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MEMORANDUM

TO: Commissioners

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

DATE: September 12, 2013

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

Repeal of Existing Hospice Services Regulations Found in COMAR 10.24.08: State Health Plan for Facilities and Services- Nursing Home, Home Health Agency, and Hospice Services

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COMAR 10.24.13, the Hospice Services Chapter of the State Health Plan, was adopted by the Commission as proposed permanent regulations at the June 20, 2013 Commission meeting. Notice of this action was published in the *Maryland Register* on July 26, 2013. A formal comment period followed, ending on August 26. Comments were received from 14 organizations and individuals. Attached are the following documents for your consideration:

1. ***Analysis of Formal Public Comments and Staff Recommendations. 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 recommends that the Commission adopt this Chapter as final regulation and also repeal the Commission's current State Health Plan regulation for hospice services, COMAR 10.24.08.12 through 10.24.08.15 (not attached).

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

MARYLAND HEALTH CARE COMMISSION

Analysis of Formal Public Comments and Staff Recommendations

State Health Plan for Facilities and Services:

Hospice Services

COMAR 10.24.13

September 19, 2013

I. State Health Plan for Facilities and Services: Hospice Services (COMAR 10.24.13)

Introduction:

The current chapter of the State Health Plan for Facilities and Services ("Plan") that addresses hospice services, COMAR 10.24.08, includes policies and standards for nursing home, home health agency, and hospice services. Going forward, standards for these services will be updated in separate Plan chapters. The first such update, COMAR 10.24.13 ("Chapter" or "Hospice Chapter") concerns hospice services and was adopted by the Maryland Health Care Commission ("Commission") as proposed permanent regulations at its June 20, 2013 meeting.

The Hospice Chapter was developed by Commission staff with the assistance of a Hospice Work Group, composed of representatives of hospices, Medicaid, the 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. After considering the informal comments received, Staff revised the draft Chapter and its need methodology, and released a revised draft Chapter for another informal public comment period from April 10- May 10, 2013. Staff analyzed the comments received and suggested changes. As noted earlier, in June, the Commission adopted the Chapter as proposed permanent regulations. Notice of the Commission's adoption of the Chapter was then published in the *Maryland Register* on June 26, 2013, which initiated a formal comment period that ended on August 26, 2013.

During the formal comment period, comments were received from 14 individuals or organizations:

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

The remainder of this document provides a summary of the written comments received and staff's 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 .03: Issues and Policies

- Senate Finance:

"The Senate Finance Committee encourages MHCC to work with the Hospice Network to develop measures of quality assessment regarding the provision of hospice services."

Staff Analysis and Recommendation:

Staff agrees that this is an important goal, as outlined in Policy 2 of the draft Chapter: "As measures are developed, the level of quality achieved by hospices, as indicated by measurement and reporting of performance on the quality measures, will be incorporated into the review criteria and standards used in Certificate of Need reviews." Staff of the Commission's Center for Quality and Reporting is working with the hospices to pursue this goal. The development of quality measures for hospice lags behind development for other health care services, such as hospitals, home health agencies, and nursing homes. The Centers for Medicare and Medicaid Services (CMS) published a final rule on August 7, 2013 that changes the requirements for the hospice quality reporting program by discontinuing currently reported measures and implementing a Hospice Item Set, with seven National Quality Forum (NQF) - endorsed measures beginning July 1, 2014. Also, this final rule will implement the Hospice Experience of Care Survey on January 1, 2015. Staff has met with the Hospice Network about collecting hospice quality data, initially on a pilot basis, and later incorporating it into the Commission's Consumer Guide to Long Term Care.

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

Section .04(A(3):

- Hospice Network; Holy Cross; Hospice of Queen Anne's; Montgomery Hospice suggest the addition of a new docketing rule:

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

Staff Analysis and Recommendation:

This change was suggested by the commenters during the informal comment period and, as noted by staff before the Commission adopted the Chapter as proposed regulations, such a docketing rule is unnecessary and redundant. 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. No change is needed.

Section .04C. Docketing: Inpatient Capacity:

- LifeBridge suggests the addition of the following sentence:

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

Staff Analysis and Recommendation:

The additional wording suggested by LifeBridge regarding relocation after acquisition is both vague and broader than the scenario described in LifeBridge's comments. However, it appears that the breadth of the suggested new language may require a change in Maryland law. Current law specifies that the relocation of a health care facility requires CON approval, with certain exceptions for merged asset systems. Most changes in the bed capacity of a health care facility also require CON review. Bed relocations are common in the case of nursing homes (also known as comprehensive care facilities, or CCFs) and require CON review. In contrast to a nursing home, which is a distinct health care facility that, by its nature, has bed capacity, a general hospice is not required to have bed capacity, but must make provisions for inpatient hospice care when needed by those to whom it provides hospice services. Bed capacity operated by a general hospice is not a health care facility, distinct and apart from the other types of service offered by a general hospice. The regulatory requirements associated with the situations that appear to fall within the scenario outlined in the comment would need to be evaluated on the particular facts of the situation, within current CON procedural regulations found in COMAR 10.24.01, or through consideration of changes to the procedural regulations or to current law.

No change is recommended.

Section .04:

- LifeBridge recommends the addition of a new subsection:

"The Commission should add a new subsection 'E' to COMAR 10.24.13.04 to read as follows:

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

LifeBridge's suggestion addresses the scope of CON regulation and would require the General Assembly to adopt legislation that a general hospice does not need a Certificate of Need to change its bed capacity. This is not an issue that can be addressed in the Chapter.

The Commission has determined that hospices may enter into agreements with health care facilities, such as hospitals and nursing homes that allow for the admission of that hospice's patients to those facility's beds when inpatient care is needed and allow for the facility's staff and the hospice staff to jointly care for the patient, without CON review and approval. This is a long-standing practice that has not been controversial and does not alter the nature of the hospital or nursing home beds that are occasionally used to accommodate hospice patients.

In 2012, LifeBridge expanded this model by entering into an agreement with Seasons Hospice that turned over licensed general hospital beds at Sinai Hospital to Seasons for its dedicated and exclusive use as general inpatient hospice beds. After consulting with MHCC, the Office of Health Care Quality ruled that this was inconsistent with licensure law and that hospital beds removed from service as hospital beds in this way needed to be licensed as hospice beds.

No change is recommended.

Section .05 (N). Public Education Programs:

- Senate Finance Committee:

"The Senate Finance Committee supports enhanced educational outreach by MHCC and the Hospice Network to meet the potential unmet need for hospice services in Maryland."

- Hospice Network; Calvert Hospice; Gilchrist Hospice; Holy Cross; Hospice of Queen Anne's; Hospice of St. Mary's; Hospice of the Chesapeake; Montgomery Hospice; Stella Maris:

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

Staff Analysis and Recommendation:

The proposed Chapter includes a standard on public education. COMAR 10.24.13.05.N, requires an applicant to document its plan to:

> "provide public education programs designed to increase awareness and consciousness of the needs of dying individuals and their caregivers, to increase the provision of hospice services to minorities and the underserved, and to reduce 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."

This was also a topic of discussion at the Senate Finance Committee hearing in January 2013. It was recognized that need is projected in Baltimore City and Prince George's Counties, and these are areas that have a relatively low hospice use rates and a large number of African Americans. Since the literature indicates that African Americans use hospice at lower rates than the general population, the Commission was directed to work with the Hospice Network on education and outreach. The Commission complied by convening a Hospice Education Work Group. The initial meeting of this group was on April 29, 2013 and the second meeting was on July 29, 2013. The membership has grown, and members have shared their experiences on what has succeeded and failed as far as outreach efforts. This has already resulted in materials being shared, and the group has continued to grow in size and diversity. In addition to hospice providers, the group includes: Baltimore City Health Department; The Ecumenical Institute of Theology; Delmarva Foundation; Maryland Hospital Association; MedChi; Monumental City Medical Society; Office of Health Care Quality; Office of Minority Health and Health Disparities; Prince George's County Department of Family Services; Prince George's County Health Department; State Advisory Council on Quality Care at the End of Life; and University of Maryland Department of Social Work.

When it was convened, the goals of the Hospice Education Work Group (presented to and reviewed by work group members) were as follows:

Goals:

- To facilitate the discussion and review of educational initiatives for end of life/hospice services in Maryland with outreach to minorities.
- To discuss best practices in order to develop provider specific educational programs.
- To facilitate the development of educational programs in Baltimore City and Prince George's County.

Commission staff serves as a facilitator and convener of this important work group, where hospice programs share promising practices and ideas. In addition, the various trade associations, Maryland Hospital Association, MedChi, and Monumental City Medical Society have offered to help with distribution and dissemination of materials to providers and consumers. Commission staff's role is not that of a direct provider of education. This is the responsibility of hospice programs and, if desired by its members, the Maryland Hospice Network, which are in the best position to understand the needs and desires of their patient populations and the communities they serve, for educational materials and programs.

The hospice providers appeared to accept the tenets of the methodology during the work group process outlined in the introduction of this report, as well as the outcome of that methodology, with need identified in Baltimore City and Prince George's County (all of which was reviewed and disseminated prior to adoption of the Chapter as proposed regulations). However, their argument now appears to be that the MHCC should delay updating the Hospice Chapter until existing hospices are permitted some unspecified time to conduct education and outreach to the minority community, the Hospice Education

Work Group develops an unspecified evaluation mechanism, and the Work Group completes its evaluation of the result.

Commission staff notes that it has published a schedule in the *Maryland Register* that does not permit letters of intent to establish new hospices or expand existing hospice service area to be submitted prior to mid-2015. In the intervening period, Commission staff will be able to evaluate any improvement in hospice use rates and receive reports from the field on successful education and outreach efforts. The staff believes there is no need for further delay in promulgating these long overdue regulations. No change is recommended.

Section .05P Inpatient Unit:

- Hospice Network; Calvert Hospice; Gilchrist Hospice; Hospice of Queen Anne's; Hospice of the Chesapeake; Montgomery Hospice; Seasons; Stella Maris:

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

Staff Analysis and Recommendation:

Staff agrees that inpatient hospice is an integral part of the continuum of care for hospice services. The approach to CON for general inpatient hospice units ("GIP") in the proposed Chapter is an improvement over what exists today. The proposed Chapter provides new guidance for CON review of inpatient hospice service projects by specifying what is required in an application to demonstrate project need, impact, and cost effectiveness.

Inpatient care constitutes a very small part of the services hospices provide. It should be noted that Medicare limits the amount of inpatient care (general inpatient or GIP, and respite combined) to 20 percent of a hospice provider's total patient days. In Maryland, as well as nationally, in 2011, general inpatient care represented slightly over two percent of patient days.[1] Hospices are required under Medicare to provide a full range of services for their patients, including GIP care as needed. The Chapter has not dictated how hospices must provide inpatient care, and doing so with their own facilities is not the primary mode that most hospices choose to provide this service. Most hospices contract with nursing homes and hospitals to assure the availability of bed capacity for inpatient care as needed on an "available bed" basis. Medicare, which pays for approximately 90% of hospice days of care in Maryland, makes no distinction among settings in which care is provided; it pays according to the level of care needed by the patient, not the location of care.

The MHCC staff decision in 2010 to change the approach for reviewing the development of inpatient hospice facilities by hospices under the CON program came after careful internal discussion and

[1] NHPCO Facts and Figures, 2012; Maryland Hospice Survey, 2012.

discussion with the industry. A hospice is defined, in law, as a health care facility and the CON law requires that "changes in the bed capacity of a health care facility" require CON approval. Prior to 2010, the Commission staff issued determinations of coverage stating that CON review and approval would only be needed for projects involving changes in inpatient hospice bed capacity if the capital costs of the project were above the capital expenditure threshold. In 2010, a review of Maryland statute and corresponding CON procedural regulations applicable to proposed hospice inpatient bed projects, showed that this earlier interpretation was erroneous. Since this was a change to previous Commission practice, the Commission staff sent letters to the Hospice Network and to all hospice providers inviting them to a meeting where this change was explained. The Commission staff also allowed for "grandfathering" of inpatient hospice projects that had obligated certain expenditures prior to the date of the corrected reading of Maryland law was made by staff. Only one hospice program raised objections to the inclusion of changes in hospice bed capacity directly operated by hospices under CON regulation. The Hospice Network and every other hospice commenting on the change concurred with the corrected position of MHCC staff and none voiced any need to adopt a bed need methodology.

The Network's call for delaying final adoption of the Hospice Chapter will not serve to address the concerns about establishment of GIPs. If action is delayed, the Commission will be required to continue to receive and review CON proposals to add inpatient hospice bed capacity without the additional guidance provided by the new Chapter, which will impose more rigorous application requirements on hospice inpatient facility projects. Any future changes should be informed by revisions in the review process already specified in the proposed regulations. Further, from a process perspective, Commission staff believes that this approach is consistent with the industry's preference for cautious deliberate changes in the Hospice Chapter. For these reasons, there is no need to delay final action on the regulations to make further changes in the GIP review standards. No change is recommended.

Section .06 Methodology for Projecting Need for General Hospice Services:

- Senate Finance Committee

"The Senate Finance Committee has significant concerns regarding the methodology that was used to determine the need for additional hospice CONs in several Maryland jurisdictions, most recently Prince George's County and Baltimore City."

- Hospice Network; Calvert Hospice; Gilchrist Hospice; Holy Cross; Hospice of Queen Anne's; Hospice of St. Mary's; Hospice of the Chesapeake; Montgomery Hospice; Stella Maris:

"The plan as prematurely drafted does not reflect or consider that the current providers in these jurisdictions have the infrastructure, capacity, and scale to serve additional patients….representatives spoke to the low utilization of hospice services in Baltimore City and Prince George's County not as a matter of access but one of utilization and acceptance. There is adequate access and capacity for hospice care given by the ten providers in Baltimore City and nine providers in Prince George's County."

- LifeBridge Health

"LifeBridge applauds the Commission's decision to revise the State Health Plan to keep pace with the growing demand for hospice in Maryland as patients, their families, and health care practitioners become more aware of the value of hospice as a holistic approach to end-of-life care."

"LifeBridge wholeheartedly agrees with the Commission that Baltimore City has a need for additional hospice capacity. Baltimore City is currently underserved….Outreach and education may mitigate this disparity , but the Proposed Regulations recognize that even traditional growth in capacity by existing hospice providers will not be enough; providers need the flexibility to meet the challenge of a higher use rate."

Staff Analysis and Recommendation:

The Commission staff notes that the new methodology is the result of work begun in September 2012. At that time, the Committee raised concerns about the demand formula that was used to project need in jurisdictions with relatively high hospice use rates (e.g. Baltimore County, Howard County, and Montgomery County). The Senate Finance Committee recommended that MHCC staff meet with staff of the Hospice Network to resolve the issue. As a result, MHCC staff collaborated with the Hospice Network and adopted its proposed methodology, which is the methodology MHCC now proposes to use. All of the assumptions of the methodology, as well as the projected outcome indicating need in Baltimore City and Prince George's County, were reviewed step-by-step at the Hospice Work Group meetings.

It is unclear why the Hospice Network now considers this Plan Chapter to be "prematurely drafted" since work has been ongoing for more than two years and the draft went through two informal public comment periods prior to this required formal comment period. As was pointed out previously, 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.

In 2012, the Hospice Network methodology proposed the following steps (emphasis added):

- 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.
- Calculate the compound annual growth rate exhibited by hospice providers during the five year period from 2006-2010. (See Step 6: Supplemental Table C.)
- 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.

These methodological steps have been adopted in the proposed Chapter.

As far as the number of providers in these jurisdictions, the numbers are a bit misleading. In Baltimore City, there are nine authorized providers. Of these, in 2011, one served 50% of total Baltimore City patients, and one served 22% of these patients and the other seven shared the remaining 28% of the market, with none of these seven serving more than 11%. In Prince George's County, there are also nine authorized providers. However, in 2011, one hospice served 32% of the County's total hospice patients, one served 25%, and one served 21%. The remaining six served the remaining 22% of the market, all with less than six percent of market share. 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.

As the comments indicate, Lifebridge supports the need for additional providers in Baltimore City.

As previously noted, the Commission staff has published a schedule in the *Maryland Register* that waits until mid-2015 to permit the filing of letters of intent for establishing new hospices or expanding existing hospices. In the intervening period, Commission staff will be able to evaluate any improvement in hospice use rates and receive reports from the field on successful education and outreach efforts. There is no need for further delay in promulgating these long overdue regulations. Commission staff recommends no changes.

Other Issues:

- Senate Finance Committee regarding a moratorium:

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

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

Staff Analysis and Recommendation:

After the discussion of hospice CON regulation at the Senate Finance Committee in September of 2012, Commission staff returned to the Senate Finance Committee in January of 2013 with an updated progress report. First, Commission staff noted that, while the General Assembly has authority to declare a moratorium on services that the Commission is required to regulate under its statute and regulations governing CON, the Commission does not have such authority. Second, Commission staff was careful to follow the direction of the Senate Finance Committee and met with the Hospice Network and adopted

the methodology recommended by the Hospice Network and its consultant. The assumptions of the methodology and its outcome were discussed at the Hospice Work Group. Third, the methodology does assess the current infrastructure of hospice providers, which is an integral part of the methodology. Finally, the last bullet referring to "adverse selection" of patients is unclear; however, staff notes that hospice care is not a service that lends itself to traditional concepts of "cherry-picking" because all hospices must structure themselves to serve the Medicare population, in order to be financially viable, and the payment levels are identical for all Medicare patients at any given level of care.

- Hospice Network; Calvert Hospice; Hospice of Queen Anne's; Montgomery Hospice regarding public comment:

"This action was considered by the Commission at an open meeting held on June 20, 2013 and there was no opportunity for public comment."

Staff Analysis and Recommendation:

For over two years, the Hospice Chapter has been discussed and debated. From 2011 through 2013, the Hospice Work Group held four meetings. Additionally, in 2012, the Commission held a public informational meeting, as well as a meeting between staff and the Board of the Hospice Network. Commission staff and hospice representatives spoke at two meetings about hospice at the Senate Finance Committee. In addition to the formal public comment period required for regulations, the Commission held two informal public comment periods. At the Commission meeting in June, 2013, staff presented an analysis of comments and a full text of all comments was distributed to the Commissioners.

- Hospice Network Calvert Hospice; Holy Cross; Hospice of Queen Anne's; Hospice of the Chesapeake; Montgomery Hospice regarding economic impact:

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

Staff Analysis and Recommendation:

The referenced quote in this comment is not from the proposed Hospice Chapter. Rather, it is from an Economic Impact Statement, prepared by MHCC as a requirement when adopting proposed permanent regulations.

Staff notes that some hospices in Maryland are small businesses and are primarily located in more rural areas, not in the two large metropolitan areas where need is currently be identified under the proposed Hospice Chapter. Commission staff's projection that the proposed regulations will have minimal or no impact on small businesses is accurate. The two hospices that account for 77% of total market share in Baltimore City, Gilchrist and Seasons, are the State's two largest hospice providers and Baltimore City

accounts for only 22% and 15% of their total hospice patients, respectively. In Prince George's County, the market is currently dominated by Capital Hospice, Hospice of the Chesapeake, and Heartlands Hospice. Capital Hospice operates in Virginia, the District, and Maryland, Hospice of the Chesapeake is the fourth largest hospice in Maryland, and Heartlands, a subsidiary of HCR ManorCare, operates in 25 states. Although the possible creation of a new hospice provider or expansion of an existing hospice into new jurisdictions, such as Baltimore City or Prince George's County, could impact existing hospices, an effective new provider may bring the benefit of a new approach and could improve the range of services provided to Maryland residents.

- Senate Finance Committee and others regarding length of stay:

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

Staff Analysis and Recommendation:

Recent data indicate that Maryland lengths of hospice stay are lower than the national average. The recommendation that MHCC staff examine incentives for hospitals and nursing facilities to make earlier referrals to hospice is helpful and will be examined. Proposed changes in Maryland's Medicare hospital waiver will make developing these incentives easier. MHCC believes incentives can be developed in parallel with this Chapter revision.

Imposing a moratorium on market entry or expansion is not a logical response to observed difference in length of stay between Maryland and other states, given that entry into the market is easier in most other states. The majority of other states do not regulate the supply or distribution of hospices. Maryland has not approved the creation of a new hospice or the expansion of an existing hospice into a new jurisdiction for over a decade, which some would argue has stalled innovation in the State.. Increases in the average length of stay could result from earlier hospital referrals to hospice, but a moratorium will not facilitate the goal of encouraging earlier referral to hospice. A moratorium could further deter innovations including those that could lead to earlier referrals to hospice.

- Joseph Richey Hospice regarding serving minority community:

"Joseph Richey Hospice operates the only freestanding hospice facilities and services in the city of Baltimore and serves the community with hospice homecare. Over 74% of the people we serve are African American. This has been a consistent picture…. There are a number of reasons there is a lower use of hospice by African Americans in Baltimore City and Prince George's County…. I am not per se opposed to adding more hospices to the city mix. We have always operated in a competitive environment. But I do not think expanding the number of hospices will yield the result you seek."

Staff Analysis and Recommendation:

Joseph Richey has served the minority community in Baltimore City and it can share its experiences with other providers regarding education and outreach. For this reason, Commission staff is pleased that this provider is on the Commission's Hospice Education Work Group.

- Western Maryland regarding sole provider:

"Here in Western Maryland, we have felt our small program to be protected by the current CON requirements for Hospice licensure…. While the philosophy of a free market is appealing, in our corner of the state it is daunting to consider the potential for additional providers of Specialized End of Life Care dividing a small pie and shrinking a limited revenue source."

Staff Analysis and Recommendation:

Staff notes that Western Maryland Health System Hospice Services is a small sole hospice provider providing care to its community. The proposed regulations are not likely to have an impact on Allegany County, with respect to increasing competition in the foreseeable future.