospice-related savings, if any, such as decreased hospital admissions and fewer hospital and intensive care unit days, and the impact of hospice on selected measures of quality of care at the end of life, including thirty-day readmission rates and in-hospital death rates.

We used the rich survey data from the Health and Retirement Study, in combination with individual Medicare claims, and adjusted for previously unmeasured factors known to influence costs, such as functional status and social characteristics. These analyses revealed that net savings to Medicare are not limited to hospice enrollment 53–105 days prior to death but are also observed across the most common enrollment periods: 1–7, 8–14, and 15–30 days before death.

Study Data And Methods

We examined data from the Health and Retirement Study, a longitudinal survey administered to a nationally representative cohort of adults over age fifty. Serial interviews are conducted every two years and include information on participants' demographic, economic, social, and functional characteristics. Each interview cycle, participants who died since the last interview are identified, and dates of death are drawn from the National Death Index. More than 80 percent of participants provided authorization to merge their survey data with Medicare claims,[26,27] a necessary step in the present analysis.

SAMPLE We sampled all survey participants who died during 2002–08. We included those age sixty-five or older who had continuous Medicare Parts A and B coverage for twelve months prior to death, while excluding those enrolled with Medicare managed care (for whom claims data were therefore incomplete). This methodology yielded a final sample of 3,069 people, both enrolled and not enrolled in Medicare hospice prior to death.

For the analyses of each enrollment period, we also excluded those who enrolled in hospice prior to the study outcome period (7, 14, 30, and 105 days, respectively) and those whose final predeath interview took place within the study period.

MEASURES We categorized periods of enrollment in Medicare hospice before death based on the number of days prior to death that enrollment occurred, as follows: 53–105 days (the period expected to maximize reduction in Medicare spending),[23] 15–30 days, 8–14 days, and 1–7 days. For each period, the primary outcome was total Medicare spending measured from the beginning of the enrollment period to death.

We adjusted expenditures for inflation (2008 dollars) and for geographic differences in Medicare prices. We also examined six other measures of care utilization: hospital admissions, hospital and intensive care unit days, intensive care unit admission (any or none), thirty-day hospital readmission (any or none), and in-hospital death.

We selected independent variables based on our conceptual framework, "Determinants of Treatment Intensity for Patients with Serious Illness," which postulates that treatment intensity is influenced by both regional and patient or family determinants.[28] We selected variables that could serve as empirical measures of each construct in the conceptual model: age; sex; race or ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity.

Variables were drawn from Health and Retirement Study data, individual Medicare claims, and the *Dartmouth Atlas of Health Care*.[29] Additional details are provided in the online Appendix.[30]

STATISTICAL ANALYSES We employed doubly robust methods combining propensity score matching and regression adjustment.[31] We first determined hospice enrollment in relation to date of death from individual Medicare hospice claims. For each enrollment period, we then developed propensity scores for hospice and nonhospice patients to estimate each subject's likelihood of hospice enrollment during the specified period.

We used logistic regression to estimate the likelihood of hospice enrollment using all of the independent variables, described above, that may be associated with treatment intensity. Additionally, we included as a covariate the number of hospital days prior to the target hospice enrollment period up to six months before death, to account for prior utilization as a predictor of subsequent utilization.

We then matched hospice enrollees to one or many nonhospice controls within ±0.02 of the standard deviation of the propensity scores. Unmatched subjects were excluded. This procedure was completed for each enrollment period, resulting in the following sample sizes: 1,801 (1–7 days), 1,506 (8–14 days), 1,749 (15–30 days), and 1,492 (53–105 days).

We examined bivariate comparisons of unadjusted measures of spending and use, as well as patient characteristics, using the matched, weighted samples. We then conducted multivariable regressions for each of the outcome measures, once again adjusting for all independent variables.

Following the estimation of each fully adjusted regression, we examined the adjusted means, including 95 percent confidence intervals, and incremental effects in outcomes between groups of hospice enrollees and matched nonhospice controls. Additional details are provided in the online Appendix.[30] Analyses were conducted using the statistical analysis software Stata, version 11.

LIMITATIONS Three study limitations are worth noting. First, the data are retrospective, following back from date of death—that is, we employed a mortality follow-back design. This retrospective approach artificially removed the prognostic uncertainty faced by patients and physicians when making treatment decisions. The mortality follow-back design and our inability to randomly assign patients to treatment groups may therefore have biased the results.

However, by using detailed survey data, propensity score matching procedures, and multivariable regression to adjust the results, we minimized the effect of this bias more than could have been achieved through the use of administrative claims data alone.

Second, we were unable to factor into the analysis direct measures of individual preferences and goals of care. We did, however, adjust for all available characteristics known to be potentially associated with treatment preferences, such as education, race, and debility.

Third, we were not able to fully assess quality of care, which, in combination with cost, determines value. We included among our secondary outcomes two markers of potentially low-quality care: thirty-day hospital readmission and in-hospital death. In addition, many prior studies have demonstrated high quality of and satisfaction with hospice and palliative care.[8,13–15,32–36]

Study Results

SUBJECT CHARACTERISTICS Among the 3,069 subjects, 1,064 (35 percent) were enrolled in hospice prior to death. The mean hospice length-of-stay was 49 days (median 16 days, range 1–362 days). Patient and regional characteristics of subjects are reported in Appendix Exhibit 1.[30] Subjects' mean age at death was eighty-three years. Subjects were predominantly non-Hispanic white (80 percent), female (56 percent), covered by supplemental private insurance (50 percent), and educated through high school or beyond (58 percent). Fifty-eight percent reported needing no assistance with basic activities of daily living leading up to the study period, while 21 percent resided in a nursing home. Twenty-three percent were eligible for both Medicare and Medicaid.

HOSPICE ENROLLMENT FOR 53–105 DAYS Eighty-eight (70 percent) subjects enrolled in hospice for 53–105 days prior to death were matched to 1,404 decedents not enrolled in hospice for 53 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 2).[30]

In fully adjusted analyses of outcomes spanning the last 105 days of life, subjects enrolled in hospice for 53–105 days prior to death had significantly lower mean total Medicare expenditures than matched controls ($22,083 versus $24,644, $p < 0.01$) (Exhibit 1). Hospice enrollees during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.01$) compared to nonhospice enrollees. Differences between the groups' total intensive care unit days were not significant in the fully adjusted model ($p = 0.11$). Additional details are provided in Appendix Exhibit 3.[30]

HOSPICE ENROLLMENT FOR 15–30 DAYS One hundred thirty-three (80 percent) subjects enrolled in hospice for 15–30 days prior to death were matched to 1,616 decedents not enrolled in hospice for 15 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 4).[30]

In fully adjusted analysis of outcomes spanning the last thirty days of life, subjects enrolled in hospice for fifteen to thirty days prior to death had significantly lower average total Medicare expenditures than matched controls ($10,383 versus $16,814, $p < 0.01$) (Exhibit 1). Those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.05$). Additional details are provided in Appendix Exhibit 5.[30]

HOSPICE ENROLLMENT FOR 8–14 DAYS Ninety (70 percent) subjects enrolled in hospice for 8–14 days prior to death were matched to 1,416 decedents not enrolled in hospice for 8 days or more days prior to death. Again, we found no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 6).[30]

In fully adjusted analysis of outcomes spanning the last fourteen days of life, subjects enrolled in hospice for eight to fourteen days prior to death had significantly lower average total Medicare expenditures than matched controls ($5,698 versus $10,738, $p < 0.01$) (Exhibit 1). Once again, we found that those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admission, hospital days, and in-hospital deaths (all $p < 0.01$).

The hospice group had fewer intensive care unit days than the nonhospice group, but this difference did not reach statistical significance ($p = 0.11$). Additional details are provided in Appendix Exhibit 7.[30]

HOSPICE ENROLLMENT FOR 1–7 DAYS Three hundred eight (80 percent) subjects enrolled in hospice for 1–7 days prior to death were matched to 1,493 decedents not enrolled in hospice for 7 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 8).[30]

In fully adjusted analysis of outcomes spanning the last seven days of life, subjects enrolled in hospice for one to seven days prior to death had significantly lower average total Medicare expenditures than matched controls ($4,806 versus $7,457, $p < 0.01$) (Exhibit 1). Consistent with those patterns observed in other enrollment periods, those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, and in-hospital deaths (all $p < 0.01$).

COMPARING OUTCOMES ACROSS HOSPICE ENROLLMENT PERIODS Exhibits 2–4 compare the incremental effects in outcomes between subjects enrolled in hospice and nonhospice matched controls across the study periods. The adjusted savings in total Medicare spending ranged from $2,561 for those enrolled 53–105 days prior to death to $6,430 for those enrolled 15–30 days (Exhibit 2).

The adjusted decrease in total hospital days ranged from 9.0 for those enrolled 53–105 days prior to death to 0.9 for those enrolled 1–7 days, and the decrease in intensive care unit days ranged from 4.9 for those enrolled 53–105 days to 0.5 days for those enrolled 1–7 days (Exhibit 3). The adjusted reduction in in-hospital deaths was similar across groups, and the adjusted reductions in intensive care unit admissions and thirty-day hospital readmissions were largest for those enrolled for 53–105 days (Exhibit 4).

Discussion

Medicare costs for patients enrolled in hospice were significantly lower than those of nonhospice enrollees across all periods studied: 1–7 days, 8–14 days, and 15–30 days, the most common enrollment periods prior to death, as well as 53–105 days, the period previously shown to maximize Medicare savings.[23]

In addition, reductions in the use of hospital services at the end of life both contribute to these savings and potentially improve quality of care and patients' quality of life. Specifically, hospice enrollment was associated with significant reductions in hospital and intensive care unit admissions, hospital days, and rates of thirty-day hospital readmission and in-hospital death.

EVIDENCE OF MEDICARE SAVINGS Our results not only are consistent with prior studies for Medicare spending, but they also strengthen this evidence by replicating the results within a sample more thoroughly matched for individual health, functional, and social characteristics, as well as regional factors. Finding no difference between the hospice and control groups' pre-enrollment health care use is evidence of this improved match, as compared to prior work.[23]

Specifically, Taylor and colleagues reported a maximum reduction in Medicare spending among patients enrolled in hospice for 53–105 days prior to death.[23] We found Medicare savings among this group, too, but we also found a similar level of savings among those enrolled for 1–7 days and increased savings among those enrolled for 8–30 days prior to death. Furthermore, we demonstrated parallel reductions in hospital and intensive care unit use, hospital readmissions, and in-hospital death.

INCREASING VALUE THROUGH MEDICARE HOSPICE These findings, albeit limited to enrollment up to 105 days, are of particular importance because they suggest that investment in the Medicare hospice benefit translates into savings overall for the Medicare system. For example, if 1,000 additional beneficiaries enrolled in hospice for 15–30 days prior to death, Medicare could save more than $6.4 million, while those beneficiaries would be spared 4,100 hospital days. Alternatively, if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, the overall savings to Medicare would exceed $2.5 million.

Although our findings suggest that hospice enrollment results in savings to the Medicare program across a number of different lengths-of-stay, this work also highlights several areas for future research.

First, because of the limitations of our data set, we were unable to precisely determine the point at which hospice approaches usual care in terms of costs. Future studies will be needed to address this question.

Second, our data were also not able to identify the differential effects of hospice on specific diagnoses. This is of particular importance given the recent growth of for-profit hospices, which typically enroll more patients with noncancer diagnoses (and longer average lengths-of-stay) compared to not-for-profit programs.

EXHIBIT 1

Health Care Use At The End Of Life For Subjects Enrolled In Hospice And Matched Nonhospice Controls

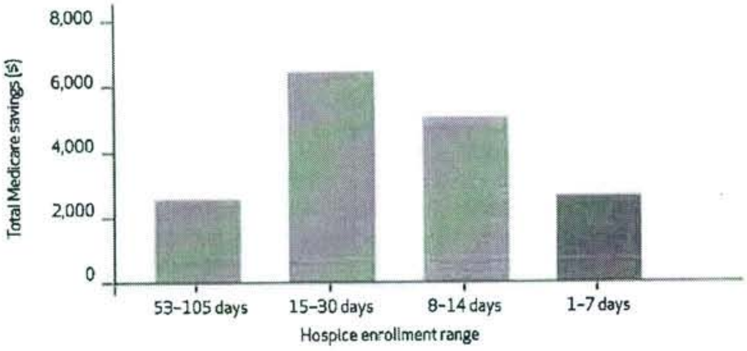
Measure of use	Hospice group, adjusted means	Propensity score matched controls, adjusted means
TOTAL MEDICARE EXPENDITURES, 2008 US DOLLARS		
Last 105 days[a]	22,083	24,644[b]
Last 30 days[c]	10,383	16,814[b]
Last 14 days[d]	5,698	10,738[b]
Last 7 days[e]	4,806	7,457[b]
TOTAL HOSPITAL DAYS		
Last 105 days[a]	3.50	12.50[b]
Last 30 days[c]	1.60	5.70[b]
Last 14 days[d]	0.19	4.36[b]
Last 7 days[e]	0.29	1.20[b]
TOTAL HOSPITAL ADMISSIONS		
Last 105 days[a]	0.58	1.22[b]
Last 30 days[c]	0.34	0.74[b]
Last 14 days[d]	0.08	0.48[b]
Last 7 days[e]	0.12	0.35[b]
TOTAL ICU DAYS		
Last 105 days[a]	0.71	5.65
Last 30 days[c]	0.31	2.91[f]
Last 14 days[d]	0.03	1.61
Last 7 days[e]	0.08	0.57[b]
PROPORTION WITH ICU ADMISSION		
Last 105 days[a]	0.15	0.37[b]
Last 30 days[c]	0.10	0.31[b]
Last 14 days[d]	0.02	0.23[b]
Last 7 days[e]	0.05	0.15[b]
PROPORTION WITH 30-DAY HOSPITAL READMISSION		
Last 105 days[a]	0.11	0.26[b]
Last 30 days[c]	0.02	0.12[b]
PROPORTION DYING IN THE HOSPITAL		
Last 105 days[a]	0.02	0.42[b]
Last 30 days[c]	0.06	0.44[b]
Last 14 days[d]	0.09	0.48[b]
Last 7 days[e]	0.15	0.53[b]

SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Sample sizes vary across periods of enrollment. For enrollment 53–105 days before death: hospice patients, $n = 88$; matched controls, $n = 1,404$. For enrollment 15–30 days before death: hospice patients, $n = 133$; matched controls, $n = 1,616$. For enrollment 8–14 days before death: hospice patients, $n = 90$, matched controls, $n = 1,416$. For enrollment 1–7 days before death: hospice patients, $n = 308$; matched controls, $n = 1,493$. Multivariable regression models adjusted for age; sex; race/ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity. 95 percent confidence intervals for all estimates are available in the online Appendix (see Note 30 in text). ICU is intensive care unit. [a]Hospice enrollment 53–105 days before death. [b]Difference between hospice and control groups statistically significant at $p < 0.01$. [c]Hospice enrollment 15–30 days before death. [d]Hospice enrollment 8–14 days before death. [e]Hospice enrollment 1–7 days before death. [f]Difference between hospice and control groups statistically significant at $p < 0.05$.

We found that net Medicare savings for patients with longer lengths-of-stay are lower because of the per diem cost of hospice services. However, we note that if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, these beneficiaries could avoid 9,000

EXHIBIT 2

Incremental Savings In Medicare Expenditures, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



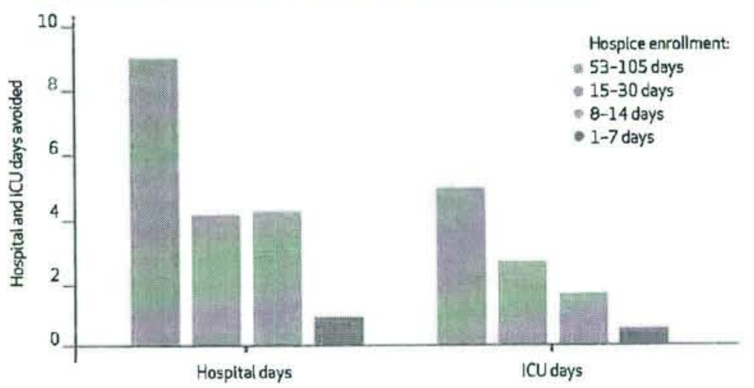
SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Total savings to Medicare denote the incremental difference in Medicare spending between hospice and nonhospice groups.

hospital days at the end of life. Indeed, our findings suggest that substantial reduction in hospital days—a primary goal of health care reform—is achieved regardless of the length of hospice enrollment.

Finally, our findings cannot be extrapolated to novel models of health care delivery or reimbursement, such as the integration of hospice programs into accountable care organizations or graded per diem payment systems, higher reimbursement for earlier and later days of enrollment, and lower reimbursement for the middle days.[20,37] The ability of these models to achieve savings while maintaining or improving quality is unclear and must be evaluated.

EXHIBIT 3

Incremental Reductions In Hospital Days And Intensive Care Unit Days, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Hospital and intensive care unit (ICU) days avoided is expressed as the incremental effect in days between hospice and nonhospice groups.

BARRIERS TO TIMELY HOSPICE ENROLLMENT Our results, when taken together with those of prior studies, suggest that hospice increases value by improving quality and reducing costs for Medicare beneficiaries at the end of life. Yet aggressive efforts to curtail Medicare hospice spending, including the Office of Inspector General's investigation of hospices that enroll patients with late-stage diseases but unpredictable prognoses, are ongoing.

Our findings suggest that these efforts may be misguided. Indeed, this study reveals that savings are present for both cancer patients and noncancer patients and that reductions in the use of hospital services and numbers of hospital days, hospital admissions, and hospital deaths appear to grow as the period of hospice enrollment lengthens within the observed study period (up to 105 days). These outcomes not only are less costly but also have all been associated with higher quality of care and increased concordance with patients' preferences.

Although sample-size limitations prevented us from examining enrollment beyond 105 days, the trend in our data and the projections by Taylor and colleagues support the idea that efforts to curtail hospice enrollment may actually increase use and spending overall. Instead of working to reduce Medicare hospice spending and creating a regulatory environment that discourages continued growth in hospice enrollment, the Centers for Medicare and Medicaid Services should focus on ensuring that patients' preferences are elicited earlier in the course of their diseases and that those who want hospice care receive timely referral.

An additional barrier to timely hospice referral may be limited knowledge or misconceptions regarding hospice and palliative care.[38] In particular, the hospice requirement to forgo curative treatments—even if they might not be beneficial—may be difficult for patients and families to accept or prompt fears of health care rationing. Because some treatments may be used for both curative and palliative purposes, this regulation and the variability with which hospice providers interpret it may also cause clinicians to be uncertain about hospice eligibility.[39]

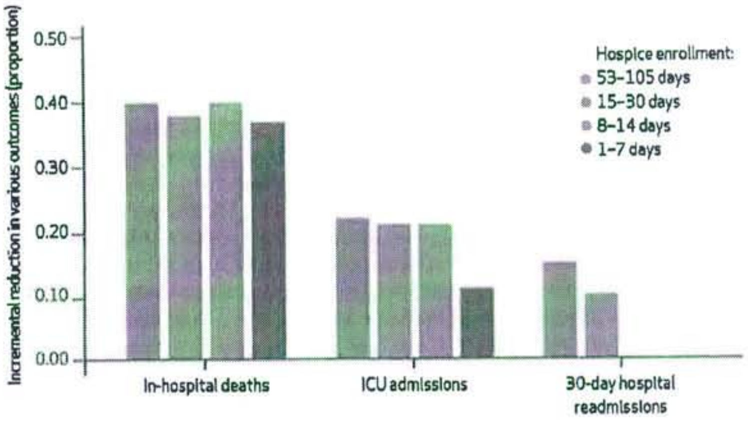
Several recent state and federal policy initiatives are designed to promote patient-centered care, specifically by increasing palliative care education among all health professionals and requiring that clinicians apprise patients of palliative treatment options early in the course of a serious illness.[40–42] Such efforts to elucidate patients' preferences and values early may increase timely referral to hospice.

Finally, highly specialized and fragmented care may also present a barrier to hospice access, particularly for patients with the most complex and highest-cost illnesses: those 5 percent of patients, many in their last year of life, who account for nearly half of the nation's health care spending.[1-3] Not only is care for this group characterized by costly hospital-based treatment, but it is also often highly fragmented and of poor quality, particularly among those who are dually eligible for Medicare and Medicaid.[43] Although many demonstration projects seek to address this concern,[43] few target this population's need for assistance in identifying individualized goals of care and developing comprehensive treatment plans to achieve those goals.

One such comprehensive treatment approach might be the enhancement of formal partnerships between hospital palliative care teams and hospice. Evidence from existing models that incorporate hospital palliative care services demonstrates improvement in quality indicators, heightened patient and family satisfaction, reduced hospital use, and increased rates of hospice referral.[44] These benefits may be even more substantial if formal relationships between established palliative care teams and community hospice programs were developed in order to offer a bridge to timely hospice enrollment.

EXHIBIT 4

Incremental Reductions In Hospital Deaths, Intensive Care Unit Admissions, And Thirty-Day Readmissions, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls



SOURCE Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Incremental reduction in various outcomes (in-hospital deaths, ICU admissions, and thirty-day hospital readmissions) is expressed as the incremental effect in proportion between hospice and nonhospice groups. ICU is intensive care unit.

Conclusion

Hospice enrollment during the longer period of 53–105 days prior to death and the most common period within 30 days prior to death lowers Medicare expenditures, rates of hospital and intensive care unit use, 30-day hospital readmissions, and in-hospital death. Building upon prior studies of hospice and palliative care that have demonstrated higher quality and improved patient and family satisfaction,[8,13-15,32-36] this finding suggests that hospice and palliative care are critical components in achieving greater value through health care reform: namely, improved quality and reduced costs.

Medicare should thus seek to expand access to hospice services so that hospice can contribute to its full potential to the overall value of care. To do so, substantial barriers to timely hospice enrollment must be overcome. The Centers for Medicare and Medicaid Services should abandon efforts to reduce Medicare hospice spending and delay hospice enrollment and should instead focus on ensuring that people who want hospice care receive timely referral.

Within the current Medicare hospice benefit, several approaches may expand access and increase appropriate and timely referral to hospice. These approaches include formalized partnerships between hospital palliative care programs and community hospice programs and the promotion of patient-centered care by educating patients, families, and physicians about the availability and benefits of hospice and palliative care services.

Finally, ongoing demonstration projects and novel models of health care delivery and reimbursement should place a high priority on the rigorous evaluation of hospice service use and its impact on the value of care. ■

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statistics from the University of Chicago.

Melissa D. Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Melissa Aldridge Carlson is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and the director of research methods training for the Mount Sinai Medical Student Training in Aging Research Program. She is a member of the National Palliative Care Research Center's Scientific Review Committee and serves on the editorial board of the *Journal of Palliative Medicine*. She earned an MBA from New York University, a master's degree in public health from Columbia University, and a doctorate in health policy and administration from Yale University.

R. Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Sean Morrison is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai; director of the school's Hertzberg Palliative Care Institute; and the Herman Merkin Professor of Palliative Care. He is the director of the National Palliative Care Research Center and was the president of the American Academy of Hospice and Palliative Medicine. Morrison serves on the editorial board of *Palliative Medicine* and is the senior associate editor of the *Journal of Palliative Medicine*. He earned a medical degree from the University of Chicago.

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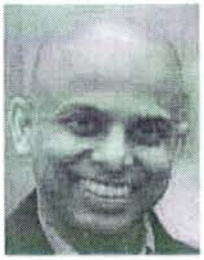
ABOUT THE AUTHORS: AMY S. KELLEY, PARTHA DEB, QINGLING DU, MELISSA D. ALDRIDGE CARLSON & R. SEAN MORRISON

Amy S. Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

In this month's *Health Affairs*, Amy Kelley and coauthors report on their study examining Medicare costs for hospice patients enrolled for different lengths-of-stay, ranging from 1 day to 105 days. Using data from the Health and Retirement Study and individual Medicare claims, they found savings for Medicare across all lengths-of-stay examined. Hospice patients also had less hospital use than matched controls, and thus a higher quality of life. The authors argue that instead of attempting to limit Medicare hospice participation for fear of not seeing savings, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.

Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and is a board-certified physician in internal medicine, geriatric medicine, and palliative medicine. Her research focuses on improving the quality of care for older adults with serious medical illness. She is particularly interested in regional practice variations and the relationship between patient characteristics and treatment intensity.

In 2012 Kelley was selected for the Paul B. Beeson Career Development Award in Aging Research from the National Institute on Aging and won the American Geriatrics Society's best paper award in geriatrics research. Kelley earned a master's degree in health services from the University of California, Los Angeles, and a medical degree from Cornell University.



Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College.

Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College and a professor at the Graduate Center, City University of New York. He is also an adjunct professor at the School of Public Health, Hunter College; a senior adviser at the Center for Medicare and Medicaid Innovation, Department of Health and Human Services; a research associate at the National Bureau of Economic Research; and a faculty fellow at the Brookdale Center for Healthy Aging and Longevity, Hunter College. Deb also serves on the editorial board of *Health Services Research*. He earned a master's degree and a doctorate in economics from Rutgers University.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

Qingling Du is a statistician in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai. Her work focuses on developing statistical models to study health care delivery systems. Du earned a master's degree in

Comments on State Health Plan for Hospice Services

1 message

Tricia Nay -DHMH- <tricia.nay@maryland.gov> Wed, May 1, 2013 at 10:48 PM
To: Linda Cole -DHMH- <linda.cole@maryland.gov>
Cc: Ben Steffen -DHMH- <ben.steffen@maryland.gov>, Eileen Lacijan -DHMH- <eileen.lacijan@maryland.gov>, Barbara Fagan -DHMH- <barbara.fagan@maryland.gov>, Margie Heald -DHMH- <margie.heald@maryland.gov>

Linda,

OHCQ has four comments on the proposed State Health Plan for Hospice Services:

1. Third page: "The establishment of a residential hospice ("hospice house") does not require a CON because a hospice house does not meet the definition of a health care facility under the Commission's statute. Currently (March, 2013), hospice houses are not licensed by the Office of Health Care Quality (OHCQ), which is in the process of developing regulations for such entities."

Change: "The establishment of a residential hospice ("hospice house") does not require a CON because a hospice house does not meet the definition of a health care facility under the Commission's statute. The Office of Health Care Quality (OHCQ) will begin licensing and regulating hospice houses on January 1, 2014."

2. Seventh page: "Furthermore, since some hospice care is provided by home health agencies, the impact of the prospective payment system on home health care may also have an impact on hospice services."

Comment: Home health agencies do not provide hospice care, though they provide home health services, including palliative care.

3. Eleventh page: "(1) An applicant shall provide the following services directly: (a) Physician services and medical direction; (b) Skilled nursing care; (c) Medical social services; (d) Counseling (including dietary counseling); (e) Hospice aide and homemaker services; (f) Spiritual services; and (g) On-call nursing response"

Comment: We believe that a, e, f, and g may be contracted rather than directly provided. Please see the federal hospice regulations.

4. Twenty-third page: "(11) Hospice House means a residence operated by a Maryland licensed general hospice care program (defined in proposed regulations, COMAR 10.07.22) that provides care to hospice patients in a home-like environment. The care provided is routine and continuous home care and it cannot be billed as general inpatient services."

Comment: We recommend that you directly quote rather than paraphrase this definition in the regulations.

Please contact me if you have any questions. Thank you.

Tricia

Tricia Tomsko Nay, MD, CMD, CHCQM, FAAFP, FAIHQ, FAAHPM
Acting Executive Director and Medical Director
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VIA EMAIL AND FIRST CLASS MAIL

May 9, 2013

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

Re: Adoption of State Health Plan for Facilities and Services:
Hospice Services, COMAR 10.24.13

Dear Ms. Cole:

I write to provide comments on the above-referenced matter on behalf of the Seasons Hospice & Palliative Care ("Seasons"), one of the largest providers of hospice services in Maryland. Seasons opposes adoption of the draft State Health Plan chapter on Hospice Services at COMAR 10.24.13 (the "Chapter") in the form proposed by Commission Staff. The reasons that Seasons Hospice opposes adoption are related below.

1. The methodology should take advantage of available data to project accurate need.

".06 Methodology for Projecting Need for General Hospice Services
A. Methodology Assumptions
(1) Historical hospice trends, including growth in hospice deaths, are reliable predictors of future capacity of existing providers.
(2) The most recent Medicare Payment Advisory Commission (MedPAC) reported national use rate is an appropriate target for Maryland.
(3) The Maryland death rate will remain constant in the planning window."
(Chapter, page 15)

The MedPac national average utilization rate applied as a benchmark for hospice demand/utilization, should be adjusted for the demographic characteristics of each county. MedPAC data show that there are significant differences in use by race, as shown in Table 1 below. The national average use rates by race should be applied to the counties demographics to project the percentage utilization in order to obtain a more accurate overall utilization rate.

SEASONS
HOSPICE &
PALLIATIVE CARE
Accredited by
The Joint Commission

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Table 1
Percent of Medicare Decedents Who Used Hospice
By Race/Ethnicity

	2000	2007	2008	2009	2010
Race/ethnicity					
White	23.8	40.5	41.8	43.7	45.8
African American	17	29.9	30.8	32.6	34
Hispanic	21.1	32.6	32.9	34.8	37
Asian American	15.2	22.9	24.5	26	28.1
Native North American	13	28.8	29.8	29.7	30.6

Source: http://www.medpac.gov/chapters/Mar12_Ch11.pdf, Table 11-2

2. The means of calculating the Volume Threshold should reflect jurisdictional differences.

> **"H. Method of Calculation**
> **The Commission uses the following procedure to project need for additional hospice capacity in the target year:**
>
> **(j) Calculate the volume threshold by calculating the median number of deaths served statewide by existing hospice providers (h) in the most recent baseline year (j=5)."**

(Chapter, page 19)

As currently proposed, volume threshold does not reflect the differences in program sizes and differences in the percentage of deaths to hospice admissions among jurisdictions. The COMMISSION should not solely base the threshold on the inappropriate application of a state based median being applied to areas that are not comparable to the State median in any other aspect. An adjustment factor should be used based on the average death numbers by jurisdiction, as compared to the median death numbers for the State, which the median rate served is then adjusted by jurisdiction. Alternatively, the Volume Threshold should be based on a percentage of deaths in that jurisdiction.

3. The importance of general hospices having the capability to meet the inpatient hospice service needs of patients should be recognized.

The draft Chapter should be amended to recognize the importance of general hospices having the capability to meet the inpatient hospice service needs of patients.

- The draft Chapter interferes with the ability of Hospices to comply with the federal and state laws requiring that they make available to their patients the full spectrum services required by their patients, including inpatient hospice services.[1] Likewise, the draft Chapter disrupts the ability of terminally ill patients to exercise their right to choose which hospice provides care and support to them. The Chapter does so by imposing limits on the ability of hospices to have sufficient inpatient capacity to meet this requirement. Hospices provide four types of services as Medicare, the principal payer for hospice services recognizes. Routine Home Care, Continuous Home Care, Respite and Inpatient. Among the health care facilities regulated under the CON, hospice is the only one in which the provider is obligated to provide services across a continuum of residential and inpatient settings. Terminally ill patients under the care of a particular hospice should not be forced by the Chapter to leave the care of the hospice providing care and support to them when they need an inpatient level of hospice care and to receive care of some other hospice the patient had not selected, because of a requirement for an additional CON approval to provide inpatient services as additional "bed capacity." A hospice with a general hospice license must be able to provide the full spectrum of services their patients need.

- The Chapter should recognized and support the various ways in which inpatient hospice services can be made available by general hospices. This can include establishing freestanding hospice facilities and contracting with hospitals and skilled nursing facilities under arrangements that meet the requirements of 42 CFR, Sections 418.108 and .110.

- The Chapter does not need to provide an additional limitation on the availability of inpatient hospice services from a particular hospice. Federal law already operates as a control on the amount of inpatient hospice services a hospice provides. Under 42 CFR, Section 418.108(d) stating: "The 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." Where the hospice provides care in excess of this limit, Medicare does not cover the inpatient services.

The Chapter should restore the Commission's historical approach to the treatment of inpatient hospice services as a service, and not regulate inpatient hospice services as subject to rules governing "bed capacity."

The Chapter treats services to hospice patients in need of inpatient hospice services as being delivered in "beds" the regulation of which, under the certificate of need ("CON") law, is considered subject to the rules governing "bed capacity." This is a

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[1] Health-General Article, Section 19-901(d); COMAR 10.07.021.02B(5); 42 CFR, Section 418.108.

recent, changed interpretation of the Commission under the CON statute, which has not been amended to support this different approach.

Hospices are a "health care facility" under Health-General, Section 19-114(d)(1)(vii) of the Annotated Code of Maryland. Subject to the CON law, health care facility increases in "bed capacity" require a CON under Health-General, Section 19-120(h)(1). For decades, it was the express governmental interpretation of the CON law since hospices were first regulated that inpatient hospice services in any setting did not represent the use of "bed capacity." This was stated to the General Assembly in a 2004 report. In a report to the General Assembly the Commission stated that "[a] general hospice may provide services in a home-based setting or in a variety of inpatient health care settings. *Report on the Study to Clarify the Status of Existing Certificates of Need for Hospice Services and the Process for Updating the State Health Plan's Hospice Chapter*, p. 2 The legislature likewise was advised that, as a matter of law,

> In Maryland, there is no separate licensure category for inpatient hospice beds. A General or limited hospice program can develop an inpatient unit under their existing license. With respect to Certificate of Need, when existing community-based providers have sought to construct a hospice facility only the capital expenditure "by or on behalf of a health care facility" is subject to Certificate of Need review. If the expenditure is below the capital threshold [footnote omitted], a Certificate of Need is not required. (Pages 6-7)

Since no change in the CON statute has occurred, the Chapter should confirm this historical interpretation.

Under the CON law, there is no other type of "health care facility" that is authorized to provide care to patients across a range of settings. For example, Under Health-General Article, Section 19-114(d)(1), hospitals and related institutions are permitted to provide care in an inpatient setting and use "beds" to provide services. Home health agencies provide services in a residential setting but are still considered a type of "health care facility." Hospices receive a "general" license to provide hospice services. This is a unique situation in which a provider/patient relationship may be established in one setting that should be preserved should the patient require hospice care in an inpatient setting. Unlike for any other type of health care facility, hospice inpatient services are simply one level of care on a continuum that includes other, residential settings.

So too, Health-General Article, Section 19-901(c) of the law governing the licensure of a hospice defines a "hospice facility" without any reference to beds (just as the CON law identifies a home health agency as a health care "facility" even though all services are provided in a residential setting). The definition encompasses hospice care in any setting.[2] It relies on the definition of a "hospice care program."[3] That definition, under Section 19-901(d) likewise refers to services in any setting, including at home or on an inpatient basis. Under Maryland's hospice licensing regulations at COMAR 10.07.21.02B(8), inpatient hospice is a "service" not a "bed." That regulation states: ""Inpatient care services" means services provided by a general hospice care program for the purpose of pain control, symptom management, or respite." Hospices receive a license to establish a hospice "program" not to establish a particular type of building or beds. When Section 19-905(a) refers to the operation of a program, it makes no reference to inpatient hospice care versus hospice care in any other setting.

The Chapter should recognize the need and ability of hospices to provide services across the continuum of services needed by terminally ill patients in the various settings needed by patients. It should avoid an approach that risks a hospice needing to interrupt the continuity of care and close relationship between the patient and the hospice nurses, counseling and related staff working together to provide compassionate care during an individual's terminal condition, because of an imposed limit on "bed capacity" for a particular hospice. For all other health care facilities under the CON law, patients are admitted and discharged from a particular facility. Here, the patient would remain admitted to the hospice that terminally ill individual or family has selected, and it would be the CON law that interrupts care due to a constraint on inpatient bed capacity.

If inpatient hospice services are considered a form of "bed capacity," page 3 of the Chapter should recognize that the "waiver" rules apply to changes in bed capacity.

If hospices are a form of health care facility with "bed capacity," the waiver rule under Health-General, Section 19-120(h)(2)(i) of the Annotated Code of Maryland should apply, enabling a hospice, just like any other health care facility to change bed capacity with the lesser of 10 beds or 10% of capacity, every two years.

Where inpatient hospice services are provided under a contractual arrangement complying with 42 CFR, Sections 418.108 and .110, using existing, licensed hospital bed capacity as the hospital designates its beds, this should not be considered hospice "bed capacity."

The Commission has always recognized that hospices need to have the ability to contract with hospitals and skilled nursing facilities to obtain services for inpatient hospice care. The data forms used by the Commission recognize and gather data on such arrangement. Thus, the Chapter should confirm that contractual arrangements for inpatient care using existing, licensed hospital or skilled nursing facility beds does not represent the addition of hospice bed capacity, so long as the hospice does not lease the beds.

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[2] See, also, Section 19-909(a) of the Hospice Statute.

[3] Regulation .05B(7) defines a hospice care program without any reference to the setting in which the care is rendered.

The Docketing rules should be conformed to each other in relation to inpatient bed capacity.

On page 8 of the draft Chapter, under Regulation .04A(1), the introductory language should state: "Except as noted in .04B(1), (2) or C below…." It is apparent that .04C is a specific rule for inpatient capacity applications. Thus, .04A(1) should make this clear.

There should only be one Impact Standard for inpatient bed capacity. This Standard should recognize the need of general hospices to have the capacity to provide services to patients in need of inpatient services.

The Hospice Standard under Regulation .05G, which is a general Impact Standard, states that it applies, in part, to a "change in inpatient bed capacity." However, in addition to this general Hospice Standard, there are specific standards applicable to an "Inpatient Unit," under Regulation .05P. It is advisable that this duplicate reference to changes in inpatient bed capacity under Regulation .05G should be eliminated in favor of one, clear standard. Since Regulation .05P states that it is "[i]n addition to" the Regulation .05G standards, there should be only one Impact reference applicable to inpatient bed capacity under Regulation .05P(2).

The reference to projections of a proposed project "impact on future demand for the hospice services provided by the existing general hospice services authorized to serve each jurisdiction affected by the proposed Project" should not be applied in the context of an inpatient bed capacity application. Hospices need to have the capability to provide the continuum of care needed by hospice patients they serve. As stated previously, this is unlike any other health care facility services, which range across settings. For example, hospitals and comprehensive care facilities do not receive CON approval to provide services in a home setting. Home health agency services do not include inpatient services. The CON law should support hospice capabilities to provide services across the continuum of care a hospice patient may require.

Also, Impact should not be judged based on prospective future demand that might be forecast. It has not been the case that the CON process, administered by the Commission or its predecessor, the former Health Resources Planning Commission, makes CON decisions based on a regulation or projection of future "demand" versus "need." It is problematic if a general hospice, that needs to provide the continuum of care to its patients, is blocked from doing so under the Chapter, because of a provision that blocks the award of a CON based on a hypothetical ability of another existing hospice to potentially meet some future demand. Moreover, other existing hospices may not actually meet the future demand that could be identified. Moreover, all hospices may not provide the same types of inpatient hospice services. Applicants should be able to demonstrate that by meeting existing needs and future growth, there will be no material negative impact. CON decisions evaluating impact should look at the utilization of existing hospices, not potential, future demand.

It is relevant to note that the above-cited Medicare regulation already imposes a limitation on the growth of inpatient services, since Medicare reimbursement above the 20% level is unavailable. By the same token, general hospices should be permitted, under the CON regulations, to meet the inpatient hospice needs of their patients, and should not be denied the capacity to do so.

Finally, Regulation .05P(2) should be removed or revised. It requires an Applicant to meet a quantitative standard for which it may have no access to information about other hospices and their capacity. This language should state that the Applicant's evaluation should be based on "publicly available data."

A revision to the Cost-Effectiveness Standard is warranted.

In evaluating options, the Applicant for inpatient bed capacity is asked to demonstrate that its project is the "best" alternative for providing care to hospice patients. Rather than using this standard, the Chapter would better provide for a comprehensive evaluation of a CON application if it required the Applicant to demonstrate that the bed capacity is a cost-effective option. "Best" is a relative term and, while cost-effectiveness is important, it is one standard among several. Taken to its extreme, opponents could continually argue that so long as existing capacity is not 100% full, new capacity is not the "best" alternative, even if denial of the application would have the effect of denying a hospice of the ability to meet the continuum of care for the patients it serves. Once a patient elects a particular hospice, it should not be forced by the CON regulation to be denied access to inpatient care from that same hospice. This interferes with patient choice and the maintenance of a continuity of provider/patient relationships at a very difficult part of the dying process.

Thank you for giving Seasons Hospice the opportunity to comment on the proposed Hospice Chapter.

Very truly yours,

Dean Forman

Dean Forman
Executive Director, Seasons Hospice & Palliative Care of Maryland

Cc: Todd Stern
Gary Applebaum, M.D.
Julie Kinsinger
Andrew Solberg

Stella Maris
60 YEARS OF CARE
30 YEARS OF HOSPICE

May 10, 2013

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

Re: State Health Plan for Facilities and Services: Hospice Services COMAR 10.24.13

Dear Ms. Cole,

On behalf of Stella Maris, Inc., I am responding to the informal public comment for the State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13).

As a member of the Hospice Work group, I am appreciative of the collaborative efforts that the Maryland Health Care Commission (MHCC) has afforded our industry in revising the methodology to update the state health plan.

The testimony that was provided during the Senate Finance Committee indicated that there is low utilization of hospice services in Baltimore City and Prince George's County, despite the fact that there are ten (10) hospice providers in Baltimore City and nine (9) providers in Prince George's County.

Many factors come into play when a patient and family are choosing hospice care. Cultural, ethnic, spiritual and psycho – social all determine whether a patient/family are understanding and accepting of end of life care.

Stella Maris also commends the Commission for its collaboration with the Hospice and Palliative Care Network of Maryland with the development of the Hospice Education Workgroup. We are hopeful that this group will be able to develop meaningful solutions to educate people on the benefits of hospice.

The mission of the Sisters of Mercy is to provide care to those that are underserved. Stella Maris is under the umbrella of Mercy Health System, which has a long standing commitment to provide care to the citizens of Baltimore City. Stella Maris will continue to develop community outreach programs that reach out to culturally diverse areas.

In continuing to develop community education programs and outreach, the existing providers will provide adequate access to hospice care in Baltimore City and Prince George's County, without the need to open these two areas for provider applications.

Stella Maris, Inc. requests that the Commission consider a moratorium on certificate of need for new hospice providers until the newly created work group has completed a study on how to increase utilization of end of life services amount all racial groups. This will allow additional time for the existing providers to improve their community outreach programs with the goal of increasing utilization of hospice services by African Americans and other racial and ethnic groups.

Thank you for your continue support of the Maryland hospice programs. If you require additional information, please feel free to contact me at your convenience.

Sincerely

Lisa Stone
Sr VP Outreach Services

Talbot Hospice
FOUNDATION

May 10, 2013

MAY 16 2013 AM 9:39

VIA EMAIL & US MAIL

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

Re: State Health Plan for Facilities and Services: Hospice Services

Dear Ms. Cole:

The Talbot Hospice Foundation (THF) welcomes the opportunity to provide informal comments on the proposal of the Maryland Health Care Commission to amend the State Health Plan pertaining to hospice services.

THF presently operates a six-bed "Hospice House" pursuant to a Coordinating Agreement with Care Health Services (CHS), an affiliate of the Shore Health System. THF, the Caroline Hospice Foundation and Shore have proposed creation of a new, unified hospice that will combine all the hospice services presently conducted by these three separate organizations. This new organization would operate under the Certificates of Need presently held by Shore for conduct of hospice services in Talbot and Caroline Counties. However, the Parties have yet to achieve a full and final agreement regarding the establishment of this new, unified hospice. Accordingly, THF retains an interest in the docketing rule found at proposed Section 10.24.13.04. If we do not achieve final agreement with Shore and Caroline, we will need to preserve the option of applying for our own CON.

Proposed Section 10.24.13.04.B.(2) allows docketing of an application by an existing limited license hospice in a "sole provider" jurisdiction to allow that limited license hospice to become a general hospice, notwithstanding volume criteria that would otherwise apply. THF strongly endorses this proposal. However, informal discussions with your office have suggested that the proposed amendment to the docketing rule may not take effect until after expiration of THF's limited license in December of 2013, and that application by THF after that date could not be docketed. This "Catch 22" situation could be avoided by a simple modification to the section in question to change the language of subsection (2) to state that "the Commission may docket an application by a hospice provider that operated under a limited license in 2013 in the jurisdiction to become a general hospice in that jurisdiction." This small change will perfect the evident intent of the proposed rule and not make it hostage to the timing of completion of the rulemaking effort.

Sincerely,

T-Smith

J. T. Smith II
Board President

RECEIVED

APR 22 2013

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Deborah Goeller, R.N., M.S.
Health Officer

April 18, 2013

Linda Cole, Chief
Long Term Care and Community Based Services
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Cole:

On behalf of the Worcester County Health Planning Advisory Council, I am pleased to provide comments on the draft regulation COMAR 10.24.13, *State Health Plan for Facilities and Services: Hospice Services*. Access to health care is one of the priorities of the Council approved Worcester *Community Health Improvement Plan 2012 through 2017*. The Council, meeting on April 18, 2013, authorized the following comments after discussion with Coastal Hospice and others:

- The Council appreciates the MHCC concern for improving patient choice, which is introduced on page 4 in section .03 B. (1). It translates to regulations about jurisdictions with only one hospice provider in .04 B. Docketing Sole Provider Jurisdictions and in .04 D on Service Exception. Taken together these two alternatives show willingness to balance viability of service providers with fostering of patient choices.

- The Council recommends the addition of the word "Disparity" to reflect concerns for use differences among religious, ethnic, cultural and other population subgroups, which is introduced on page 4 in section .03 B. (1). This is a timely and important issue affecting access and use. We note continued reference on page 5 under data collection and then again with .05 Standard N. Public Education Programs on page 13. Though the section on public education programs is excellent, our concern is that the word "disparity" is not used in any of these sections and should appear at least in .05 Standard N. Using the term "disparity" will facilitate development of more comprehensive focused education for high risk population segments. For example, the *Maryland State Health Improvement Plan* uses local Minority Outreach and Technical Assistance (MOTA) agencies to augment public education and outreach programs targeting regions with "health disparities."

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- On page 5 into page 6 the document identifies the increase in the numbers of patients with live discharges as conditions improve. It is not clear in the standards where this is reflected as the calculation of need only uses death data. Can you add a note on page 6 that hospice agency capacity uses all discharges in calculation of services provided, but as yet the impact of the increasing number of live discharges is not sufficient to impact need calculations.

- We found a few minor typographical and grammatical errors you might want to correct:
  - On page 4 section B (1) first paragraph refers to "increased by 75% from 12,427 to 21.834" the last number should use a comma and be "21,834";
  - On page 15 the sentence in .06 C. Services (1) is not clear with respect to the use of the word "both". Please consider moving it to before "general and limited" or before "need projections and inventory", whichever is appropriate.

The Council appreciates the Commission's accommodation of rural and diverse populations reflected in this document. We will offer our assistance to our local provider, Coastal Hospice, related to improving public education and outreach.

Sincerely,

Mary Stevens

Mary Stevens, Chairman
Worcester County Health Planning Advisory Council

cc: Lori Brewster, Health Officer, Wicomico County
James C. Church, President, Worcester County Commissioners
Deborah Goeller, Health Officer, Worcester County
Craig Stofko, Health Officer, Somerset County