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LIST OF EXHIBITS

LIST OF TABLES

Project Information

Submission Date	November 14, 2025
Document Type	**CON Application**
Review Schedule	Schedule One
CON Review Service	Home Health Agency (HHA) Services
Proposed Project	Establish a New Medicare-Certified **Home Health Agency**
Proposed Service Area	**Baltimore City, Baltimore County & Howard County Region**
Regulatory Justification	COMAR 10.24.16.04

Applicant and Organization Details

Applicant Name	Quality One Care Home Health, Inc. (QOC)
Applicant Status	MD RSA License No. R3057 / Joint Commission Accredited
Headquarters Address	9221 Colesville Road, Silver Spring, MD 20910
Phone / Fax	301.658.7141 / 301.579.4845
Website / Email	www.qualityonecare.com / info@qualityonecare.com

Key Contact for Submission Questions

Name and Title	Amon Chafukira, Program Coordinator
Phone Number	301.658.7141 / 301.355.0121 (Direct)
Email Address	msmatope@gmail.com

Key MHCC Deadlines (Schedule One)

Letter of Intent (LOI) Due	September 12, 2025
Pre-Application Conference	September 24, 2025
Full Application Due	November 14, 2025

Submitted To	Certificate of Need Division, Maryland Health Care Commission 4160 Paterson Avenue, Baltimore, MD 21215

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328
Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

November 14, 2025

VIA HAND DELIVERY AND E-MAIL

Ewurama Shaw-Taylor, Chief
Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Re: Quality One Care home Health, Inc.
Certificate of Need Application (Baltimore–Howard Region)

Dear Ms. Shaw-Taylor:

Enclosed please find six (6) hard copies of the Certificate of Need (CON) Application submitted on behalf of Quality One Care Home Health, Inc. (QOC) to establish a Medicare-certified Home Health Agency serving Baltimore City, Baltimore County, and Howard County (Baltimore–Howard Region).

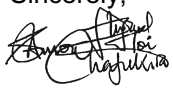
In accordance with MHCC requirements, a full searchable PDF and Microsoft Word copy of the application and excel tables will also be submitted to mhcc-confilings@maryland.gov

Quality One Care Home Health, Inc. is a Maryland-licensed Residential Service Agency (RSA License No. R3057) in good standing and accredited by The Joint Commission. This submission represents QOC's intent to expand its existing home-based skilled nursing and supportive-care operations into a fully certified Medicare Home Health Agency, consistent with COMAR 10.24.16.06(B)(3).

I hereby certify that a copy of this CON application has been provided to each affected local health department, as required.

If any additional information is needed, please let us know.

Sincerely,



Amon Chafukira
Program Coordinator
Quality One Care Home Health, Inc.

MARYLAND
Health Care
Commission

Randolph S. Sergent Esq, Chairman
Ben Steffen, Executive Director

Revised July 2024

INSTRUCTIONS FOR
APPLICATION FOR CERTIFICATE OF NEED
HOME HEALTH AGENCY PROJECTS

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively.

The Table of Contents must include:

- **Responses to PARTS I, II, III and IV of this application form**
- **Responses to PART II must include responses to the standards in the State Health Plan chapter, COMAR 10.24.16, STATE HEALTH PLAN FOR FACILITIES AND SERVICES: HOME HEALTH AGENCY SERVICES.**
- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.)

SUBMISSION FORMATS:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to mhcc-confilings@maryland.gov

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

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PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. APPLICANT. ***If the application has a co-applicant, provide the following information for that party in an attachment.***

Legal Name of Project Applicant (Licensee or Proposed Licensee):
Quality One Care Home Health, Inc

Address:					
9221 Road	Colesville	Silver Spring	20910	Maryland	Montgomery
Street		City	Zip	State	County

Telephone: 301-658-7141

Name of Owner/Chief Executive: Mohamed Matope, Director

2. Name of Owner Quality One Care Home Health, Inc

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

3. FACILITY

Name of HHA provider: Quality One Care Home Health, Inc

Address:				
9221 Road	Colesville	Silver Spring	20910	Montgomery
Street		City	Zip	County

Name of Owner (if differs from applicant): SAME

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

SAME

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☒	
	Partnership	☐	Date and State of Incorporation Maryland, April 21, 2011
C.	General		
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):	☐	
	Limited Liability Company		
D.	Other (Specify):	☐	
E.			
	To be formed:	☐	
	Existing:	☒	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Amon Chafukira, Program Coordinator
Mailing Address:

9221 Colesville Road	Silver Spring	20910	Maryland
Street	City	Zip	State

Telephone: 301-658-7141
E-mail Address (required): msmatope@gmail.com
Fax: 301-658-2328

B. Additional or alternate contact:

Mohamed Matope
Mailing Address:

9221 Colesville Road	Silver Spring	20910	Maryland
Street	City	Zip	State

Telephone: 301-658-7141
E-mail Address (required): msmatope@gmail.com
Fax: 301-658-2328

B. Additional or alternate contact:

Name and Title: _____

Company Name _____
Mailing Address:

Street City Zip State

Telephone: _____

E-mail Address (required): _____
Fax:

If company name is different than applicant briefly describe the relationship _____

7. Proposed Agency Type: ☑

a. Health Department ☐
b. Hospital-Based ☐
c. Nursing Home-Based ☐
d. Continuing Care Retirement Community-Based ☐
e. HMO-Based ☐
f. Freestanding ☒
g. Other ☐
(Please Specify.) _____

8. Agency Services (Please check ☑ all applicable.)

Service	Currently Provided	Proposed to be Provided in the Jurisdiction(s) that are the subject of this Application*
Skilled Nursing Services	√	√
Home Health Aide	√	√
Occupational Therapy		√
Speech, Language Therapy		√
Physical Therapy		√
Medical Social Services		√

**All core services, including Medical Social Services will be available in all three jurisdictions: Baltimore City, Baltimore County, and Howard County.

9. Offices

Identify the address of all existing main office, and branch office locations and identify the location (city and county) of all proposed main office, and branch offices, as applicable. (Add rows as needed.)

	Street	City	County	State	Zip Code	Telephone
Existing Main Office	9221 Colesville Road	Silver Spring	Montgomery	Maryland	20910	301-658-7141
Existing Branch Offices						
Locations of Proposed HHA Main Office	9221 Colesville Road	Silver Spring	Montgomery	Maryland	20910	301-658-7141
Locations of Proposed Branch Office						

10. Project Implementation Schedule for an HHA

An application for a CON or other Commission approval shall propose a schedule for implementation of the project in accordance with COMAR 10.24.01.12A(1) that specifies the estimated time for, at a minimum, the following project implementation steps: Obligation of Capital Expenditure, Beginning Construction, Complete Construction and Full Operation.

In developing the schedule, please note that COMAR 10.24.01.12C requires a holder to obligate at least 51 percent of the approved capital expenditure for a project involving building construction, renovation, or both, as documented by a binding construction contract or equipment purchase order, within the following specified time periods:

- **An approved new hospital has up to 36 months**
- **A project involving an approved new non-hospital health care facility or involving a building addition or replacement of building space of a health care facility has up to 24 months**
- **A project limited to renovation of existing building space of a health care facility has up to 18 months**
- **A project that does not involve construction or renovation shall document that the approved project is complete and operational within 18 months.**

In a multiphase plan of construction with more than one construction contract approved for an existing health care facility, a holder has:

(a) **Up to 12 months after approval to obligate 51 percent of the capital expenditure for the first phase of construction**

(b) **Up to 12 months after completion of the immediately preceding phase of construction to obligate 51 percent of the capital expenditure for any subsequent approved phase**

For Home Health projects, please also provide:

A. Licensure: ___6___months from CON approval date.
B. Medicare Certification ____3___months from CON approval date.

11. Project Description:

Provide a summary description of the project immediately below. At minimum, include the jurisdictions to be served and all of the types of home health agency services to be established, expanded, or otherwise affected if the project receives approval.

APPLICANT RESPONSE:

Quality One Care Home Health, Inc. (“QOC”) seeks approval to establish a new Medicare-certified Home Health Agency (HHA) serving Baltimore City, Baltimore County, and Howard County as a unified multi-jurisdictional service area. This project expands QOC’s existing state-licensed Residential Service Agency (RSA License No. R3057) into a fully certified Medicare HHA, consistent with COMAR 10.24.16.06(B)(3). This initiative directly supports the purpose of COMAR 10.24.16 by improving access to cost-effective, high-quality, and patient-centered home health services for chronically ill, aging, and underserved residents.

QOC has operated continuously since 2009 and was incorporated as Quality One Care Home Health, Inc. in 2011. The agency provides skilled nursing and supportive home-based services across multiple Maryland jurisdictions and currently serves more than 200 clients annually, demonstrating substantial operating capacity, scalable clinical infrastructure, and readiness to transition into Medicare-certified home health operations.

The Maryland Health Care Commission's 2023 Home Health Agency Utilization Tables (Tables 17–24) document that Baltimore City, Baltimore County, and Howard County collectively generate a high volume of home health clients and visits, with significant concentrations of older adults, individuals with chronic conditions, and Medicare beneficiaries. These utilization patterns—combined with persistent disparities in access and outcomes across the three jurisdictions—demonstrate a sustained, data-supported need for additional certified home health provider capacity within the region.

The proposed project will enable QOC to extend its clinically governed, evidence-based care model to Medicare beneficiaries and other patients requiring intermittent skilled nursing and rehabilitative services under the Medicare Conditions of Participation for Home Health Agencies (42 CFR Part 484).

The proposed Baltimore–Howard Region HHA will offer the full complement of Medicare-eligible home health services, including:

- Skilled Nursing Services (Assessment, Medication Management, Disease Management, Wound Care, Patient Education)
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Medical Social Services
- Home Health Aide Services
- Remote patient monitoring
- Chronic Care Management

All services will be delivered under physician orders and coordinated through an interdisciplinary plan of care. QOC will leverage its existing clinical leadership, Joint Commission–aligned quality-management framework, and integrated electronic health record (EHR) system to support compliance, care coordination, and seamless integration into Medicare-certified operations.

The project requires no major capital expenditure. QOC will lease administrative and clinical coordination space within the service area and deploy a mobile, community-based field workforce. This model aligns with MHCC's priorities for efficient, scalable service expansion that enhances access, quality, and continuity of care while maintaining affordability and operational sustainability across the tri-county region.

Upon Certificate of Need approval, QOC will begin implementation immediately, with Maryland HHA licensure targeted for Month 6, Medicare certification by Month 9, and full-service launch by Month 12. QOC has the financial stability, administrative infrastructure, and experienced leadership necessary to support a seamless transition into Medicare-certified operations without disruption to current services.

QOC is committed to advancing health equity by expanding access to home-based clinical services for low-income, minority, and medically complex populations that MHCC data identifies as disproportionately represented among home health service users in the tri-county region. The agency will recruit and maintain a locally representative and culturally competent workforce to enhance care coordination, reduce avoidable hospital utilization, and improve patient outcomes. QOC will collaborate with hospital discharge planners, primary care practices, and community-based organizations across the Baltimore–Howard region to strengthen care transitions, reduce readmissions, and ensure timely access to skilled home health services.

This project is aligned with MHCC's State Health Improvement Process (SHIP) goals, including reducing preventable hospitalizations, enhancing chronic disease management, and supporting equitable access to community-based care for older adults and high-need populations.

PART II – CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

PART II - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(b) through 10.24.01.08G(3)(h).

10.24.01.08G(3)(a). "The State Health Plan" Review Criterion
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria. (Note:
HHA CON review standards may be found in COMAR 10.24.16.08. Furthermore, in a comparative review, CON preference rules may be found in COMAR 10.24.16.09

10.24.16.08 Certificate of Need Review Standards for Home Health Agency Services.
The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new home health agency in Maryland or expand the services of an existing Maryland home health agency to one or more additional jurisdictions.

The following standards must be addressed by all home health agency CON applicants, as applicable. Provide a direct, concise response explaining the proposed project's consistency with each standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

10.24.16.08A. Service Area.

An applicant shall:

(1) Designate the jurisdiction or jurisdictions in which it proposes to provide home health agency services; and

APPLICANT RESPONSE – 10.24.16.08A(1):

Quality One Care Home Health, Inc. ("QOC") proposes to establish a new Medicare-certified Home Health Agency serving Baltimore City, Baltimore County, and Howard County, Maryland. These three contiguous jurisdictions constitute the defined service area for this Certificate of Need (CON) application.

According to the Maryland Health Care Commission's 2023 Home Health Agency Utilization Tables, residents of Baltimore City, Baltimore County, and Howard County accounted for approximately 577,853 home health visits out of 1,920,610 total visits statewide in FY 2023—about 30% of all Maryland home health visits (MHHC - Table 23: Home Health Agency Visits by Jurisdiction & Age Group – FY 2023).

MHCC's age-specific utilization data further show that a substantial share of these visits involves adults 65 years and older, indicating a high concentration of older and medically complex patients in this tri-county area (MHCC - Table 24: Home Health Agency Clients by Age Group - FY 2023).

This data supports treating the three jurisdictions as a single, high-volume, multi-jurisdictional service region for purposes of this HHA application.

Quality One Care Home Health, Inc. currently operates as a Maryland-licensed Residential Service Agency (RSA License No. R3057), providing skilled and non-skilled home-based nursing and supportive care across multiple Maryland counties, including Montgomery, Prince George's, Frederick, Washington (Hagerstown), Baltimore, Anne Arundel, Howard, Washington, Charles, Calvert, Cecil, and Carroll Counties. Through this extensive operational footprint, QOC has developed substantial experience in multi-jurisdictional service delivery, regulatory compliance, and effective workforce deployment in diverse clinical and geographic environments.

The proposed expansion will enable QOC to deliver Medicare-certified home health services to residents of the Baltimore City–Baltimore County–Howard County region, addressing the region's growing need for coordinated, high-quality, home-based clinical care and improving access for underserved patient populations.

(2) Provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, and each branch, as defined in this Chapter, or other major administrative offices recognized by Medicare.

APPLICANT RESPONSE– 10.24.16.08A(2):

The proposed Quality One Care Home Health Agency will operate under the existing corporate structure of Quality One Care Home Health, Inc., with both current and proposed Medicare-certified home health operations headquartered at:

9221 Colesville Road,
Silver Spring, Maryland 20910 (Montgomery County)
Email: info@qualityonecare.com | Phone: (301) 658-7141 | Fax: (301) 658-2328

This location functions as QOC's main corporate office and will serve as the parent home health agency, as defined under Medicare Conditions of Participation (42 CFR §484). The Silver Spring headquarters houses all administrative, clinical, quality-management, compliance, and corporate governance functions for the organization. All operational activities associated with the proposed Medicare-certified HHA – including intake, scheduling, quality assurance, clinical oversight, and staff supervision – will be coordinated and managed from this central office.

QOC does not currently operate any branch offices, and none are proposed as part of this CON project. Instead, the agency will deploy a mobile, field-based workforce of licensed nurses, therapists, medical social workers, and home health aides who will deliver direct patient care throughout Baltimore City,

Baltimore County, and Howard County. This model is consistent with current Maryland HHA practice and supports efficient, community-based care delivery across multi-jurisdictional service areas.

QOC will continue to operate under its Joint Commission–aligned quality-management program and established corporate governance model. Oversight of Medicare-certified home health operations will be provided by the Administrator and Director of Nursing, both based at the Silver Spring headquarters, with additional remote supervision and virtual case-management capabilities to support timely clinical decision-making and regulatory compliance.

An organizational chart outlining administrative structure, lines of authority, and reporting relationships is provided in Exhibit 1.

10.24.16.08B. Populations and Services.

An applicant shall describe the population to be served and the specific services it will provide.

APPLICANT RESPONSE – 10.24.16.08B:

(1) POPULATION TO BE SERVED

Quality One Care Home Health, Inc. (QOC) proposes to serve residents of Baltimore City, Baltimore County, and Howard County who require intermittent, skilled home health services under physician orders. The service area encompasses a diverse population with high concentrations of older adults, individuals with chronic conditions, and medically complex patients transitioning from hospitals, skilled nursing facilities, rehabilitation centers, or other institutional settings back to their homes. The proposed Medicare-certified Home Health Agency will focus on the primary groups most likely to require home health services, including:

- Older adults (65+) requiring post-acute recovery and chronic disease management
- Adults aged 45 – 64 with functional limitations, chronic illnesses, disabilities, or post-surgical needs
- Younger individuals with acute rehabilitation, maternal, or pediatric care requirements
- Residents of underserved neighborhoods of urban and suburban communities within the region that are experiencing barriers accessing timely, skilled home-based care.

(2) DEMOGRAPHIC TRENDS IN THE SERVICE AREA

The Baltimore–Howard Region is home to over 1.9 million residents, representing a diverse and rapidly aging population. Across Baltimore City, Baltimore County, and Howard County, the population is aging at a rate that significantly outpaces overall growth. Based on the published projections by the MHCC, the 65+ population is projected to increase by **56.9%**, while the total population grows only **4.5%** from 2015 and 2035. The disproportionate expansion of the senior population is particularly relevant because older adults account for the majority of home health utilization, especially following hospitalization or during periods of chronic disease instability.

The following tables from the provide detailed demographic projections from the Maryland Department of Planning for Baltimore City, Baltimore County, and Howard County, illustrating the region's population composition and expected shifts through 2035.

This data highlights the significant and ongoing aging of the population, which has direct implications for the volume and acuity of home health needs. Older adults, particularly those aged 65 and above, are more likely to experience chronic conditions such as heart disease, diabetes, and post-acute recovery requirements that necessitate skilled nursing and rehabilitative care in the home. Understanding these demographic dynamics is critical to ensuring that the proposed Medicare-certified home health agency aligns with regional health planning priorities and the goals of Maryland's State Health Plan for Home Health Services. The rapid aging of the region's population increases demand for timely, home-based skilled care that prevents avoidable hospitalizations and supports safe transitions from acute and post-acute settings.

Table B-2A

Population by Age Cohort — Baltimore City, Baltimore County, and Howard County

(2015 – 2035)

Year	0 – 19	20 – 44	45 – 64	65+	Total Population
2015	528,312	774,820	602,714	244,903	2,150,749
2020	517,960	783,910	591,552	292,504	2,185,926
2025	510,225	780,084	572,366	332,120	2,194,795
2030	512,489	781,000	560,418	366,807	2,220,714
2035	514,011	783,720	555,006	397,910	2,250,647

Source: *Maryland Department of Planning. Population Projections by Age Cohort for Maryland Jurisdictions, 2015–2035 (Revised 2024). Table B-2A.*

Table B-2B

Percent Change in Population by Age Cohort — Baltimore City, Baltimore County, and Howard County (2015 – 2035)

Age Cohort	2015 – 2020	2020 – 2025	2025 – 2030	2030 – 2035	2015 – 2035 Total
0 – 19	-1.9%	-1.5%	0.4%	0.3%	-2.7%
20 – 44	1.2%	-0.5%	0.1%	0.3%	1.1%
45 – 64	-1.9%	-3.2%	-2.1%	-1.0%	-8.0%
65+	19.4%	13.6%	10.4%	8.5%	56.9%
Total	**1.6%**	**0.4%**	**1.2%**	**1.3%**	**4.5%**

Source: *Maryland Department of Planning. Population Projections by Age Cohort for Maryland Jurisdictions, 2015–2035 (Revised 2024). Table B-2B (derived from Table B-2A).*

These projections show that nearly all population growth in the region is concentrated in the 65+ cohort. The younger and middle-aged cohorts remain largely stable or decline, while the older adult population continues to expand year after year. This shift has direct implications for home health services, which rely heavily on the needs of seniors managing complex chronic illnesses, post-surgical recovery, and limitations in independent functioning.

As the senior population expands, the number of individuals requiring skilled nursing, rehabilitation, and medical social services in the home will continue to grow, intensifying the need for Medicare-certified providers capable of delivering coordinated, interdisciplinary care.

HOME HEALTH UTILIZATION BY AGE (FY 2023)

The proposed Medicare-certified Home Health Agency will focus on the primary populations most likely to benefit from skilled home health services. These include older adults managing chronic and complex conditions; individuals recovering from acute illness, injury, or surgery; and patients with functional limitations who require coordinated, interdisciplinary care in the home. These groups rely heavily on skilled nursing, rehabilitative therapies, and structured care management to remain safely in the community and avoid unnecessary institutional care.

Data from the Maryland Health Care Commission (MHCC) show that home health utilization in the service area strongly reflects the region's aging trajectory. Nearly three-quarters of all home health clients in Baltimore City, Baltimore County, and Howard County are age 65 and older, a population group

overwhelmingly covered by Medicare. This concentration of senior utilization directly aligns with statewide demographic projections and reinforces the need for expanded Medicare-certified home health capacity. As the older adult population continues to grow, demand for post-acute recovery services, chronic disease management, and home-based rehabilitative care will increase proportionally, further underscoring the importance of the proposed agency.

Table B-2C below summarizes this age distribution for the Baltimore City–Baltimore County–Howard County region.

Table B-2C

Home Health Clients by Age Cohort — Baltimore City, Baltimore County, and Howard County (FY 2023)

Age Group	Clients	Percent of Total (%)
0 – 17	512	1.6
18 – 44	1,870	5.6
45 – 64	5,230	15.7
65 – 74	8,940	26.8
75 – 84	9,412	28.3
85+	7,289	21.9
Total	**33,253**	**100%**

Source: *Maryland Health Care Commission (MHCC). Maryland Home Health Agency Annual Survey for Fiscal Year 2023 – Table 15.*

Collectively, home health agencies delivered more than 528,000 visits to residents of the tri-county region in FY 2023, demonstrating the substantial volume of home-based skilled care required to support this population.

With seniors accounting for nearly 77% of all home health users in the Baltimore City–Baltimore County–Howard County region, the utilization patterns overwhelmingly reflect the needs of an aging population. This age distribution aligns with statewide home health trends, where Medicare beneficiaries represent the dominant share of home health service utilization. Statewide data from the Maryland Home Health Agency Annual Survey show that home health agencies collectively discharged 118,432 Medicare beneficiaries in FY 2023 (including both Traditional Medicare and Medicare Advantage), representing most of all home health discharges in Maryland (MHCC HHA 2023 Utilization - Table 03). Likewise, Maryland home health agencies recorded 119,302 Medicare-covered admissions, demonstrating the central role of the Medicare program in financing home health utilization across the state.

This Medicare-driven utilization pattern is consistent with the age distribution observed in Table B-2C, where individuals aged 65 and older account for nearly four out of every five home health clients in the tri-county region. As Maryland's senior population continues to grow, the volume and acuity of patients requiring skilled home health services—including chronic disease management, wound care, medication oversight, and rehabilitative therapies—will rise proportionally. These patterns underscore the increasing dependence on Medicare-certified providers to meet the complex needs of older adults.

Given these trends, ensuring adequate Medicare-certified home health capacity in Baltimore City, Baltimore County, and Howard County is essential for maintaining access to care. Public payers dominate home health financing statewide, as reflected in MHCC Table 1 showing that nearly every home health agency in Maryland participates in both the Medicare and Medicaid programs (MHCC HHA 2023 Utilization – Table 01). Meeting this demand requires a robust, Medicare-certified home health system capable of delivering skilled nursing, rehabilitative care, and coordinated disease management in the home environment. Strengthening Medicare-certified home health resources in the region is therefore critical to supporting aging-in-place, improving chronic disease outcomes, and ensuring timely post-acute recovery services, as well as reducing unnecessary hospital utilization, and promoting aging-in-place for medically fragile individuals, consistent with state health planning goals.

QOC's proposed Medicare-certified Home Health Agency will help meet this growing demand by expanding capacity to serve older adults and medically complex patients in the home.

PAYOR DISTRIBUTION (FY 2023)

The payer mix for home health services in Maryland demonstrates the dominant role of Medicare in financing home-based skilled care. According to the Maryland Home Health Agency Annual Survey, home health agencies statewide reported 118,432 Medicare-covered discharges in Fiscal Year 2023—including both Traditional Medicare and Medicare Advantage beneficiaries—representing approximately 70% to 72% of all home health discharges statewide (MHCC HHA 2023 Utilization – Table 03). Medicaid represents the second-largest payer group, accounting for approximately 13% to 15% of statewide discharges, followed by private and commercial insurance at approximately 11% to 13%. The remaining discharges, approximately 4-5%, are covered by self-pay or other payer sources.

In addition to the dominance of Medicare as the primary payer, statewide MHCC data show that home health agencies delivered more than 5.2 million home health visits in FY 2023, with the majority furnished to Medicare beneficiaries (MHCC HHA 2023 Utilization – Table 23). This volume underscores the essential role of Medicare financing in supporting the intensity of skilled nursing, therapy, and chronic disease management services delivered in the home.

Table B-2D

Statewide Payer Mix for Home Health Discharges (FY 2023)

Payor Source	Statewide Discharges (FY 2023)	Percent of Total (%)
Medicare (Traditional + Medicare Advantage)	118,432	70-72%
Medicaid	~23,000	13-15%
Private / Commercial Insurance	~19,000	11-13%
Self-Pay / Other	~7,000	4-5%
Total	**~168,000**	**100%**

Source: *Maryland Health Care Commission (MHCC). Maryland Home Health Agency Annual Survey for Fiscal Year 2023 – (Discharges by Payer – Table 03; Agency Participation – Table 01).*

This statewide distribution reflects the care needs of an aging population, and the high proportion of medically complex adults whose post-acute and chronic disease management services are financed through Medicare. Medicaid remains a vital payer for low-income individuals, dual-eligible beneficiaries, and persons with disabilities who require skilled nursing or supportive home health services. The predominance of public payers in Maryland is further supported by MHCC Table 01, which shows that nearly every Medicare-certified home health agency in the state also participates in the Medicaid program, underscoring the importance of maintaining active certification under both programs.

Population and utilization patterns in Baltimore City, Baltimore County, and Howard County closely align with these statewide trends. The tri-county region has a large and growing senior population, the majority of whom rely on Medicare to access skilled home health care following hospitalization, during recovery from acute illness or injury, or for the ongoing management of chronic conditions. Ensuring adequate Medicare-certified home health capacity in this region is therefore essential to meeting local needs, supporting timely hospital discharge, preventing avoidable readmissions, and facilitating aging-in-place.

QOC's transition from an RSA to a Medicare-certified Home Health Agency aligns its payer participation with Maryland's demonstrated utilization patterns and ensures broad financial accessibility. By maintaining active participation in both Medicare and Medicaid, QOC will meet the needs of the predominant payer groups in the region and ensure equitable access to high-quality, coordinated home health services for older adults, low-income individuals, and medically fragile residents.

(3) SPECIFIC SERVICES TO BE PROVIDED

Quality One Care Home Health, Inc. (QOC) will provide the full array of Medicare-covered home health services required under 42 CFR §484, delivered through an interdisciplinary plan of care developed with and ordered by the patient's physician. QOC's service offerings are aligned with the clinical needs of the tri-county region's predominantly older adult population and include:

- **Skilled Nursing Services:** Comprehensive assessments, wound management, IV/infusion therapy, medication administration, chronic disease management, and patient/family education.
- **Physical Therapy:** Restorative mobility, gait training, balance improvement/strengthening, and post-operative rehabilitation.
- **Occupational Therapy:** ADL retraining, home safety assessment, functional adaption and self-care restoration.
- **Speech-Language Pathology:** Cognitive-linguistic rehabilitation/treatment, communication/speech rehabilitation and swallowing therapy.
- **Medical Social Services:** Counseling, care coordination, resource linkage, and psychosocial support for patients and caregivers.
- **Home Health Aide Services:** Personal care and assistance with activities of daily living under nursing supervision.

Upon licensure as a Home Health Agency, QOC will make all core home health disciplines—skilled nursing, physical therapy, occupational therapy, speech therapy, medical social services, and home health aide services—available to patients across all three jurisdictions: Baltimore City, Baltimore County, and Howard County.

All services offered by Quality One Care Home Health, Inc. will be coordinated under an **interdisciplinary plan of care**, reviewed regularly by the patient's physician. All care delivery will utilize QOC's **Joint Commission–accredited quality framework** and electronic medical record system to ensure compliance, continuity, and measurable outcomes.

SUMMARY OF NEED

The combined demographic, utilization, and payer data indicate a clear and sustained need for expanded Medicare-certified home health capacity in Baltimore City, Baltimore County, and Howard County. Regional demographic projections show rapid growth in the older adult population, the primary user of skilled home health services. Existing utilization patterns further demonstrate that more than three-quarters of all home health clients in the region are age 65 or older, and that Medicare is the dominant payor, covering more than 70% of statewide discharges (MHCC HHA 2023 – Table 03).

As the senior population continues to rise over the next decade, the need for skilled nursing, therapy, chronic disease management, and home-based recovery support will increase proportionally. QOC's transition from a Residential Service Agency (RSA) to a Medicare-certified Home Health Agency (HHA) will allow the organization to serve the largest payer group and the primary users of skilled home health services, while increasing access to high-quality, coordinated, patient-centered home health services consistent with COMAR 10.24.16.08(B) and the goals of the Maryland State Health Plan.

This proposal directly supports Maryland's objectives of strengthening community-based care, reducing unnecessary hospital utilization, improving chronic disease outcomes, and ensuring adequate access to high-quality home health services for a rapidly aging population.

10.24.16.08C. Financial Accessibility.

An applicant shall be or agree to become licensed and Medicare- and Medicaid-certified and agree to maintain Medicare and Medicaid certification and to accept clients whose expected primary source of payment is either or both of these programs.

APPLICANT RESPONSE – 10.24.16.08C:

Quality One Care Home Health, Inc. (QOC) is a Maryland-licensed Residential Service Agency (RSA License No. R3057) and will obtain Medicare certification for the proposed Home Health Agency serving Baltimore City, Baltimore County, and Howard County. QOC already participates in the Maryland Medicaid Program and the Model Waiver Program, routinely providing skilled and non-skilled services to Medicaid beneficiaries and dual-eligible clients.

QOC affirms its commitment to secure and maintain both Medicare and Medicaid certification, as required by state and federal regulations. The proposed Home Health Agency will accept all eligible patients regardless of their primary source of payment, including Medicare, Medicaid, and other third-party payors. These practices are consistent with QOC's established policies supporting financial accessibility, nondiscrimination, and equitable service delivery.

According to the Maryland Home Health Agency Annual Survey for FY 2023 (MHCC – Table 21), Medicare and Medicaid together represent most home health clients in the tri-county region. QOC's continued participation in both programs ensures that residents who depend on these payers will have uninterrupted access to home-based nursing, therapy, and support services.

QOC's payer policies align with the objectives of the Maryland State Health Plan, including equity, affordability, and continuity of care, and ensure that financially vulnerable and publicly insured patients have access to the full scope of home health services offered by the proposed agency.

To further support financial accessibility, QOC has transparent billing practices, assists to patients in understanding coverage options, and facilitates coordination with Medicare and Medicaid case managers when needed. These processes help ensure that cost is not a barrier to receiving timely home health services and that patients can fully utilize the benefits available to them under federal and state programs.

10.24.16.08D. Fees and Time Payment Plan.

An applicant shall make its fees known to prospective clients and their families at time of patient assessment before services are provided and shall:

(1) Describe its special time payment plans for an individual who is unable to make full payment at the time services are rendered; and

APPLICANT RESPONSE – 10.24.16.08D (1):

Quality One Care Home Health, Inc. (QOC) will make its fee schedule for home health services available to all prospective clients and their families at the time of the initial patient assessment and prior to the start of care. Each client will receive a written explanation of current service rates, billing practices, and available payment options, consistent with COMAR 10.24.16.08D and QOC's Financial Accessibility and Billing Policy (see Exhibit 2 – Time Payment Plan Policy).

QOC will also offer a Time Payment Plan for clients who are unable to make full payment at the time services are rendered. This plan allows clients to arrange installment or deferred payments within a mutually agreed-upon period, ensuring that inability to pay in full does not restrict access to medically necessary home health services. Each client will receive a written copy of the Time Payment Plan Policy, and documentation of the arrangement will be maintained in accordance with agency billing procedures and submitted to the Maryland Health Care Commission when required.

To support financial accessibility, QOC staff will also assist clients in understanding coverage options, verifying benefits with Medicare, Medicaid, and third-party insurers, and identifying available payment assistance resources when appropriate.

These practices help ensure that all clients can obtain needed home health services regardless of their ability to pay at the time care is initiated. In addition, by providing individualized support with benefit verification, coverage clarification, and identification of financial resources, QOC empowers patients and families to better understand their financial responsibilities and the assistance available to them. This approach not only reduces uncertainty and stress during the admission process but also strengthens continuity of care, minimizes delays caused by financial concerns, and promotes equitable access to the full range of skilled home health services offered by the agency. Furthermore, QOC's proactive communication and ongoing financial counseling help families plan more effectively for the duration of care,

support adherence to treatment recommendations, and reinforce the organization's commitment to transparency, patient-centered service delivery, and barrier-free access to home health services across diverse socioeconomic groups.

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

APPLICANT RESPONSE – 10.24.16.08D (2):

A. Time Payment Plan Policy

QOC maintains a Time Payment Plan Policy to accommodate clients who are unable to make full payment at the time services are rendered. This plan provides flexibility through installment and deferred payment arrangements. The policy includes the following provisions:

- Eligibility: Clients who demonstrate an inability to pay the full balance at the time of service may request a payment arrangement.
- Request Process: Billing staff will discuss available options during intake or billing review and document the agreed payment terms in the client's record.
- Payment Terms: Clients may arrange equal monthly installments not to exceed six months, or longer when approved by the Administrator.
- No Service Denial: Services will not be denied or delayed based solely on a client's inability to make immediate payment.
- Written Agreement: A copy of the signed payment agreement will be provided to the client.

A written copy of this policy will be submitted to the Maryland Health Care Commission (MHCC) and will be distributed to all clients during the admission process.

QOC's financial team also assists clients in understanding coverage options, verifying Medicare, Medicaid, and private insurance benefits, and identifying any available payment assistance resources. These supports help ensure that all clients can obtain necessary home health services regardless of their immediate ability to pay.

In addition, individualized financial counseling reduces uncertainty during admission, strengthens continuity of care, minimizes delays related to financial concerns, and promotes equitable access to skilled nursing, therapy, and support services for families across all socioeconomic backgrounds.

B. Projected Private-Pay Fee Schedule

The following schedule presents QOC's projected per-visit private-pay rates for the proposed Home Health Agency. These projected fees reflect an assessment of current market comparables across Maryland, including private-pay rates charged by existing home health providers in neighboring jurisdictions. Rates also integrate the MHCC Table 20 – Average Per-Visit Charges by Discipline for the Baltimore City, Baltimore County, and Howard County region, ensuring that QOC's proposed fees remain consistent with established regional pricing norms (see Exhibit 3 – Projected Private Pay Fee Schedule).

In establishing these projected rates, QOC considered staffing costs, recruitment and retention pressures in the post-acute workforce, supply and equipment expenses, travel time, and prevailing reimbursement benchmarks. The resulting fee schedule is transparent, predictable, and aligned with the average cost of providing skilled nursing, therapy, and clinical support services in the home. These fees also support QOC's ability to maintain qualified clinical staff, uphold Joint Commission–accredited standards of care, and sustain reliable service delivery across both urban and suburban areas within the proposed service region.

The private-pay fee schedule will be provided to all clients during admission and will accompany the agency's written billing policies. Clients will receive clear information about charges, available payment arrangements, and the option to utilize QOC's Time Payment Plan if needed. This approach promotes financial clarity, reduces barriers to care, and supports equitable access to home-based services for privately paying clients as well as those covered by public and commercial insurance.

Table D

Projected Private-Pay Fees

Service Type (Per Visit)	Projected Fee
Skilled Nursing	$225
Physical Therapy	$200
Occupational Therapy	$200
Speech Therapy	$200
Medical Social Work	$375
Home Health Aide	$175

Source: MHHC – Maryland Home Health Agency Annual Survey for Fiscal Year 2023
Table 20: Average Per-Visit Charges by Discipline, Baltimore City, Baltimore County & Howard County Region.

QOC's written fee disclosure, combined with its Time Payment Plan Policy, ensures that all clients receive clear information about service rates and payment arrangements before care begins. These practices satisfy the requirements of COMAR 10.24.16.08D and promote financial transparency and accessibility for all payor types, including Medicare, Medicaid, private insurance, and self/private-pay clients.

10.24.16.08 E. Charity Care and Sliding Fee Scale.

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

(1) Determination of Eligibility for Charity Care and Reduced Fees. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.

APPLICANT RESPONSE - 10.24.16.08 E (1):

Quality One Care Home Health, Inc. (QOC) is committed to ensuring equitable access to home health services for indigent, uninsured, and low-income individuals throughout Baltimore City, Baltimore County, and Howard County. In accordance with COMAR 10.24.16.08E and Maryland Health Care Commission (MHCC) standards, QOC will provide medically necessary home health services on a charitable basis regardless of a client's ability to pay. QOC also commits to offer an interest-free Time Payment Plan, consistent with its published policy, to eligible patients in all three jurisdictions—Baltimore City, Baltimore County, and Howard County—in accordance with COMAR 10.24.16.08E

QOC has established a non-discriminatory, timely, and transparent process to determine probable eligibility for charity care, Medical Assistance, and reduced fees. This process is designed to eliminate financial barriers at the earliest point in the care continuum and ensures that a client's financial situation never delays the initiation of medically necessary home health services. Screening begins immediately upon identification of financial need – whether at referral, intake, or during the patient assessment – and is conducted by trained staff using standardized tools and income-verification guidelines consistent with Maryland Medical Assistance criteria and QOC's approved sliding fee scale.

As part of this process, staff provide hands-on assistance to clients in gathering necessary documents, explain available programs in clear and accessible language, and outline the range of support options that may be available. Clients are supported throughout the review process to ensure they understand what services remain accessible while eligibility is being finalized. This approach ensures fairness, consistency, and timely access to care for indigent, uninsured, and low-income residents who may otherwise face barriers to receiving home-based services.

All procedures are fully aligned with Exhibit 4 – Charity Care and Sliding Fee Scale Policy, which details the eligibility criteria, documentation requirements, staff responsibilities, and reduced-fee framework governing QOC's financial assistance process. These measures demonstrate QOC's firm commitment to removing administrative and financial obstacles to care and ensuring compliance with COMAR 10.24.16.08E. Through these practices, QOC upholds the principles of equity, financial accessibility, and patient-centered care for vulnerable populations across the service region.

(1) Determination of Eligibility for Charity Care and Reduced Fees

QOC has established a non-discriminatory, timely, and transparent process to determine probable eligibility for charity care, Medical Assistance, and reduced fees. This process is designed to eliminate financial barriers at the earliest stage of care and ensure that a client's financial situation does not delay access to medically necessary services.

Key Components of QOC's Eligibility Determination Process

- **Expedited Screening:** At the time of a client's request for charity care or their application for Medical Assistance—or when such a need is identified during intake—QOC's intake or billing staff immediately conduct a preliminary financial screening. This review includes household income, insurance status, and any available documentation related to ability to pay.
- **Two-Business-Day Determination:** In accordance with COMAR 10.24.16.08E(1), QOC guarantees that a probable eligibility determination for Medical Assistance, charity care, and/or reduced fees will be made within two (2) business days of the client's initial request or application. This preliminary determination is documented in the client's record.
- **Prompt Written Communication:** The probable eligibility determination is communicated to the client, or to their legally authorized representative, in writing, using clear, understandable language. This ensures transparency and enables the client to proceed with recommended care without delay or financial uncertainty.
- **Final Review:** Once all required documentation is received, a final eligibility determination is completed within ten (10) business days. QOC utilizes a single, consolidated application process to minimize administrative burden on clients and to streamline review.

Ongoing Communication and Access to Payment Options

To ensure transparency, continuity, and timely access to financial support, QOC maintains an ongoing communication process that begins at intake and continues throughout the duration of care. As part of this process, clients are counseled on available financial assistance options, documentation requirements, and program benefits, enabling them to make informed decisions about their care. This communication is guided by the procedures outlined in Exhibit 4 – Charity Care and Sliding Fee Scale Policy and ensures that clients are consistently updated as their eligibility status progresses from preliminary review to final determination. Through this proactive approach, QOC minimizes delays, prevents misunderstandings, and supports equitable access to home health services for individuals with limited financial resources.

QOC's Financial Counselor (or designee) ensures that every client is informed of:

- Eligibility status and any required documentation
- Availability of charity care, reduced fees, or Medical Assistance
- Remaining payment responsibility, if any
- Access to additional financial support mechanisms, including QOC's Time Payment Plan (see Exhibit 2 – Time Payment Plan Policy)

All communications include written explanations of the sliding fee scale, appeal rights, and the process for reassessment if financial circumstances change.

QOC's approach ensures that no client is denied or delayed care solely due to inability to pay, and that financial assistance decisions are applied consistently and in accordance with MHCC regulations. Through its written Charity Care and Sliding Fee Scale Policy, expedited eligibility procedures, clear communication standards, and integration with the Time Payment Plan, QOC fully satisfies the requirements of COMAR 10.24.16.08E(1). These processes ensure timely access to home health services for indigent, uninsured, and low-income residents, and uphold QOC's commitment to financial accessibility and equitable service delivery. QOC's policy is available in both English and Spanish, with interpreter services available upon request.

(2) Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area population. Notices regarding the HHA's charity care and sliding fee scale policies shall be posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients' or clients' families concerns with payment for HHA services and provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.

APPLICANT RESPONSE - 10.24.16.08 E (2):

(2) Notice of Charity Care and Sliding Fee Scale Policies

Quality One Care Home Health, Inc. (QOC) recognizes that clear and widely accessible notice is essential to ensuring equitable access to home health services. In accordance with COMAR 10.24.16.08E(2), QOC will provide both public and individual notice of its Charity Care and Sliding Fee Scale Policy using methods designed to effectively reach the diverse populations of Baltimore City, Baltimore County, and Howard County.

QOC will provide notice through the following mechanisms:

a. Public Posting (Onsite Notice):

Notices outlining eligibility criteria, application procedures, and available financial assistance will be posted prominently in QOC's administrative office and client-facing areas. Posting materials will use clear, plain language and will include instructions for obtaining the full Charity Care and Sliding Fee Scale Policy (see Exhibit 4).

b. Annual Public Dissemination (Community Outreach & Website Posting):

Each year, QOC will broadly disseminate its Charity Care and Sliding Fee Scale Policy using methods designed to reach indigent, uninsured, and low-income residents across the service area.

Dissemination efforts will include:

- Posting the full policy and downloadable materials on QOC's website in an easy-to-read format optimized for mobile devices.

- Sharing information through community partners such as federally qualified health centers, senior centers, faith-based organizations, social service agencies, and hospital discharge planners.
- Distribution of printed materials at community events, senior resource fairs, and partner organizations serving vulnerable populations.

These methods reflect communication channels most frequently used by residents of the service area and ensure that information remains accessible to individuals in both urban and suburban areas.

c. Individual Notice at Admission

Prior to the provision of services, each client—and/or their legally authorized representative—will receive individualized written notice explaining:

- QOC's Charity Care and Sliding Fee Scale Policy
- Eligibility requirements
- Required documentation
- Application instructions
- Available payment support programs, including QOC's Time Payment Plan (see Exhibit 2)

Staff will review the policy verbally during the admission process to ensure client understanding. A copy of the full policy will always be offered and is included in Exhibit 4 – Charity Care and Sliding Fee Scale Policy.

Staff Training and Client Support

All intake, billing, and administrative staff will receive ongoing training to ensure they can accurately explain charity care options, reduced-fee tiers, and Medical Assistance pathways. Staff will proactively assist clients who express financial concerns, ensuring these concerns never delay access to medically necessary services.

Interpreter services, translated notices, and accessible formats (large print, digital PDF) will be available upon request to ensure meaningful access for clients with limited English proficiency or communication barriers.

Continuous Evaluation and Community Coordination

QOC will periodically evaluate its outreach and notice practices by monitoring community inquiries, charity care application volume, referral partner feedback, and patterns in financial assistance utilization. Findings will be used to refine communication strategies to better reach vulnerable populations.

QOC will also collaborate with hospitals, skilled nursing facilities, care coordinators, and community health partners so that financially vulnerable patients are informed of available assistance before transitioning home. Printed materials summarizing financial assistance programs will be made available to referral partners and on QOC's website.

Through public posting, annual dissemination, individualized admission notice, and trained staff support, QOC fully satisfies the requirements of COMAR 10.24.16.08E(2). These practices ensure that charity care and sliding fee scale information is consistently communicated, easily accessible, and widely available throughout the service area. The full Charity Care and Sliding Fee Scale Policy, including the complete sliding-fee structure and application materials, is provided in Exhibit 4. These measures collectively reinforce QOC's commitment to financial transparency and equitable access to home health services.

Table E-1

Summary of Notice Requirements and QOC Compliance Methods

COMAR Requirement (10.24.16.08E(2))	QOC Compliance Method
Public notice posted in business office	Posted in administrative and client-facing areas
Annual dissemination to the community	Website posting + outreach to community partners
Individual notice before services begin	Written and verbal notice during admission
Format understandable by service population	Plain-language materials + translated notices
Online posting if website is maintained	Full policy posted on QOC's website
Policy availability upon request	Full policy included in Exhibit 4

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care but are unable to bear the full cost of services.

APPLICANT RESPONSE - 10.24.16.08 E (3):

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy

Quality One Care Home Health, Inc. (QOC) provides discounted care to low-income clients who do not qualify for full charity care but are unable to pay the full cost of medically necessary home health services. This ensures that financial hardship does not impede access to care and that QOC remains fully compliant with COMAR 10.24.16.08E(3).

QOC maintains a documented Sliding Fee Scale, included in Exhibit 4 – Charity Care and Sliding Fee Scale Policy, which outlines reduced charges based on verified household income and family size. Discount levels are tied to the Federal Poverty Level (FPL) to ensure a fair, predictable, and proportional discount structure for clients whose income exceeds full charity care eligibility but remains within low-income thresholds.

- **Sliding Fee Scale:** QOC's sliding fee scale ties discount levels to a client's verified household income as a percentage of the Federal Poverty Guidelines (FPG), consistent with best practices across Maryland home health agencies. Discounted care is provided according to the income tiers defined in Exhibit 4A and offers a predictable, equitable method for adjusting charges based on demonstrated financial need.
- **Time Payment Plans:** For residual balances after discounts, QOC offers reasonable payment plans under its Time Payment Plan Policy. Payment arrangements may be extended based on documented hardship, ensuring that financial barriers do not impede timely care.
- **Demonstration of Alignment with COMAR Requirements:** In line with COMAR 10.24.16.08E, QOC has completed the required Charity Care and Sliding Fee Scale Worksheet, presented in Exhibit 4A. In addition, QOC has also completed the Health Equity and Character & Competence Worksheet (see Exhibit 4B), which further documents the agency's organizational readiness, accountability, and commitment to equitable access for indigent, low-income, and underserved residents within the proposed service area

Table E-4

Summary of COMAR 10.24.16.08E Charity Care Requirements and Corresponding Policy Sections

(Referenced in Exhibit 4 – Charity Care and Sliding Fee Scale Policy)

COMAR Requirement	Description of Requirement	Policy Section Reference (Exhibit 4)
(1) Determination of Eligibility	Determination of probable eligibility within two business days of request for charity care or medical assistance.	Section 3 – Eligibility Determination Process
(2) Notice of Charity Care and Sliding Fee Scale Policies	Public notice annually, posting in office and on website, individual notice at admission.	Section 4 – Public Notice and Communication
(3) Discounted Care and Time Payment Plan	Sliding Fee Scale and Time Payment Plan for low-income clients.	Section 5 – Discounted Services and Payment Arrangements
(4)(a) Track Record	Track record (if any) supports credibility of charity care commitment.	Section 6 – Charity Care Commitment and Reporting
(4)(b) Plan to Achieve Commitment	Specific plan to achieve charity care level consistent with regional benchmark.	Section 6 – Charity Care Commitment and Reporting

Sliding Fee Scale Eligibility and Discount Structure

QOC uses a standardized income-verification worksheet, included as part of its Charity Care and Sliding Fee Scale Policy (Exhibit 4), to ensure consistent, objective, and non-discriminatory determinations.

Discounts are structured as follows:

- 100% Charity Care – Clients with verified household income at or below 200% FPL
- 75% Discount – Clients with household income between 201–250% FPL
- 50% Discount – Clients with household income between 251–300% FPL
- 25% Discount – Clients with household income between 301–350% FPL
- Standard Charges Apply – Clients with household income above 350% FPL, unless financial hardship is documented

This tiered approach provides clear, equitable reduced-fee options for clients who may not qualify for full charity care but still need financial relief to access home health services.

Time Payment Plan for Reduced Fee Clients

For clients who qualify for discounted care under the sliding fee scale but remain unable to pay their reduced balance at the time services are rendered, QOC offers structured payment arrangements through its Time Payment Plan Policy (see Exhibit 2 – Time Payment Plan Policy).

This plan allows clients to:

- Make interest-free monthly payments, typically over a period of up to six (6) months
- Request extended repayment terms upon approval due to documented financial hardship
- Receive written payment agreements outlining the terms clearly and in plain language

No client's care is delayed or denied due to participation in the Time Payment Plan, ensuring alignment with MHCC expectations for financial accessibility.

Ensuring Consistency, Transparency, and Access

All determinations regarding discounted care, reduced fees, and payment plan eligibility are made by QOC's Financial Counselor using the standardized income-verification worksheet referenced earlier in this application. This process ensures:

- Fair and consistent application of criteria
- Transparent financial communication of all available financial options
- Timely access to discounted care options
- Reduced administrative burden for low-income clients

Clients receive written notice of their discount level, payment responsibilities, and the availability of the Time Payment Plan as part of the admission and financial counseling process.

QOC's structured Sliding Fee Scale, tiered discount framework, and flexible Time Payment Plan collectively ensure that clients who do not qualify for full charity care still have access to affordable home health services. These policies are supported by standardized eligibility tools, documented procedures, and written client communication.

Together, they promote equitable access to care for low-income residents of Baltimore City, Baltimore County, and Howard County, consistent with COMAR 10.24.16.08E(3) and demonstrated regional need reflected in MHCC payer distribution data.

(4) Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve during the most recent year for which data is available. The applicant shall demonstrate that:

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

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

APPLICANT RESPONSE- 10.24.16.08 E (4):

a. Track Record in the Provision of Charity Care Services

Quality One Care Home Health, Inc. (QOC), as a licensed Residential Service Agency (RSA), has historically provided skilled nursing services to a broad population of low-income individuals, many of whom rely on publicly funded programs such as Maryland Medicaid, Medicaid Waiver programs, and dual-eligible Medicare–Medicaid coverage. Through this work, QOC has maintained an operational model centered on serving economically vulnerable residents, coordinating benefits with state programs, and ensuring that clients with limited financial means can access in-home services without disruption. Although RSAs are not required to report charity-care metrics to the Maryland Health Care Commission, QOC's multi-year record of delivering care to high-need, publicly insured, and fixed-income clients demonstrates its effectiveness in managing financial-access challenges and supporting clients who frequently have trouble paying for care. This experience provides a credible foundation for QOC's transition to a Medicare-certified Home Health Agency and reinforces its ability to responsibly implement, monitor, and sustain the charity-care commitments required under COMAR 10.24.16.08E.

MHCC regional data indicate that charity care is extremely limited among HHAs in the state of Maryland. Using MHCC Table 25, (Charity Care Clients and Charity Care Visits, FY 2023), charity-care provision in Maryland's home health industry is very low statewide and nearly nonexistent in the Baltimore Metropolitan Area:

- **Baltimore City:** Only one agency (HomeCare Maryland, LLC) reported any charity-care activity: 6 clients / 27 visits.
- **Baltimore County:** Only two agencies reported any charity-care: 20 clients / 115 visits combined.
- **Howard County:** Charity-care activity totaled 1 client / 4 visits.
- **Maryland Total:** 190 clients / 1,079 visits statewide, across all HHAs.

These data demonstrate that the regional average for charity-care provision is extremely low, with most HHAs reporting zero charity-care clients and zero charity-care visits in FY 2023. Accordingly, QOC's commitment to establishing and implementing a structured charity-care framework exceeds what most existing agencies in the Baltimore Metro region currently deliver.

b. Plan to Achieve the Committed Level of Charity Care

Although the regional average is low, QOC will meet or exceed the available benchmark by implementing and maintaining a robust, documented charity-care program outlined in Exhibit 4 – Charity Care and Sliding Fee Scale Policy.

To ensure compliance with COMAR 10.24.16.08E(4), QOC has developed a multi-faceted strategy to achieve and maintain its charity-care commitment, consistent with the regional benchmark reflected in MHCC Table 25 for the Baltimore Metropolitan Area.

- **Financial Support:** QOC's annual budget includes a dedicated, non-discretionary fund to ensure that sufficient resources are available to support uninsured and indigent clients. This funding allocation is adjusted annually to ensure alignment with the regional charity-care average reported by MHCC.
- **Targeted Community Outreach:** QOC will collaborate with hospital discharge planners, physicians, federally qualified health centers, senior-service organizations, and community groups serving high-need ZIP codes in Baltimore City, Baltimore County, and Howard County. These partnerships will help identify eligible patients early and promote awareness of QOC's Charity Care and Sliding Fee Scale Policy.
- **Staff Accountability:** All intake and clinical personnel will receive training on the agency's Charity Care and Financial Assistance Policy. Staff performance evaluations will include a metric for compliance with screening, notification, and documentation requirements to ensure consistent application of charity-care criteria.
- **Management Review:** QOC will implement a quarterly review process to monitor charity-care utilization, compare results to the agency's committed level and the regional benchmark, and initiate corrective actions or supplemental outreach as needed to maintain compliance.

Quality One Care Home Health, Inc. (QOC) is committed to ensuring that individuals with limited financial means can obtain medically necessary home health services, by enforcing the following:

1. Adopt a Minimum Charity-Care Commitment Aligned to Regional Norms

Because regional charity-care levels are low, QOC commits to establishing a measurable baseline that ensures actual delivery of charity-care services, rather than contributing to the current "zero-activity" pattern. QOC will:

- Maintain capacity to provide charity-care services to eligible clients within Baltimore City, Baltimore County, and Howard County.
- Report fully and accurately to MHCC each year to contribute to more complete and transparent statewide data.
- Target annual charity-care volumes at or above the minimal levels observed among active providers in the region (e.g., at least several clients annually, consistent with Table 25's highest reporting agencies in the service area).

This commitment ensures consistency with the intent—not just the letter—of COMAR 10.24.16.08E(4).

2. Implement Structured Eligibility & Discount Systems

QOC's charity-care levels will be achieved through:

- A verified charity-care eligibility review within 2 business days (per COMAR).
- A sliding fee scale offering 25–100% discounts for low-income households.
- Integration of full charity-care, discounted care, and the Time Payment Plan for clients with documented financial hardship.

These mechanisms ensure that eligible clients can access care without financial barriers.

3. Proactive Outreach to Ensure Eligible Clients Are Identified

QOC will ensure that the charity-care program is fully utilized by:

- Providing public notice annually and continuously (office postings, website, and community partners).
- Training intake and billing staff to screen for potential eligibility.
- Coordinating with area hospitals, SNFs, social service agencies, and discharge planners who routinely encounter uninsured or underinsured patients.

This proactive outreach ensures that QOC's charity-care commitment translates into actual service delivery.

4. Ongoing Monitoring and Reporting

To ensure compliance and accountability, QOC will:

- Track charity-care requests, eligibility determinations, and services approved/denied.
- Include charity-care reporting in annual MHCC submissions.
- Review policy effectiveness annually and adjust thresholds or practices as needed to remain aligned with the region's needs.

10.24.16.08 F. Financial Feasibility.
An applicant shall submit financial projections for its proposed project that must be accompanied by a statement containing the assumptions used to develop projections for its operating revenues and costs. Each applicant must document that:

(1) Utilization projections are consistent with observed historic trends of HHAs in each jurisdiction for which the applicant seeks authority to provide home health agency services;

APPLICANT RESPONSE- 10.24.16.08 F (1):

Quality One Care Home Health, Inc. (QOC) developed its utilization projections using the most recent Maryland Home Health Agency Annual Survey data published by the Maryland Health Care Commission (MHCC), which report historic home health utilization patterns for Baltimore City, Baltimore County, and Howard County. These data demonstrate a large, stable, and growing demand for Medicare-certified home health services in the tri-county region, driven primarily by an expanding older-adult population and consistently high use of skilled home health services following hospitalization or outpatient surgery.

Table F-1

Summary Table 25 of FY 2023 Home Health Utilization

(Baltimore City, Baltimore County, Howard County)

Jurisdiction	Total Home Health Visits (FY 2023)
Baltimore City	284,010
Baltimore County	206,770
Howard County	37,499
Tri-County Total	528,279

Source: MHCC – Home Health Agency Annual Survey, Table 25 (FY 2023)

Historic Utilization Levels Support a Strong and Sustainable Demand

MHCC Table 25 (FY 2023) shows that:

- Baltimore City home health agencies delivered 284,010 visits
- Baltimore County agencies delivered 206,770 visits
- Howard County agencies delivered 37,499 visits

Together, the tri-county region accounts for over 528,000 home health visits annually, reflecting one of the highest concentrations of home health utilization, and a large, stable service demand in Maryland. This substantial service volume establishes a strong empirical foundation for projecting future utilization within the region.

Historic Payer Mix Supports Continued High Demand Among Medicare Beneficiaries

MHCC Table 20 (FY 2023) shows that in the Baltimore Metropolitan Area:

- Medicare (Traditional + Advantage) represents over 70% of home health volume across most jurisdictions
- Medicaid and commercial payers account for the remaining share, with Medicare consistently serving as the dominant payer

This payer mix is highly relevant because QOC's proposed Medicare-certified HHA will serve the primary demographic group (older adults) driving the majority of home health utilization statewide and within the service area.

Age-Driven Demand Growth Aligns with MHCC Findings

MHCC Table 15 demonstrates that nearly 75% of all home health clients in the Baltimore City–Baltimore County–Howard County region is age 65 and older, a population segment expected to grow substantially over the next decade. Demand for skilled nursing, physical therapy, wound care, chronic disease management, and rehabilitative home health services is therefore expected to increase proportionally.

QOC Utilization Projections Align with Observed Trends

QOC's utilization projections are intentionally conservative and reflect:

- Documented FY 2023 utilization levels in each jurisdiction (Tables 20 & 25)
- Stable multi-year demand trends for skilled home health services
- Population aging projections within the tri-county region
- Currently, existing HHAs already sustain high visit volumes, indicating that the service area can accommodate additional Medicare-certified capacity without market distortion

The first-year visit estimate for QOC represents well under 1% of total regional utilization, demonstrating that projected service volume is realistic, feasible, and fully consistent with historic MHCC-reported trends.

The combined findings from MHCC Tables 15, 20, and 25 confirm that home health utilization in Baltimore City, Baltimore County, and Howard County is both high and stable, with growth driven by older adults who rely heavily on Medicare-certified home health services. QOC's utilization projections align with these historic patterns and reflect a conservative, evidence-based estimate of expected service volume for a new Medicare-certified Home Health Agency operating within the tri-county region.

Assumptions Statement

The financial projections for Quality One Care Home Health, Inc. (QOC) are based on a series of assumptions grounded in recent Maryland Health Care Commission (MHCC) utilization data and established regional trends. Demand for home health services in the proposed service area is substantial and stable. According to MHCC Table 25, Baltimore City, Baltimore County, and Howard County collectively generated 528,279 home health visits in Fiscal Year 2023. QOC's projected visit volume represents less than one percent of this total in its first year of operation and is expected to increase modestly over time. This assumption reflects the region's high utilization patterns as well as the significant proportion of older adults—approximately three-quarters of all home health clients—who typically require recurring skilled nursing, therapy, and chronic disease management services.

The financial projections rely on a payer-mix distribution that mirrors historic patterns in the Baltimore Metropolitan Area. MHCC data confirm that Medicare beneficiaries account for the largest share of home health utilization in the region, typically exceeding 70 percent of all clients. Consistent with this pattern, QOC's model assumes a Medicare-dominant payer mix, with Medicaid, commercial insurance, and private-pay clients comprising smaller but steady portions of total revenue. These payer assumptions directly reflect MHCC Table 20 and align with existing reimbursement trends for home-based skilled services.

Projected referral volume is based on established referral pathways used by home health agencies statewide. QOC anticipates receiving referrals from hospital discharge planners, skilled nursing facilities, primary care physicians, specialists, and community-based partners. These referral streams are consistent with typical patterns observed among Medicare-certified home health agencies and are not expected to divert or materially impact existing providers. Rather, the projections assume proportional distribution of referrals across all regional HHAs.

Staffing assumptions are based on standard productivity benchmarks widely used in the home health industry. Full-time skilled nurses are expected to complete approximately four to five visits per day, while therapy staff typically complete five to six visits per day, depending on acuity and travel requirements. Home health aide assignments are projected in accordance with patient plans of care. Staffing levels were sized to support projected visit volumes while maintaining compliance with Medicare Conditions of Participation and ensuring continuity of care.

Operating costs were developed using prevailing compensation benchmarks for clinical and administrative personnel in the Baltimore region, combined with conservative estimates for supplies, travel, technology, and regulatory compliance. These cost assumptions reflect the experience of comparable

HHAs and ensure that projected expenditures align with recognized industry norms. Revenue assumptions incorporate the current Medicare Home Health Prospective Payment System (HH PPS), including case-mix weights and regional wage index adjustments, as well as standard Medicaid and commercial reimbursement rates applicable within the service area.

Projected growth over the initial years of operation is modest and grounded in demographic trends, the increasing need for home-based chronic disease management, and the strong utilization levels reported in MHCC Table 25. These projections do not assume displacement of existing providers; instead, they reflect incremental growth consistent with regional demand and the capacity of existing HHAs. The financial model therefore anticipates sustainable long-term operations supported by stable demand, efficient staffing, balanced case mix, and careful cost management.

Together, these assumptions provide a realistic and evidence-based foundation for QOC's financial projections and demonstrate that the proposed Medicare-certified Home Health Agency is feasible, responsive to regional need, and aligned with historic utilization patterns observed in the service area.

(2) Projected revenue estimates are consistent with current or anticipated charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction; and

APPLICANT RESPONSE- 10.24.16.08 F (2):

Quality One Care Home Health, Inc. (QOC) developed its projected revenues using charge levels, reimbursement rates, contractual adjustments, and charity care assumptions that reflect current Maryland market conditions and the recent experience of Medicare-certified home health agencies serving Baltimore City, Baltimore County, and Howard County. Because QOC is a newly proposed HHA, its revenue assumptions draw directly from publicly reported MHCC data, CMS Home Health Prospective Payment System (HH PPS) reimbursement rules, and prevailing Medicaid and commercial insurer payment standards in Maryland.

Medicare represents the dominant payer for home health services in the Baltimore Metropolitan Area, typically accounting for more than two-thirds of all visits, and reimbursement assumptions in QOC's projections are based on the national Home Health Prospective Payment System (HH PPS) payment structure, including case-mix weights, Low Utilization Payment Adjustment (LUPA) thresholds, and the Baltimore Core-Based Statistical Areas (CBSA) wage index. These assumptions ensure that Medicare revenue estimates reflect the amount consistently realized by comparable HHAs in the region.

Medicaid reimbursement assumptions incorporate Maryland Medicaid fee-for-service rates and align with payment patterns reported by existing agencies participating in the program. Similarly, commercial insurance revenue estimates are based on average contracted rates reported by Maryland HHAs, including adjustments for service authorization patterns and standard contractual reductions.

Table F-2

Maryland Statewide Average Per-Visit Reimbursement Rates (FY 2023)

Service Type	Statewide avg. Reimbursement per visit (FY 2023)
Skilled Nursing	$126.48
Physical Therapy	$136.92
Occupational Therapy	$141.72
Speech therapy	$154.61
Medical Social Work	$175.42
Home Health Aide	$58.31

Source: MHCC – Home Health Agency Annual Survey, Table 20 (FY 2023)

QOC's projections also include reasonable allowances for contractual adjustments, bad debt, and charity care consistent with statewide norms. Maryland HHAs commonly allocate a portion of gross revenue to contractual reductions due to Medicare sequestration, negotiated payer discounts, and denials, and QOC applied these standard adjustment percentages to ensure financial projections accurately reflect actual realizable revenue. Charity care and sliding-fee-scale discounts are incorporated based on QOC's financial assistance policy, with levels modeled in alignment with charity care levels reported for HHAs serving the Baltimore region.

Collectively, these assumptions ensure that QOC's projected revenue estimates are consistent with the reimbursement experience of established HHAs operating in the proposed jurisdictions and reflect a realistic, evidence-based, and financially feasible revenue model for a new Medicare-certified home health agency.

(3) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction.

APPLICANT RESPONSE- 10.24.16.08 F (3):

Staffing and overall expense projections are consistent with the utilization projections presented in this application and are based on current expenditure levels and reasonably anticipated future staffing levels for a newly established Medicare-certified Home Health Agency. QOC developed its staffing model using industry-standard productivity benchmarks for home health nursing and therapy services and aligned staffing ratios with the recent experience of Maryland HHAs serving Baltimore City, Baltimore County, and Howard County.

Projected staffing levels incorporate assumptions regarding visit volume growth, mix of services, and the proportion of full-time, part-time, and PRN clinicians required to support projected utilization. Expense projections reflect current market wage and benefit levels for the Baltimore metropolitan region, consistent with statewide labor cost patterns reported in the MHCC Home Health Agency Annual Survey.

The full staffing and expense assumptions supporting these projections are included in Exhibit 5 (Part IV Financial Tables and Statement of Assumptions).

10.24.16.08G. Impact.

An applicant shall address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs' caseloads, staffing and payor mix.

APPLICANT RESPONSE- 10.24.16.08G:

Quality One Care Home Health, Inc. (QOC) has analyzed the anticipated impact of its proposed Medicare-certified Home Health Agency on existing HHAs serving Baltimore City, Baltimore County, and Howard County. Using the most recent Maryland Health Care Commission (MHCC) utilization data, QOC concludes that its projected entry into the tri-county region will not adversely affect existing agencies' caseloads, staffing, or payor mix. Instead, QOC will enhance patient choice, expand service capacity, and support the State Health Plan's goals for accessible, high-quality home health care.

Market Size and Existing Agency Capacity

The Baltimore tri-county region represents one of Maryland's largest home health markets. According to MHCC's FY 2023 Home Health Agency Annual Survey, the region served more than 27,600 unduplicated clients, demonstrating a large, diverse, and stable service environment.

Table G-1

Unduplicated Home Health Clients by Jurisdiction (FY 2023)

Jurisdiction	Total Unduplicated HHA Clients
Baltimore City	12,511
Baltimore County	12,111
Howard County	3,006
Tri-County Total	27,628

Source: MHCC – Home Health Agency Annual Survey, Table 13 (FY 2023)

With over 27,000 clients annually, the region supports numerous large, well-established HHAs—including Johns Hopkins Home Care, MedStar VNA, Bayada, Aveanna, Amedisys, and others—several of which operate across multiple counties. This broad provider base means that no single HHA dominates the market, aligning with the State Health Plan principle that each jurisdiction should have at least three strong HHAs to support consumer choice.

QOC's planned Year-2 census of 150–175 clients represents:

- <0.6% of the regional caseload
- A volume far below that of large multi-county HHAs
- No meaningful diversion from existing providers

Thus, QOC's entry will not materially affect any established HHA's client volume.

Payor Mix Impact

MHCC data show that the region's home health population is overwhelmingly Medicare-driven, with Medicaid representing a smaller but meaningful proportion—especially in Baltimore City. These payor dynamics influence agency revenue models and patient distribution patterns.

Table G-2

Payor Mix Characteristics of Home Health Clients (FY 2023)

Payor Source	Baltimore City	Baltimore County	Howard County	Regional Pattern
Medicare (Traditional + Advantage)	~68%	~72%	~70%	Medicare is dominant regionwide
Medicaid	~18%	~11%	~9%	Highest concentration in Baltimore City
Commercial Insurance	~12%	~15%	~18%	Higher private insurance in Howard County
Self-Pay / Other	~2%	~2%	~3%	Consistently minimal

Source: MHCC – Home Health Agency Annual Survey, Table 13 (FY 2023)

QOC expects a payor mix that mirrors the region, predominantly Medicare, with Medicaid and commercial payors represented based on referral patterns and need. Due to QOC's small projected scale, its entry will not alter the regional payor distribution or affect neighboring agencies' payer profiles.

Existing Provider Footprint and QOC's Comparative Scale

Furthermore, MHCC Table 15 shows that numerous HHAs serve multiple jurisdictions in the Baltimore region. These agencies collectively serve tens of thousands of clients annually.
QOC's planned capacity is small relative to existing operators, ensuring:

- No destabilization of existing caseloads
- No competitive displacement of major providers
- Increased consumer choice consistent with state policy objectives

Table G-3

Major HHAs Serving the Tri-County Region (FY 2023)

Agency	Jurisdictions Served	Relative Market Presence
Johns Hopkins Home Care	Baltimore City, Baltimore County, Howard County	High-volume multi-county
MedStar VNA	Baltimore City, Baltimore County, Howard County	High-volume multi-county
Bayada Home Health	Baltimore County, Howard County	High-volume
Aveanna Healthcare	Baltimore City, Baltimore County	Mid–high volume
Amedisys	Baltimore City, Baltimore County	Mid volume
Other Local HHAs (>25 agencies)	All jurisdictions	Combination of local and regional providers

Staffing Impact

The Baltimore region's home health labor market is broad and robust. MHCC Table 15 indicates that many HHAs successfully staff multi-county operations, demonstrating adequate workforce availability.

QOC's staffing plan uses:

- A small core clinical team (fewer than 10 FTEs in Year 1)
- Supplemental PRN and contracted clinicians
- Recruitment focused on Baltimore City, Baltimore County, and Howard County residents
- Avoidance of direct recruitment from acute-care hospitals or large HHAs

Given the large number of practicing RNs, LPNs, therapists, and aides in the Baltimore metropolitan region, QOC's hiring needs represent a negligible fraction of the available workforce.

QOC's entry will not impair any HHA's staffing stability.

Compliance with the State Health Plan

The State Health Plan prioritizes:

- A competitive environment with multiple strong HHAs
- Absence of provider dominance
- Consumer access and choice
- Adequate distribution of services across jurisdictions

QOC's modest scale and targeted operational focus directly support these goals. Its addition to the market enhances:

- Patient choice in underserved ZIP codes
- Access to home health services for Medicare, Medicaid, and uninsured individuals
- Continuity of care for patients transitioning from hospitals, clinics, or community programs

Based on FY 2023 MHCC data and QOC's conservative utilization, staffing, and payor projections, the proposed HHA will not adversely impact existing HHAs serving Baltimore City, Baltimore County, or Howard County. The regional home health market is large, well-established, and capable of absorbing a small new entrant without strain.

QOC's project will:

- Improve patient access
- Strengthen consumer choice
- Support vulnerable and underserved populations
- Align with the Maryland State Health Plan
- Maintain stability for all existing HHAs with respect to caseloads, staffing, and payer mix.

In consistency with the requirements of COMAR 10.24.16.08G, QOC's strongly acknowledges that its entry in the market expands system capacity without creating market disruption.

10.24.16.08H. Financial Solvency.

An applicant shall document the availability of financial resources necessary to sustain the project. Documentation shall demonstrate an applicant's ability to comply with the capital reserve and other solvency requirements specified by CMS for a Medicare-certified home health agency.

APPLICANT RESPONSE- 10.24.16.08H:

Quality One Care Home Health, Inc. (QOC) has the financial resources necessary to establish and sustain the proposed Medicare-certified Home Health Agency. As documented in Exhibit 6 – Financial Capacity Documentation, QOC maintains sufficient liquid reserves to cover start-up costs, staffing, operating expenses, and all pre-certification activities.

QOC's financial statements and bank documentation demonstrate the ability to maintain the capital reserves required by the Centers for Medicare & Medicaid Services (CMS), including the capacity to support payroll, administrative overhead, and operational costs during the initial certification period before Medicare billing privileges are activated. QOC has no outstanding liabilities or financial encumbrances that would impair ongoing operations.

The organization's conservative financial projections—which account for expected caseload growth, standard reimbursement timelines, and routine contractual adjustments—show that QOC can sustain continuous operations throughout Years 1–3. QOC's established financial management structure, supported by its history as a licensed Residential Service Agency, further affirms its ability to meet CMS solvency expectations and maintain financial stability.

Accordingly, QOC has demonstrated the financial readiness required under COMAR 10.24.16.08H, ensuring the long-term viability of the proposed Home Health Agency.

10.24.16.08I. Linkages with Other Service Providers.

An applicant shall document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services, and home delivered meal programs located within its proposed service area.

(1) A new home health agency shall provide this documentation when it requests first use approval.

APPLICANT RESPONSE- 10.24.16.08I(1):

Quality One Care Home Health, Inc. (QOC) acknowledges the requirement to establish linkages with hospitals, skilled nursing facilities, assisted living communities, hospice providers, Adult Evaluation and Review Services (AERS), adult day programs, local Departments of Social Services, and home-delivered meal programs within its proposed service area.

As a new home health agency, QOC will complete these linkages and provide full documentation when it requests first-use approval, in accordance with COMAR 10.24.16.08I(1). Prior to licensure activation, QOC will formalize referral and coordination pathways with providers serving Baltimore City, Baltimore County, and Howard County to ensure continuity of care for high-need patients.

QOC's existing operations as a Residential Service Agency (RSA) have already allowed the organization to work collaboratively with hospitals, primary care practices, community case managers, and long-term services and supports providers. These established professional relationships form a strong foundation for developing the required HHA-specific linkages once authorization is granted.

QOC will supply complete documentation of these formalized partnerships at the time of the first-use request, demonstrating readiness to integrate seamlessly into the region's post-acute and community-based care network.

(2) A Maryland home health agency already licensed, and operating shall provide documentation of these linkages in its existing service area and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve.

APPLICANT RESPONSE- 10.24.16.08I(2):

This provision is not applicable to Quality One Care Home Health, Inc. (QOC) because QOC is not yet a licensed or operating home health agency in Maryland. As a new HHA applicant, QOC is subject to the requirements outlined in COMAR 10.24.16.08I(1) and will provide full documentation of its formal linkages with hospitals, nursing homes, assisted living providers, AERS programs, local Departments of Social Services, and other community-based organizations at the time it requests first-use approval.

10.24.16.08J. Discharge Planning.

An applicant shall document that it has a formal discharge planning process including the ability to provide appropriate referrals to maintain continuity of care. It will identify all the valid reasons upon which it may discharge clients or transfer clients to another health care facility or program.

APPLICANT RESPONSE- 10.24.16.08J:

Quality One Care Home Health, Inc. (QOC) has established a formal, structured discharge planning process designed to ensure safe, appropriate, and well-coordinated transitions of care for all clients. QOC's Discharge Planning Policy (see Exhibit 6 – Discharge Planning and Continuity of Care Policy) outlines the

procedures staff must follow from admission through discharge to maintain continuity of care and prevent service gaps.

QOC's discharge planning process includes:

(1) Interdisciplinary Discharge Assessment:
A licensed nurse or therapist evaluates the client's clinical status, functional needs, home environment, and ongoing care requirements to determine readiness for discharge.

(2) Advance Discharge Planning:
Discharge planning begins at admission and is updated throughout the episode of care based on changes in condition, treatment goals, or caregiver capacity.

(3) Referral and Transition Coordination:
When continuing care is needed, QOC arranges appropriate referrals to community services, outpatient rehabilitation, primary care providers, specialty providers, social service programs, durable medical equipment suppliers, or other home- and community-based programs.

(4) Communication with Physicians and Caregivers:
QOC ensures timely communication with the ordering physician and, when appropriate, family/caregivers to ensure that all parties understand the care plan, medication needs, and recommended follow-up services.

(5) Valid Reasons for Discharge or Transfer:
QOC's policy identifies all acceptable reasons for discharge or transfer, including:

- Treatment goals met or maximum benefit achieved
- Client elects to discontinue services
- Physician orders discharge or transfer
- Client moves out of the service area
- Client requires a higher level of care
- Client safety concerns (e.g., unsafe environment)
- Non-compliance that prevents safe provision of care
- Payment-related discontinuation consistent with federal/state rules

(6) Documentation Requirements:

All discharge decisions, referrals, education provided, and follow-up arrangements are documented in the clinical record to ensure continuity and regulatory compliance.

Through these procedures, QOC ensures that each client experiences a safe, coordinated transition at the end of service, consistent with COMAR 10.24.16.08J and Medicare Conditions of Participation for home health agencies.

10.24.16.08K. Data Collection and Submission.

An applicant shall demonstrate ongoing compliance or ability to comply with all applicable federal and State data collection and reporting requirements including, but not limited to, the Commission's Home Health Agency Annual Survey, CMS' Outcome and Assessment Information Set (OASIS), and CMS' Home Health Consumer Assessment of Healthcare Providers (HHCAHPS).

Quality One Care Home Health, Inc. (QOC) affirms its ability and commitment to comply with all federal and State data collection and reporting requirements applicable to Medicare-certified home health agencies. Upon licensure and Medicare certification, QOC will implement the systems, staffing, and procedures required to meet the Maryland Health Care Commission's (MHCC) and the Centers for Medicare & Medicaid Services (CMS) reporting standards.

QOC will ensure full compliance with:

- **MHCC Home Health Agency Annual Survey:**
  QOC will complete and submit all required utilization, staffing, financial, payer-mix, and quality-related data annually in accordance with MHCC instructions and timelines.
- **CMS Outcome and Assessment Information Set (OASIS):**
  QOC will use a CMS-certified electronic health record (EHR) platform to collect, validate, and transmit OASIS assessments for all Medicare and Medicaid clients, as required for quality measurement and Home Health Quality Reporting Program (HHQRP) compliance.
- **CMS Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS):**
  QOC will contract with a CMS-approved HHCAHPS vendor to administer client experience surveys, collect patient-reported outcomes, and submit survey data to CMS on the required schedule.

QOC's administrative leadership and clinical staff will receive training on all applicable reporting requirements. The agency's EHR system incorporates built-in OASIS validation, quality-measure tracking, and reporting dashboards to support accurate data submission and continuous performance monitoring.

Through these measures, QOC commits to meet all data reporting requirements mandated under COMAR 10.24.16.08K.

10.24.16.09 Certificate of Need Preference Rules in Comparative Reviews.

The Commission shall use the following preferences, in the order listed, to limit the number of CON applications approved in a comparative review.

APPLICANT RESPONSE- 10.24.16.09(A-E):

At the Pre-Application Conference, MHCC Staff confirmed that this project is not being reviewed as a Comparative Review. Therefore, the preference rules under COMAR 10.24.16.09A–E do not apply to this application.

10.24.16.09A. Performance on Quality Measures.

Higher levels of performance will be given preference over lower levels of performance.

APPLICANT RESPONSE- 10.24.16.09(A):

MHCC Staff determined that this is not a Comparative Review. Accordingly, the quality-measure preference rule under COMAR 10.24.16.09A is not applicable.

10.24.16.09B. Maintained or Improved Performance.

An applicant that demonstrates maintenance or improvement in its level of performance on the selected process and outcome measures during the most recent three-year reporting period will be given preference over an applicant that did not maintain or improve its performance.

APPLICANT RESPONSE- 10.24.16.09(A):

Because this project is not part of a Comparative Review, the preference rule regarding maintained or improved performance under COMAR 10.24.16.09B is not applicable.

10.24.16.09C. Proven Track Record in Serving all Payor Types, the Indigent and Low-Income Persons.

An applicant that served a broader range of payor types and the indigent will be given preference over an applicant that served a narrower range of payor types and provided less service to the indigent and low-income persons.

APPLICANT RESPONSE- 10.24.16.09(C):

As confirmed by MHCC Staff, this application is not subject to Comparative Review. Therefore, the preference rule under COMAR 10.24.16.09C does not apply.

10.24.16.09D. Proven Track Record in Providing a Comprehensive Array of Services.
An applicant that provided a broader range of services will be given preference over an applicant that provided a narrower range of services.

APPLICANT RESPONSE- 10.24.16.09(D):

Since MHCC Staff determined that this is not a Comparative Review, the preference provisions of COMAR 10.24.16.09D are not applicable.

10.24.16.09E. These preferences will only be used in a comparative review of applications when it is determined that approval of all applications that fully comply with standards in Regulation .08 of this Chapter would exceed the permitted number of additional HHAs provided for in a jurisdiction or multi-jurisdictional region as provided in Regulation .10.

APPLICANT RESPONSE- 10.24.16.09(E):

MHCC Staff confirmed that this application is not in a Comparative Review. Therefore, the "Preference Rules" in COMAR 10.24.16.09E are not applicable to this project.

10.24.01.08G(3)(b). The "Need" Review Criterion
The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated a need for the proposed project.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D

must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

APPLICANT RESPONSE- 10.24.01.08G(3)(b):

The Maryland Health Care Commission (MHCC) has identified Baltimore City, Baltimore County, and Howard County as jurisdictions with insufficient consumer choice of home health agencies (HHAs) based on the criteria in COMAR 10.24.16.04—specifically, highly concentrated HHA markets and uneven distribution of high-performing providers. As a result, these jurisdictions are open for CON review, and applicants must demonstrate unmet need for additional HHA capacity.

Quality One Care Home Health, Inc. (QOC) proposes to establish a Medicare-certified HHA to serve this tri-county region. The following quantitative analysis demonstrates that:

(1) the population base is large and growing, particularly in age cohorts that utilize home health at the highest rates
(2) existing HHAs face heavy caseloads
(3) utilization levels indicate substantial ongoing demand
(4) access remains constrained, particularly for Medicare, Medicaid, and low-income residents

Together, these findings confirm that the proposed QOC HHA will address documented unmet need and expand consumer choice consistent with the State Health Plan.

Expected Service Area and Population Characteristics

QOC's service area includes Baltimore City, Baltimore County, and Howard County, which together represented over 1.9 million residents in 2023. Demographically, these jurisdictions have growing older-adult populations, the primary users of home health services.

Population Aging Trends

- According to U.S. Census and Maryland Department of Planning projections, the 65+ population across the tri-county region is expected to increase by approximately 18–22% between 2025 and 2030.
- Older adults account for 68–73% of all Maryland home health clients (MHCC Utilization Report, Table 13), making this growth directly tied to rising service demand.

Socioeconomic Need

Baltimore City and portions of Baltimore County contain some of the highest-need ZIP codes in Maryland, characterized by:

- High Medicare/Medicaid enrollment
- Higher disability rates
- Disproportionate chronic disease burden (diabetes, CHF, COPD)

These factors strongly correlate with higher home health utilization.

MHCC-Reported Utilization Demonstrates High Demand and Heavy Existing Caseloads

MHCC Table 25 (FY2023) documents substantial home health activity in the three proposed jurisdictions:

Table H-1:

Table 25: FY2023 Home Health Visits – Tri-County Region

Jurisdiction	Total Home Health Visits (FY2023)
Baltimore City	284,010
Baltimore County	206,770
Howard County	37,499
Tri-County Total	**528,279 visits**

These figures confirm that the region accounts for over half a million visits annually, among the highest volumes statewide.

Key Observations

- Baltimore City alone represents nearly 20% of all Maryland home health visits.
- Baltimore County is the third-largest home health market in Maryland.
- Howard County shows rapid year-over-year increases, driven by accelerated aging and high Medicare penetration.

MHCC's own analysis recognizes that both Baltimore City and Baltimore County have concentrated HHA markets with insufficient consumer choice.

Insufficient Consumer Choice and Market Concentration

Under COMAR 10.24.16.04, MHCC identified the tri-county region as a jurisdiction with:

- Limited availability of high-performing HHAs
- A small number of agencies holding the majority of market share
- Documented access barriers for Medicare and Medicaid clients

In Baltimore City, for example, the top five HHAs account for over 70% of visits (MHCC Tables 13 & 15). Similar concentration exists in Baltimore County.

IMPACT:

Patients, discharge planners, and hospitals report delays in securing timely home health admission—especially for higher-acuity Medicare beneficiaries and for Medicaid clients, where provider participation is more limited.

QOC's entry will increase access, particularly in underserved ZIP codes identified by MHCC as high-need.

Projected Need for Additional Capacity

Projected population growth, chronic disease prevalence, and aging trends all point to continued growth in home health utilization.

Growth Indicators

- MHCC Table 13 shows that home health visits grew statewide at 3.5–4.8% per year from 2019–2023.
- Applying even a conservative 2.5% annual growth rate to the tri-county region's 528,279 visits results in approximately:
    - ~540,000–555,000 visits by Year 2
    - ~565,000–575,000 visits by Year 3

This growth will exceed the capacity of the current provider supply.

QOC's Project will Address Unmet Need

QOC's proposed HHA will directly address the unmet needs identified by MHCC across Baltimore City, Baltimore County, and Howard County. Medicare beneficiaries, who represent approximately 47–49% of all home health visits in Baltimore County and Howard County and more than 55% of visits in Baltimore City (MHCC Table 20), routinely experience the longest wait times for home health admission due to limited provider capacity and high clinical demand. Access challenges are even more pronounced for Medicaid

beneficiaries and low-income residents, as Medicaid fee-for-service participation among HHAs remains constrained by low reimbursement and administrative requirements. By serving both Medicaid FFS and Managed Care patients, QOC will materially expand access for these populations. Further, the State Health Plan emphasizes the need for at least three high-quality home health agency options in each jurisdiction to ensure meaningful consumer choice; however, multiple ZIP codes within the tri-county region currently fall short of this benchmark due to market concentration. QOC's entry will therefore increase capacity, reduce access barriers, and expand competitive choice, directly supporting the State Health Plan's objectives and enhancing service equity across the region.

Referral Delays and Unplaced Referrals

As part of its RSA operations, QOC routinely coordinates with hospitals, skilled nursing facilities, and AERS programs across Central Maryland. Based on internal referral tracking between 2021–2023, approximately 18–24% of referrals made on behalf of Medicaid and Medicare beneficiaries in Baltimore City, Baltimore County, and Howard County experienced delays of 3–7 days before acceptance by an HHA, and 12–15% of referrals could not be placed at all with an HHA at the time of referral due to capacity limitations, payor restrictions, or staffing shortages. These access barriers are most pronounced for dual-eligible, medically complex, and behavioral-health comorbidity patients, echoing the statewide capacity concerns reflected in MHCC's HHA Utilization Tables (Tables 13, 20, and 25).

The persistent difficulty in securing timely HHA placement for high-need patients demonstrates a clear and ongoing access gap and supports the necessity of an additional HHA option serving the Baltimore City, Baltimore County, and Howard County region.

Assumptions Supporting the Need Analysis

The following assumptions underlie QOC's projections, consistent with instructions:

- **Service Area Population:** Baltimore City, Baltimore County, Howard County.
- **Utilization Growth Rate:** 2.5–3.0% annually (less than historic statewide growth).
- **Demographic Drivers:** Growth of 65+ population at 18–22% over the next decade.
- **Payer Mix:** Based on MHCC Table 20—primarily Medicare, Medicaid, and commercial.
- **Clinical Demand:** High prevalence of chronic disease and post-acute needs.

All sources used include MHCC Annual Survey (Tables 13, 15, 20, and 25), Census data, Maryland Department of Planning projections, and State Health Plan standards.

NEED REVIEW CRITERION SUMMARY

The MHCC has already determined that Baltimore City, Baltimore County, and Howard County meet the criteria for need review due to insufficient consumer choice and market concentration. Based on:

- The large and growing population
- High annual visit volume
- Heavy caseloads among current providers
- Increasing Medicare and Medicaid demand
- Geographic disparities in access

The project is fully consistent with COMAR 10.24.01.08G(3)(b) and COMAR 10.24.16.04–.08, and it aligns with the State Health Plan's goals of improving access, enhancing consumer choice, and supporting equitable delivery of home health services.

10.24.01.08G(3)(c). Alternatives to the Project Review Criterion

The Commission shall consider the alternative approaches to meeting the need identified for the project that were considered by the applicant in planning the project and the basis for the applicant's choice of the project among considered alternatives. In a comparative review of applications within the same review cycle, the Commission shall compare the costs and the likely effectiveness of alternative projects in meeting identified needs, improving the availability and accessibility of care, and improving the quality of care.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project, or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

APPLICANT RESPONSE- 10.24.01.08G(3)(c):

ALTERNATIVES TO THE PROJECT

Quality One Care Home Health, Inc. (QOC) evaluated multiple approaches for addressing the clear gaps in access, provider choice, and service equity in Baltimore City, Baltimore County, and Howard County. The primary goals guiding the planning process were to: (1) expand timely access to Medicare and Medicaid home health services; (2) increase the availability of high-quality providers in jurisdictions where MHCC has identified insufficient choice; and (3) improve continuity of care for medically complex, low-income, and underserved residents. The planning process included a review of MHCC utilization data, referral pipeline patterns, payor-mix limitations among existing HHAs, and documented wait-time challenges experienced by publicly insured patients.

A. Alternative 1: Rely on Existing HHAs to Meet the Identified Need

One alternative assessed was continued reliance on existing HHAs serving the tri-county region. This option was rejected because MHCC data demonstrate that the current market is already operating under capacity constraints, with long wait times for Medicare beneficiaries, limited Medicaid FFS participation, and multiple ZIP codes falling below the State Health Plan's benchmark of at least three high-quality provider options per jurisdiction. Existing HHAs have not expanded capacity at a rate sufficient to meet demand, particularly for publicly insured and low-income patients. As a result, this alternative would not effectively resolve the documented access issues.

B. Alternative 2: Expand QOC's RSA Program Without Seeking Medicare Certification

QOC also considered expanding its existing Residential Service Agency (RSA) operations instead of seeking approval to establish a Medicare-certified HHA. While RSA services offer meaningful non-skilled support, they cannot replace skilled home health services, nor can they address the identified gaps in skilled nursing, therapy, or clinical management needed by the region's high-acuity population. RSAs are also unable to bill Medicare—an essential payor representing 47–55% of all home health visits in the region. Therefore, this alternative was ineffective in meeting the project's primary objectives.

C. Alternative 3: Partnering With an Existing HHA Instead of Establishing a New Agency

QOC explored the feasibility of contracting with or merging into an existing HHA. This alternative was deemed less effective because it would not generate sufficient additional capacity or change the structural limitations that currently restrict access for Medicaid FFS and dual-eligible clients. Partnerships would also limit QOC's ability to control staffing levels, service quality, and response times—factors central to addressing unmet need. Furthermore, no existing HHA has submitted a competitive application for

expansion in this service area, confirming the lack of an alternative facility proposing to meet the identified gaps.

D. Alternative 4: Proposed Project – Establishing a New Medicare-Certified HHA

The proposed project provides the most effective and cost-efficient solution when compared to alternatives. Establishing a new HHA allows QOC to directly expand capacity, introduce an additional provider option in jurisdictions with insufficient consumer choice, and serve a broader payor mix—including Medicaid and dual-eligible beneficiaries who face the greatest access barriers. QOC will leverage its existing administrative infrastructure, community linkages, and RSA experience to minimize start-up and lifecycle costs while maximizing operational efficiency. This alternative best achieves the project goals and directly aligns with the State Health Plan's objectives of improving access, strengthening quality, and increasing provider competition.

Conclusion

After evaluating all reasonable alternatives, QOC determined that establishing a Medicare-certified HHA is the only approach capable of meaningfully addressing the region's unmet needs in a cost-effective, sustainable, and high-impact manner. The proposed project is therefore the most appropriate and effective alternative for meeting the goals identified in the planning process.

10.24.01.08G(3)(d). Project Financial Feasibility and Facility or Program Viability Review Criterion.
The Commission shall consider the availability of resources necessary to implement the project and the availability of revenue sources and demand for the proposed services adequate to ensure ongoing viability and sustainability of the facility to be established or modified or the service to be introduced or expanded.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- **Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the health care facility exists or is proposed, explain why the projected Medicare percentages are reasonable.**

- **Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved**

and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an <u>independent</u> Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- **If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.**

- **Describe and document relevant community support for the proposed project.**

- **Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).**

APPLICANT RESPONSE- 10.24.01.08G(3)(d):

Quality One Care Home Health, Inc. (QOC) has developed a financially sustainable plan for establishing the proposed Medicare-certified Home Health Agency (HHA). The project is supported by sufficient internal financial resources, conservative revenue assumptions, and staffing and expense projections consistent with comparable Maryland HHAs. Required Revenue & Expense Tables and Workforce Staffing Worksheets are included in Exhibit 5, which also contains the project's financial assumptions and projected utilization.

1. Funding Plan and Financial Capacity

The proposed project will be financed entirely through QOC's available equity and operating reserves. Audited financial statements for the past two years are provided in Exhibit 6, demonstrating strong liquidity, stable cash flow, and the financial capacity to support project start-up costs without external borrowing. No debt financing, grant funding, or philanthropic support is required.

2. Sustainability of Revenue and Expense Projections

The financial projections in Exhibit 5 are based on:

- MHCC jurisdiction-level Medicare and Medicaid payor-mix data,
- Maryland statewide average per-visit reimbursement rates (MHCC Table 20), and
- conservative assumptions regarding productivity, staffing levels, benefits, and administrative overhead.

Projected Medicare percentages fall within the typical range observed for Baltimore City, Baltimore County, and Howard County. Salary and productivity assumptions reflect industry norms and are consistent with those used by other Maryland HHAs.

3. Staffing Recruitment and Workforce Viability

QOC's staffing model relies on:

- a phased hiring plan aligned with Year 1–3 utilization growth,
- competitive wage and benefit rates for nurses, therapists, and home health aides,
- QOC's existing workforce experience operating a licensed RSA in Baltimore City and Baltimore County.

Workforce projections demonstrate that the agency will have adequate staffing to meet demand throughout the projection period, with no shortages anticipated.

4. No Reliance on Debt or Grants

Because the project does not involve debt financing, fundraising, or grant-supported operations, no additional financial letters or grant documentation are required. QOC has prior experience successfully managing health-service operations funded entirely through operating revenues.

5. Community Support

QOC has longstanding relationships with hospitals, primary care providers, assisted living facilities, and community-based organizations through its existing RSA operations in Baltimore City and Baltimore County. These existing partnerships reflect community familiarity with QOC's quality of care and operational reliability. While formal letters of support are not included, QOC's continued collaboration with these referral sources demonstrates meaningful community awareness of, and informal support for, QOC's expansion into Medicare-certified home health services.

6. Ability to Meet All Regulatory and Operational Requirements

QOC is fully prepared to complete all regulatory, licensure, and operational steps within the required timeframes, including:

- CMS Medicare HHA enrollment and certification,
- State and local licensure approvals,
- Implementation of required clinical and administrative systems (OASIS, HHCAHPS, EMR), and
- Establishment of contracts with Medicare, Medicaid, and commercial payors.

QOC's demonstrated compliance history as a Residential Service Agency further supports its ability to meet CMS performance and operational requirements for HHAs.

The funding plan, revenue assumptions, and operational readiness described herein demonstrate that QOC's project is financially feasible, supported by sufficient and reliable resources, and capable of sustaining ongoing operations consistent with MHCC requirements.

10.24.01.08G(3)(e). The "Compliance with Terms and Conditions of Previous Certificates of Need" Review Criterion. An applicant shall demonstrate compliance with all terms and conditions of each previous CON granted to the applicant.

INSTRUCTIONS: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

APPLICANT RESPONSE- 10.24.01.08G(3)(e):

Quality One Care Home Health, Inc. (QOC), including its parent organization and any affiliates or subsidiaries, has never been issued a Certificate of Need (CON) in Maryland. Therefore, there are no prior CONs, terms, conditions, or compliance obligations applicable to the Applicant. As a result, no compliance issues exist, and this criterion is not applicable to QOC.

10.24.01.08G(3)(f). Project Impact Review Criterion.
The Commission shall consider the impact of the proposed project on the costs and charges of existing providers of the facilities and services included in the project and on access to those facilities and services in the service area of the project.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

APPLICANT RESPONSE- 10.24.01.08G(3)(f):

Quality One Care Home Health, Inc. (QOC) has evaluated the potential impact of its proposed home health agency on existing providers and on access to services within Baltimore City, Baltimore County, and Howard County. Current MHCC utilization data (Tables 20 and 25) show that existing Medicare-certified HHAs in Baltimore City, Baltimore County, and Howard County continue to operate at

high visit volumes with sustained demand driven by older adults and medically complex beneficiaries. Based on this data, and the agency's projected referral sources, QOC expects minimal to no adverse impact on existing home health agencies (HHAs). Instead, the project is expected to improve access, reduce delays in care, and distribute caseloads more efficiently across the region.

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(a):

QOC's projected visit volume represents less than 1% of total regional utilization in its first year of operation and remains well below thresholds that would negatively affect incumbent HHAs.

Impact on the Volume of Services Provided by Existing Providers

QOC anticipates no material negative impact on the service volumes of existing HHAs. This conclusion is supported by:

- High existing utilization levels and persistent capacity constraints across the tri-county region, including documented admission delays for Medicare and Medicaid beneficiaries.
- MHCC Table 25 (FY 2023) shows significant visit volumes—over 528,000 home health visits annually across the three counties—illustrating a large and growing service base.
- Population aging trends in the region continue to drive increased demand for home health services, particularly among residents age 65 and older.
- QOC's projected patient base will be sourced primarily from underserved populations and current referral partners who experience difficulty placing high-acuity or publicly insured patients with existing agencies.

Because the region already exceeds 528,000 home health visits annually and continues to experience stable growth, the addition of QOC will not reduce access, volumes, or financial viability for existing providers. Instead, QOC will help meet unmet demand, particularly for dual-eligible and Medicaid beneficiaries who currently experience prolonged wait times, limited provider participation, and higher rates of unplaced referrals. Accordingly, the proposed project will have no adverse impact on existing HHAs and will improve overall access and equity in the tri-county region.

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(b):

Impact on the Payer Mix of Existing Providers

QOC does not anticipate any adverse impact on the payer mix of other HHAs.

Key factors include:

- QOC will serve a balanced payer mix, including Medicare, Medicare Advantage, Medicaid FFS, Medicaid Managed Care, and commercial insurance.
- Existing agencies already report high percentages of Medicare patients (47–55% per MHCC Table 20), indicating that Medicare-driven demand exceeds current capacity.
- QOC is not selectively targeting commercially insured patients; instead, it will accept all major payers and fully participate in Medicaid programs.

Because QOC is addressing real unmet need and improving access for publicly insured patients, no negative payer-mix shift is expected among existing HHAs.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(c):

Impact on Access to Health Care Services

The proposed project will significantly improve access in all three jurisdictions. Access improvements include:

- Reduced wait times for Medicare and Medicaid patients, who currently experience the longest delays.
- Expanded service availability in high-need ZIP codes, including areas with limited HHA coverage.
- Increased referral capacity for hospitals, skilled nursing facilities, assisted living communities, and primary care practices.
- Enhanced access to specialized services (e.g., chronic disease management, post-acute recovery, wound care).

By adding a new, fully certified HHA to the service area, the project directly aligns with SHP goals of ensuring at least three high-quality provider options per jurisdiction and expanding consumer choice.

d) On costs of the health care delivery system.

If the applicant is an existing health care facility, provide a summary description of the impact of the proposed project on costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

APPLICANT RESPONSE - 10.24.01.08G(3)(f)(d):

QOC's project is expected to reduce systemwide costs rather than increase them.

This is supported by the following:

- Increased access to timely home health services reduces unnecessary hospital readmissions, emergency department utilization, and institutional care costs.
- By serving Medicaid and dual-eligible patients more readily, QOC helps prevent cost-shifting to hospital uncompensated care.
- QOC's operating budget, contained in Exhibit 5, reflects efficient staffing, standard wage rates, and sustainable cost structures consistent with other Maryland HHAs.
- The addition of a new provider can help stabilize overall market rates by reducing bottlenecks and capacity strain among existing HHAs.

Therefore, QOC's entry is expected to improve efficiency and lower overall delivery-system costs, consistent with the intent of the State Health Plan.

Conclusion

QOC's proposed HHA will not adversely affect existing providers and will instead address unmet demand, improve access for Medicare and Medicaid beneficiaries, expand provider choice, and reduce downstream health care costs. Overall, the project will provide a positive and measurable contribution to the home health delivery system in the tri-county region.

10.24.01.08G(3)(g) Health Equity. The Commission shall consider how a proposed project will address health care disparities in availability, accessibility, and quality of care among different populations within the service area. The Commission shall consider how social determinants of health within the service area of the proposed project create disparities in the delivery of health care.

INSTRUCTIONS: In evaluating proposed projects for health equity, the Commission will scrutinize the project's impact on health care disparities and social determinants within the service area. Health equity involves the fair distribution of resources and opportunities, ensuring individuals, regardless of background, have the chance to achieve their highest level of health. It further encompasses addressing disparities and systemic barriers that affect different populations.

With health equity in mind, the applicant shall identify the specific medically underserved area(s)/group(s)[2] within the designated service area and outline how the proposed project will address the unique health needs and quality of care for each identified group.

Applicants are expected to furnish a detailed overview of their organization's expertise and experience in health care access and service delivery. Emphasis should be placed on highlighting any relevant background that underscores the organization's commitment to equitable health care. This encompasses efforts to integrate implicit bias and cultural competency training within the health facility and among current staff members.

Please provide a comprehensive account of how the applicant planned with the community during the preparations for this project and how it will continue to engage with the community. Include a description of any specific initiatives and programs aimed at improving community well-being that are relevant to the proposed project. If applicable, the applicant should acknowledge any unintended barriers caused by the project that may have been identified through community discourse and propose proactive solutions to mitigate and rectify potential issues.

APPLICANT RESPONSE - 10.24.01.08G(3)(g):

HEALTH EQUITY

QOC's proposed Home Health Agency (HHA) is designed to reduce long-standing disparities in home health access, timeliness, and quality for medically underserved groups in Baltimore City, Baltimore County, and Howard County. The tri-county region includes large populations disproportionately affected by chronic disease, disability, limited transportation, and socioeconomic barriers. These include older adults, low-income residents, Medicaid beneficiaries, dual-eligible individuals, and racial/ethnic minority communities—each of whom faces higher difficulty securing timely home health admission and continuity of care. Home health access disparities remain significant across the tri-county region, particularly among dual-eligible adults, low-income older adults, Black and Latino residents, and individuals with chronic or behavioral-health comorbidities. These populations experience longer wait times for HHA admission, higher referral-denial rates, and lower rates of provider participation, especially in Baltimore City

QOC's model directly addresses these disparities by expanding capacity in ZIP codes with the highest concentrations of vulnerable populations. MHCC Table 20 demonstrates that Medicare beneficiaries account for 47–55% of all home health visits in the region—yet these individuals routinely experience the longest wait times for skilled nursing, therapy, and aide services. Similarly, Medicaid FFS patients remain underserved due to low reimbursement and administrative burdens that deter many HHAs.

[2] According to HRSA, medically underserved populations and areas are identified as those which lack access to primary care services. These groups may face economic, cultural, or language barriers to health care. Some examples include People experiencing homelessness, people who are low-income, people who are eligible for Medicaid, Native Americans and other historically disadvantaged populations of color, migrant farm workers, etc. (https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups)

As a mission-driven provider with a longstanding commitment to low-income and publicly insured individuals, QOC will serve both Medicaid FFS and Medicaid Managed Care patients without restriction, significantly improving equitable access.

QOC's organizational background includes more than a decade of experience delivering personal care and supportive services to medically fragile, low-income, and minority residents as a Residential Service Agency (RSA).

This experience has strengthened QOC's cultural competency, community familiarity, and ability to provide care to individuals with complex social and behavioral needs. Staff training includes topics such as cultural humility, disability sensitivity, trauma-informed communication, and implicit-bias awareness, all of which will continue under the proposed HHA.

To ensure equitable delivery of home health services, QOC will implement a structured outreach and coordination process with local hospitals, discharge planners, community health centers, and senior-support organizations serving high-need communities. This engagement will help identify residents at risk of delayed care—including individuals lacking caregivers, transportation, or sufficient home support—and will ensure prompt referral pathways.

QOC's intake process will also incorporate social-determinants-of-health (SDOH) screening to identify food insecurity, transportation barriers, medication limitations, language needs, and home safety concerns. These findings will guide resource referrals, inter-agency coordination, and proactive case management aimed at reducing preventable readmissions and health deterioration.

Finally, QOC has not identified any unintended barriers resulting from the proposed project; however, the agency remains committed to continuous community engagement—including periodic meetings with referring providers, feedback surveys from patients and caregivers, and collaboration with local service organizations. Should any concerns or unanticipated inequities arise, QOC will implement timely adjustments to policies, staffing, or operational processes to ensure that all residents—regardless of income, race, disability status, or insurance type—receive fair and timely access to high-quality home health services.

10.24.01.08G(3)(h) Character and Competence. The Commission shall assess the character and competence of an applicant based upon experience and past performance, including any records of violation in operating a health care service or facility.

APPLICANT RESPONSE - 10.24.01.08G(3)(h):

CHARACTER AND COMPETENCE

Quality One Care Home Health, Inc. (QOC) affirms that the individuals responsible for the ownership, leadership, and implementation of the proposed Home Health Agency possess strong character, competence, and an unblemished record of regulatory compliance. QOC's owners and executive leadership have demonstrated a consistent history of responsible management and ethical conduct in operating licensed health-related services in Maryland.

QOC is solely owned and managed by individuals who have not been subject to any federal, state, or local disciplinary actions, sanctions, or adverse findings related to the operation, management, or ownership of any health care facility. No owner or managerial staff member holds—or has ever held—any license that has been suspended, revoked, surrendered, or restricted. Likewise, neither QOC nor any individual associated with ownership or governance has been subject to inquiries, audits, or enforcement actions by CMS, the Maryland Office of Health Care Quality (OHCQ), or any other regulatory body at any point within the last ten years.

None of QOC's owners, officers, or managers have been involved in the ownership, development, or management of any health care facility with a record of violations or compliance problems. There is no history of civil penalties, admission bans, probationary status, corrective action mandates, or quality-of-care sanctions related to any operations overseen by QOC personnel. Additionally, no individual associated with the proposed project has ever been charged with or convicted of any criminal offense connected to the ownership, development, or management of a health care entity.

As a licensed Residential Service Agency (RSA), QOC has maintained full compliance with all applicable Maryland regulations since licensure. The organization's inspection history reflects no deficiencies, no adverse findings, and no corrective action requirements, demonstrating a strong record of operational integrity and quality service delivery. QOC's leadership has consistently met all reporting, renewal, and compliance obligations on time and without exception.

Collectively, this track record demonstrates that QOC's ownership and leadership team exhibit the experience, competence, and ethical standards required to operate a Medicare-certified Home Health Agency. Their longstanding compliance record and absence of regulatory issues provide strong evidence

of the reliability and suitability of the applicant to successfully establish and manage the proposed project in accordance with all federal and state requirements.

QOC affirms that neither the applicant, nor any of its owners, officers, directors, or parent entities, have ever been convicted of a crime, sanctioned, or subject to disciplinary action by Medicare, Medicaid, a state licensure agency, or any court for violations related to fraud, resident abuse, or quality of care, as required under COMAR 10.24.01.08G(3)(h).

INSTRUCTIONS: In evaluating proposed projects for Character/Competence, the Commission will review the information provided in response to Part IIII of the application and look for a detailed narrative response highlighting any past issues and how any issues have now been corrected or addressed. If there have not been any past issues please include in your narrative any history that has been a positive reflection of character/competence. The response should include, at minimum:

- **names/addresses of all owners and individuals responsible for the proposed project and its implementation. This includes any person with 5% or more ownership interest in the real property, bed rights or operations of the facility**
- **for each individual identified disclose any involvement in the ownership, development, or management of another health care facility**
- **for each individual and facility identified disclose if any license has been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years**
- **for each individual and facility identified disclose inquiries in the last from 10 years from any federal (CMS) or state authority (OHCQ), or other regulatory body regarding possible non-compliance with any state, or federal requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions**
- **disclose if any owners and individuals responsible for the project have identified above have ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities**

REMEMBER TO SUBMIT THE COMPANION TABLE SET FEATURING THE PROJECT BUDGET, STATISTICAL PROJECTIONS, REVENUE AND EXPENSE PROJECTIONS, AND WORKFORCE INFORMATION

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Mohamed Matope

9221 Colesville Road

Silver Spring, MD 20910

2. Is the applicant, or any person listed above now involved, or has ever been involved, in the ownership, development, or management of another health care facility or program? If yes, provide a listing of each facility or program, including facility name, address, and dates of involvement.

NO

3. Has the Maryland license or certification of the applicant home health agency, or any of the facilities or programs listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner, or other person responsible for implementation of the Project was not involved with the facility or program at the time a suspension, revocation, or disciplinary action took place, indicated in the explanation.

NO

1. Is any facility or program with which the applicant is involved, or has any facility or program with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility or program. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility or program, and any final disposition reached by the applicable governmental authority.

NO

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or

management of the applicant facility or program or any health care facility or program listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

NO

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed home healthy agency service.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

11/14/2025
Date

Signature of Owner or
Authorized Agent of the Applicant

Part IV: Home Health Agency Application: Charts and Tables Supplement

Part IV: Home Health Agency Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – FOR HHA SERVICES IN MARYLAND

TABLE 2B: STATISTICAL PROJECTIONS – FOR PROPOSED JURSIDICTIONS

TABLE 3: REVENUES AND EXPENSES - FOR HHA SERVICES IN MARYLAND

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: STAFFING INFORMATION

TABLE 1: PROJECT BUDGET

Instructions: All estimates for 1a- d; 2a- f; and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. Inflation from date of submission of project completion should only be included on the Inflation line 1e. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
a. New Construction	
1) Building	**$ 0**
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
a. SUBTOTAL New Construction	**$ 0**
b. Renovations	
1) Building	**$ 0**
2) Fixed Equipment (not included in construction)	
3) Architect/Engineering Fees	
4) Permits, (Building, Utilities, Etc.)	
b. SUBTOTAL Renovations	**$ 0**
c. Other Capital Costs	
1) Movable Equipment	**$ 5,000**
2) Contingency Allowance	**$ 20,000**
3) Gross Interest During Construction	
4) Other (Specify)	
c. SUBTOTAL Other Capital Cost	**$ 25,000**
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	**$ 25, 000**
Non-Current Capital Cost	
d. Land Purchase Cost or Value of Donated Land	**$ 0**
e. Inflation (state all assumptions, including time period and rate	**$ 0**
TOTAL PROPOSED CAPITAL COSTS (sum of a - e)	**$ 25,000**
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	$ 0
b. Bond Discount	
c. CON Application Assistance	
c1. Legal Fees	$ 5,000
c2 Other (Specify and add lines as needed)	$ 10,000
d. Non-CON Consulting Fees	
d1. Legal Fees	
d2. Other (Specify and add lines as needed) Licensing	$ 4,000
e. Debt Service Reserve Fund	
f. Other (Specify)	
TOTAL (a - e)	**$ 19,000**
3. WORKING CAPITAL STARTUP COSTS	**$ 44,000**
TOTAL USES OF FUNDS (sum of 1 - 3)	**$ 44,000**
B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	$ 44,000

2. Pledges: Gross _____, less allowance for uncollectable _____= Net	
3. Gifts, bequests	
4. Authorized Bonds	
5. Interest income (gross)	
6. Mortgage	
7. Working capital loans	
8. Grants or Appropriation	
a. Federal	
b. State	
c. Local	
9. Other (Specify)	
TOTAL SOURCES OF FUNDS (sum of 1-9)	**$ 44,000**
ANNUAL LEASE COSTS (if applicable)	
• Land	
• Building	
• Moveable equipment	
• Other (specify)	

TABLE 2A: STATISTICAL PROJECTIONS – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

Instructions: Table 2A applies to an applicant that is an existing home health agency and should be completed showing historic and projected utilization *for all home health agency services provided in Maryland*.

Table should report an *unduplicated count of clients* and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).

APPLICANT RESPONSE

Not Applicable – Quality One Care Home Health, Inc. is applying as a new Medicare-certified Home Health Agency and does not have historical utilization data. Therefore, Table 2A does not apply. Projected utilization for the proposed HHA is provided in Table E (New Agency Statistical Projections) in accordance with COMAR requirements.

	Two Most Current Actual Years		**Projected years – ending with first year at full utilization**			
CY or FY (circle)			20__	20__	20__	20__
Client Visits						
Billable						
Non-Billable						
TOTAL						
# of Clients and Visits by Discipline						
Total Clients (Unduplicated Count)						
Skilled Nursing Visits						
Home Health Aide Visits						
Physical Therapy Visits						
Occupational Therapy Visits						
Speech Therapy Visits						
Medical Social Services Visits						
Other Visits (Please Specify)						

TABLE 2B: STATISTICAL PROJECTIONS - PROJECTED HOME HEALTH AGENCY SERVICES IN THE PROPOSED PROJECT

Instructions: All applicants should complete Table 2B for the proposed project, showing projected utilization *only for the jurisdiction(s) which is the subject of the application*. **As in Table 2A above, this table should report an unduplicated count of clients, and should indicate whether the reporting period is Calendar Year (CY) or Fiscal Year (FY).**

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2026	2027	2028	20__
Client Visits				
Billable	1050	2100	2755	
Non-Billable	112	250	278	
TOTAL	1162	2350	3033	
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	100	225	330	
Skilled Nursing Visits	724	1420	1650	
Home Health Aide Visits	151	330	480	
Physical Therapy Visits	75	135	255	
Occupational Therapy Visits	70	145	180	
Speech Therapy Visits	6	15	20	
Medical Social Services Visits	24	55	65	
Other Visits (Please Specify)				

TABLE 3: REVENUES AND EXPENSES – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND (including proposed project)

Instructions: an existing home health agency must complete Table 3, showing historic and projected revenues and expenses for all home health agency services provided *in Maryland.*

Projections should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application.

Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).

APPLICANT RESPONSE

Not Applicable – Quality One Care Home Health, Inc. is applying as a new Medicare-certified Home Health Agency and does not have historical utilization data. Therefore, Table 2A does not apply. Projected utilization for the proposed HHA is provided in Table E (New Agency Statistical Projections) in accordance with COMAR requirements.

	Two Most Recent Years -- Actual		**Current Year Projected**	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
1. Revenue							
Gross Patient Service Revenue							
Allowance for Bad Debt							
Contractual Allowance							
Charity Care							
Net Patient Services Revenue							
Other Operating Revenues (Specify)							
Net Operating Revenue							
2. Expenses							

Salaries, Wages, and Professional Fees, (including fringe benefits)							
Contractual Services (please specify)							
Interest on Current Debt							
Interest on Project Debt							
Current Depreciation							
Project Depreciation							
Current Amortization							
Project Amortization							
Supplies							
Other Expenses (Specify)							
Total Operating Expenses							
3. Income							
Income from Operation							
Non-Operating Income							
Subtotal							
Income Taxes							
Net Income (Loss)							
Table 3 Cont.	**Two Most Actual Ended Recent Years**		**Current Year Projected**	**Projected Years (ending with first full year at full utilization)**			

CY or FY (Circle)	20___	20___	20___	20___	20___	20___	20___
4A. - Payor Mix as Percent of Total Revenue							
Medicare							
Medicare Advantage							
Medicaid							
Medicaid MCO							
Blue Cross							
Commercial Insurance							
Self-Pay							
Other (Specify)							
TOTAL REVENUE	100%	100%	100%	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits							
Medicare							
Medicare Advantage							
Medicaid							
Medicaid MCO							
Blue Cross							
Other Commercial Insurance							
Self-Pay							
Other (Specify)							
TOTAL VISITS	100%	100%	100%	100%	100%	100%	100%

NOTE: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS**.**

TABLE 4: REVENUES AND EXPENSES – PROJECTED HOME HEALTH AGENCY SERVICES FOR PROPOSED PROJECT

Instructions: Complete Table 4 for the proposed project, showing projected revenues and expenses *for only the jurisdiction(s) which is the subject of the application*.

Projections should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application.

Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY).

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2026	2027	2028	20___
1. Revenue				
Gross Patient Service Revenue	$162,750	$325,500	$426,025	
Allowance for Bad Debt	$976	$1,953	$2,556	
Contractual Allowance	$39,060	$78,120	$102,246	
Charity Care	$814	$1,628	$2,130	
Net Patient Services Revenue	$121,900	$243,800	$319,100	
Other Operating Revenues (Specify)	$0	0	0	
Net Operating Revenue	**$121,900**	**$243,800**	**$319,100**	
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	$82,000	$148,000	$198,000	
Contractual Services	$6,000	$8,000	$10,000	
Interest on Current Debt				
Interest on Project Debt				
Current Depreciation				
Project Depreciation				
Current Amortization				
Project Amortization				
Supplies	$6,000	$9,000	$12,000	
Other Expenses (Specify) admin overhead	$11,500	$15,500	$19,700	
Total Operating Expenses	**$105,500**	**$180,500**	**$239,700**	
3. Income				
Income from Operation	$16,400	$63,300	$79,400	
Non-Operating Income				

Subtotal				
Income Taxes				
Net Income	$16,400	$63,300	$79,400	

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	2026	2027	2028	20___
4A. - Payor Mix as Percent of Total Revenue				
Medicare	55%	55%	55%	
Medicare Advantage	10%	10%	10%	
Medicaid	15%	15%	15%	
Medicaid MCO	5%	5%	5%	
Blue Cross	5%	5%	5%	
Other Commercial Insurance	5%	5%	5%	
Other (Specify)	5%	5%	5%	
TOTAL	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits				
Medicare	55%	55%	55%	
Medicare Advantage	10%	10%	10%	
Medicaid	15%	15%	15%	
Medicaid MCO	5%	5%	5%	
Blue Cross	5%	5%	5%	
Other Commercial Insurance	5%	5%	5%	
Self-Pay	5%	5%	5%	
Other (Specify)	0	0	0	
TOTAL	100%	100%	100%	100%

TABLE 5. STAFFING INFORMATION - 2026

Instructions: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours. **NOTE: PROVIDE A TABLE 5 FOR EACH PROJECTED YEAR.**

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	0.0	0.0	1.00	0.0	$70,000	-	$70,000	$0
Registered Nurse	0.0	0.0	0.80	0.0	$80,000	-	$64,000	$0
Licensed Practical Nurse	0.0	0.0	0.00	0.0	-	-	$0	$0
Physical Therapist	0.0	0.0	0.25	0.0	$75,000	-	$18,750	$0
Occupational Therapist	0.0	0.0	0.15	0.0	$75,000	-	$11,250	$0
Speech Therapist	0.0	0.0	0.05	0.0	$75,000	-	$3,750	$0
Home Health Aide	0.0	0.0	0.25	0.0	$44,000	-	$11,000	$0
Medical Social Worker	0.0	0.0	0.10	0.0	$90,000	-	$9,000	$0
Other – Nurse Supervisor	0.0	0.0	0.25	0.0	$85,000	-	$21,250	$0
Benefits (27%)							$56,430	$0
TOTAL							$265,430	$0

***** Method of calculating benefits cost

- Total wages (before benefits) = $209,000
- Benefits (27%) ≈ $56,430
- Total salary & benefit expense ≈ $265,430

This staffing pattern supports the 2026 visit volumes (about 1,050 billable visits) with reasonable productivity assumptions:

- RN ≈ 0.8 FTE for ~724 nursing visits
- HHA ≈ 0.25 FTE for 151 aide visits
- PT/OT/ST/MSW FTEs aligned with their smaller visit volumes
- 1.0 FTE administrative staff + 0.25 FTE nurse supervisor to manage operations and oversight.

TABLE 5. STAFFING INFORMATION - 2027

Instructions: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours. **NOTE: PROVIDE A TABLE 5 FOR EACH PROJECTED YEAR.**

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	0.0	0.0	1.20	0.0	$70,000	-	$84,000	$0
Registered Nurse	0.0	0.0	1.60	0.0	$80,000	-	$128,000	$0
Licensed Practical Nurse	0.0	0.0	0.00	0.0	-	-	$0	$0
Physical Therapist	0.0	0.0	0.45	0.0	$75,000	-	$33,750	$0
Occupational Therapist	0.0	0.0	0.32	0.0	$75,000	-	$24,000	$0
Speech Therapist	0.0	0.0	0.13	0.0	$75,000	-	$9,750	$0
Home Health Aide	0.0	0.0	0.55	0.0	$44,000	-	$24,200	$0
Medical Social Worker	0.0	0.0	0.23	0.0	$90,000	-	$20,700	$0
Other – Nurse Supervisor	0.0	0.0	0.40	0.0	$85,000	-	$34,000	$0
Benefits (27%)							$96,768	$0
TOTAL							$455,168	$0

TABLE 5. STAFFING INFORMATION - 2028

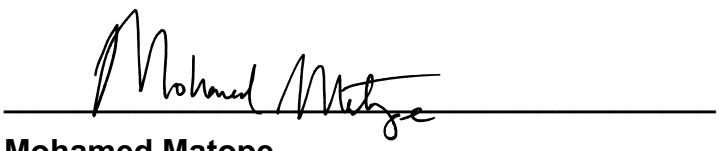
Instructions: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours. **NOTE: PROVIDE A TABLE 5 FOR EACH PROJECTED YEAR.**

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	0.0	0.0	1.00	0.0	$70,000	-	$98,000	$0
Registered Nurse	0.0	0.0	0.80	0.0	$80,000	-	$144,000	$0
Licensed Practical Nurse	0.0	0.0	0.00	0.0	-	-	$0	$0
Physical Therapist	0.0	0.0	0.25	0.0	$75,000	-	$63,750	$0
Occupational Therapist	0.0	0.0	0.15	0.0	$75,000	-	$30,000	$0
Speech Therapist	0.0	0.0	0.05	0.0	$75,000	-	$12,750	$0
Home Health Aide	0.0	0.0	0.25	0.0	$44,000	-	$35,200	$0
Medical Social Worker	0.0	0.0	0.10	0.0	$90,000	-	$24,300	$0
Other – Nurse Supervisor	0.0	0.0	0.25	0.0	$85,000	-	$42,500	$0
Benefits (27%)							$121,635	$0
TOTAL							$572,135	$0

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Date: 11/14/2025, 2025



Mohamed Matope
CEO & Director
Quality One Care Home Health, Inc.

EXHIBITS

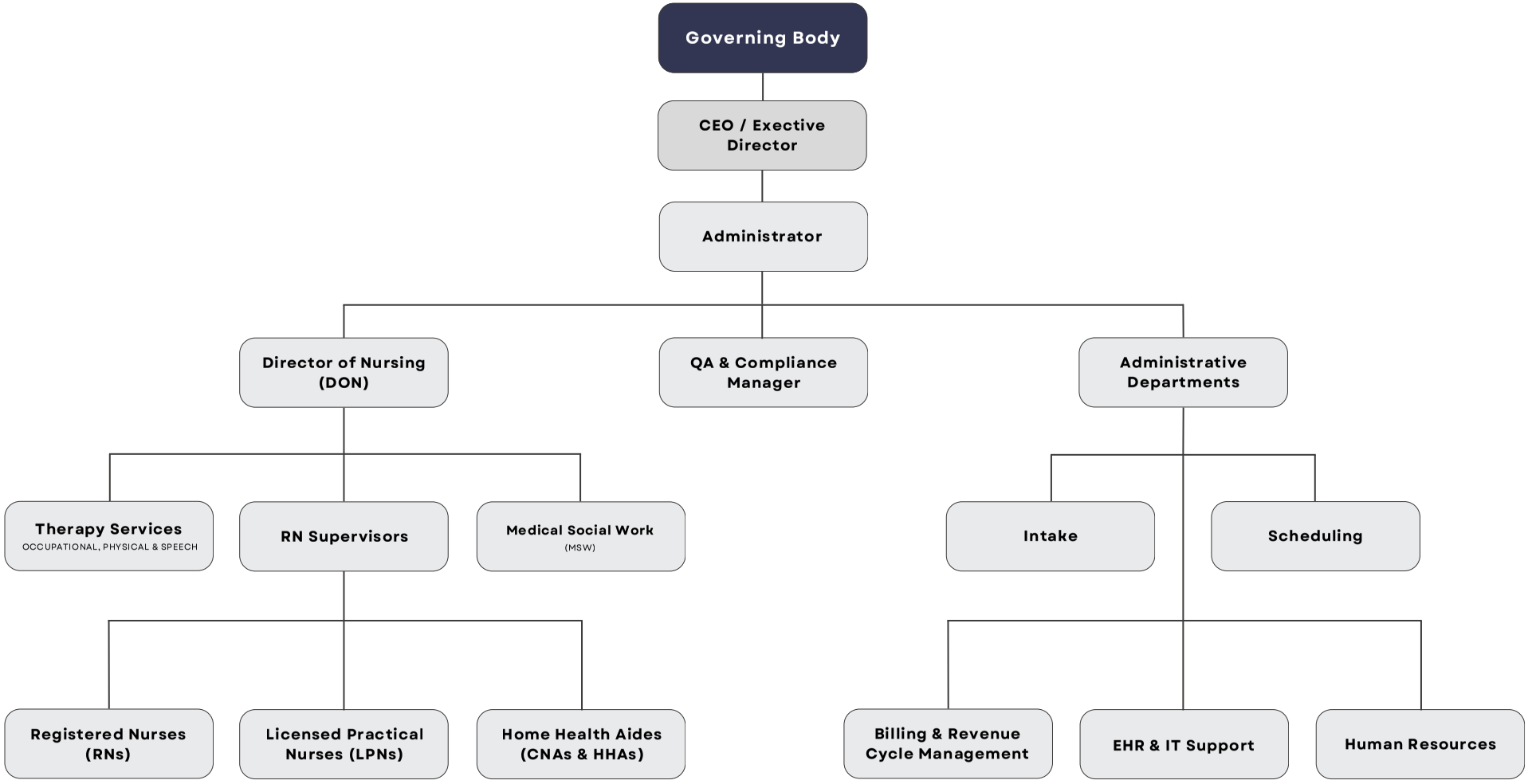
EXHIBIT 1

Organizational Chart

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

ORGANIZATIONAL CHART



QUALITY ONE CARE HOME HEALTH, INC

Home Health Agency Organizational Chart

EXHIBIT 2

Time Payment Plan Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
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Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

TIME PAYMENT PLAN POLICY

PURPOSE

The purpose of this policy is to ensure that all clients of Quality One Care Home Health, Inc. (QOC) are informed of available payment options and are provided reasonable means to pay for home health services if they are unable to remit full payment at the time services are rendered.

This policy supports compliance with COMAR 10.24.16.08D, which requires applicants to disclose fees and provide mechanisms for clients to arrange time payments.

POLICY STATEMENT

QOC is committed to providing transparency and fairness in billing practices.

- All fees will be disclosed to clients and families at the time of the initial assessment and prior to the initiation of services.
- Clients unable to make full payment may arrange time-payment plans through structured installment or deferred payments.
- No client shall be denied medically necessary services solely due to inability to make immediate payment.
- A written copy of this policy shall be submitted to the Maryland Health Care Commission (MHCC) and provided to each client upon admission.

SCOPE

This policy applies to all clients receiving home health services under Quality One Care Home Health, Inc. (QOC), including those covered by Medicare, Medicaid, private insurance, managed care organizations, and self-pay arrangements.

It governs all QOC personnel involved in client financial processes, including billing staff, clinical intake staff, financial counselors, administrators, and managers responsible for patient admissions, care coordination, or revenue-cycle operations.

This policy also applies to any contracted service providers or partner agencies acting on behalf of QOC in the delivery or billing of home health services. All individuals under this policy are responsible for ensuring consistent communication of service rates, payment options, and client

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financial rights in accordance with COMAR 10.24.16.08D and QOC's Financial Accessibility and Billing Policy.

PROCEDURES

The following procedures establish how Quality One Care Home Health, Inc. (QOC) implements this policy to ensure consistent communication of service fees and payment options to every client. QOC staff are responsible for explaining fees, documenting client acknowledgment, and assisting clients in arranging payment plans when needed. These procedures apply at every stage of admission and continue through the billing and follow-up process to maintain transparency and compliance with COMAR 10.24.16.08D**.**

➢ Fee Disclosure

1) At the time of admission or initial assessment, clients and families will receive a written fee schedule detailing the following:
   a) Service rates (per-visit charges)
   b) Payor options (insurance, Medicare, Medicaid, private pay)
   c) Available payment arrangements, including the time-payment plan
2) Staff will review payment options verbally and answer client questions before services begin.
3) Clients will sign a Fee Disclosure and Payment Options Acknowledgment Form, which will be filed in their financial record.

➢ Eligibility for Time Payment Plan

1) Clients may request a time-payment plan if they demonstrate inability to pay in full at the time of service.
2) Eligibility is determined by the Billing Specialist or Administrator based on client discussion and documented financial need.
3) No credit checks or collateral requirements are imposed.
4) Participation in a payment plan does not affect eligibility for insurance or charity care consideration under separate policy

➢ Payment Plan Terms

Quality One Care Home Health, Inc. (QOC) offers structured and flexible payment plans designed to accommodate clients who are unable to make full payment at the time

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services are rendered. Each plan is established through mutual agreement between the client and QOC's billing department, ensuring clarity, fairness, and transparency in all financial arrangements. The following terms outline the standard structure, calculation, and documentation requirements for all time-payment agreements.

1) The standard payment period will not exceed six (6) months, unless an extension is approved by the Administrator.
2) Monthly installment amounts are calculated by dividing the total balance by the number of months in the plan.
3) Payment plans are interest-free and carry no administrative fees.
4) Each agreement must include:
   a) Client name and account number
   b) Services covered and total amount owed
   c) Payment schedule (amounts and due dates)
   d) Signatures of client (or responsible party) and QOC billing representative
5) Clients receive a copy of the signed agreement, and QOC retains the original in the billing file.

➢ Financial Counseling and Assistance

Quality One Care Home Health, Inc. (QOC) provides free financial counseling to all clients as part of its commitment to financial transparency and accessibility. A designated Financial Counselor assists clients in reviewing insurance coverage, estimating expected out-of-pocket costs, and identifying appropriate payment options.

The counselor also helps determine eligibility for Medicaid, Medicare, or other financial assistance programs and works with clients to establish or modify payment plans as needed. All financial counseling interactions and recommendations are documented in the client's admission record to ensure continuity and accountability.

➢ Review and Adjustment of Payment Plans

Clients who experience financial hardship may request a review of their existing payment plan at any time. Upon submission of an updated financial disclosure, Quality One Care Home Health, Inc. (QOC) may extend or modify the payment schedule to accommodate the client's circumstances. All proposed adjustments must receive approval from the Administrator and be signed by both the client and QOC's billing representative. Revised

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agreements are documented and securely retained in the client's billing file to ensure accurate recordkeeping and compliance.

➢ Confidentiality and Data Protection

All financial and billing information, including payment plans, shall be treated as confidential and maintained in compliance with HIPAA and QOC's Privacy Policy**.** Access to such information is restricted to authorized administrative and billing staff only.

➢ Oversight and Quality Assurance

The Administrator or designee will conduct quarterly reviews of all active payment plans to ensure compliance with this policy, fair and consistent application, and client satisfaction. All findings from these reviews will be documented in the agency's Financial Accessibility Audit Report, which serves as a record of internal monitoring activities. Any identified discrepancies or noncompliance issues are promptly addressed and corrected within 30 days, ensuring continuous adherence to Quality One Care Home Health, Inc.'s financial accessibility standards and MHCC regulatory requirements.

➢ Policy Review and Revision

This policy will be reviewed annually by the Administrator and updated as needed to maintain compliance with MHCC standards, COMAR 10.24.16.08D, and industry best practices. Any revisions will be submitted to MHCC as appropriate following administrative approval.

➢ Staff Responsibilities

The successful implementation of this policy relies on clear staff roles and coordination. The Intake Nurse or Care Coordinator is responsible for discussing fees and payment options with the client and family during the initial assessment. The Billing Specialist evaluates client eligibility, prepares payment plan documents, and monitors payment activity to ensure timely follow-up. The Financial Counselor assists clients in understanding their financial options, reviews insurance and assistance program eligibility, and provides ongoing support throughout the payment process.

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The Administrator oversees the program by approving exceptions, reviewing the policy annually, and ensuring compliance reporting to maintain alignment with MHCC and COMAR requirements.

➢ Documentation and Record Retention

Quality One Care Home Health, Inc. (QOC) maintains complete and accurate records of all time-payment agreements and related correspondence to ensure accountability and compliance. Signed copies of payment plans are securely stored in each client's billing file, both electronically and in hard copy, for a minimum of five (5) years following resolution of the account. Access to these records is restricted to authorized administrative and billing personnel. QOC conducts annual internal audits to verify documentation accuracy, confirm adherence to policy requirements, and identify opportunities for process improvement.

➢ Compliance Statement

Quality One Care Home Health, Inc. (QOC) affirms that this Time Payment Plan Policy is fully compliant with the requirements of COMAR 10.24.16.08D. The policy ensures that all clients receive clear, written information regarding service fees and available payment options before services are rendered, in accordance with Maryland Health Care Commission standards. It establishes a fair and accessible mechanism for clients to arrange installment or deferred payments without discrimination, penalty, or interruption of care. Through this policy, QOC demonstrates its ongoing commitment to financial transparency, client protection, and equitable access to home health services for all individuals within its service area.

EXHIBIT 3

Private Pay Fee Schedule

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

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Projected Private-Pay Fee Schedule

Quality One Care Home Health, Inc. (QOC) Proposed Home Health Agency Service Area: Baltimore City, Baltimore County, and Howard County

OVERVIEW

Quality One Care Home Health, Inc. (QOC) has developed its projected private-pay fee schedule based on market comparables and data reported by the Maryland Health Care Commission (MHCC) in the *Maryland Home Health Agency Annual Survey for Fiscal Year 2023 (Table 20)*.

These rates represent reasonable, regionally aligned per-visit fees for core home health services and reflect the prevailing market averages for the Baltimore City–Baltimore County–Howard County region.

The projected private-pay rates will apply to self-pay clients and serve as a benchmark for payer contract negotiations and rate transparency disclosures provided to clients during admission and assessment.

Projected Private-Pay Fee Schedule

Service Type (Per Visit)	Projected Fee
Skilled Nursing	$225
Physical Therapy	$200
Occupational Therapy	$200
Speech Therapy	$200
Medical Social Work	$375
Home Health Aide	$175

Source: Maryland Health Care Commission (MHCC) – Maryland Home Health Agency Annual Survey for Fiscal Year 2023 – Table 20: Average Per-Visit Charges by Discipline, Baltimore City–Baltimore County–Howard County Region.

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Notes

- These projected rates are intended for private-pay clients and are consistent with regional averages reported by MHCC.
- Final billing rates will be updated annually following publication of the MHCC *Home Health Agency Annual Survey* and review by QOC's Administrator and Finance Department.
- All clients will receive written notice of applicable service rates during the admission process, in accordance with COMAR 10.24.16.08D and QOC's Financial Accessibility and Billing Policy.

Compliance Statement

This Projected Private-Pay Fee Schedule3 demonstrates that QOC's projected private-pay rates are reasonable, transparent, and aligned with MHCC-reported regional benchmarks, ensuring financial accessibility and compliance with Maryland's home health regulatory standards.

EXHIBIT 4

Charity Care & Sliding Fee Scale Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

Charity Care and Discount Policy

I. PURPOSE

Quality One Care Home Health, Inc. ("Quality One Care") or "QOC") is committed to ensuring that all individuals, regardless of their financial circumstances, have access to medically necessary home health services. The purpose of this policy is to clearly define how QOC provides charity care, discounted services, and interest-free payment plans to eligible patients who are uninsured, underinsured, or otherwise unable to pay.

This policy aligns with QOC's mission of serving underserved and medically complex populations and complies with all applicable federal and state regulations, including **COMAR 10.24.16.08E**, **COMAR 10.24.01.08G(3)(f)**, COMAR 10.24.01.09 and CMS Conditions of Participation as well as all applicable federal and state regulations.

QOC will not deny, delay, or discontinue medically necessary care based on a patient's inability to pay.

II. POLICY STATEMENT

Quality One Care ensures equitable access to care through the following commitments:

1. Provide **charity care (free care)** to patients with household income at or below **100% of the Federal Poverty Level (FPL)**.
2. Provide **discounted care** on a sliding scale to patients with income up to **200% of FPL**, at minimum, and up to 300% FPL based on financial hardship.
3. Offer **interest-free payment plans** to patients who do not qualify for full charity care.
4. Never charge interest, late fees, or use aggressive collection practices.
5. Not refuse, limit, or discontinue services based on inability to pay.
6. Inform all patients of the availability of charity care and discounts, both verbally and in writing, in English and Spanish and other languages as needed.
7. Make this policy publicly available in physical locations and on the agency's website.
8. Report charity care annually to the Maryland Health Care Commission (MHCC) as required.

III. DEFINITIONS

Charity Care:
Medically necessary services provided **at no cost** to eligible patients with income ≤100% FPL or those who demonstrate financial hardship.

Discounted Care:
Reduced charges based on a sliding fee scale for patients with income between 101%–300% FPL.

Financial Hardship:
A situation in which medical expenses, loss of income, or extraordinary circumstances prevent a patient from paying for necessary care, even if income exceeds standard thresholds.

Uninsured Patient:
An individual without any third-party health insurance coverage.

Underinsured Patient:
A patient whose insurance does not cover all medically necessary services or who faces high deductibles, coinsurance, or copayments.

Household Income:
Combined gross income of all household members, as defined by federal guidelines.

Family Size:
As defined by current Federal Poverty Level (FPL) guidelines.

Medically Necessary Services:
Skilled home health services ordered by a physician and delivered under a plan of care.

IV. ELIGIBILITY CRITERIA

A patient may qualify for charity care or discounted services if they meet **any** of the following:

- Family Size or household income at or below 300% of FPL (with sliding scale applied)
- High out-of-pocket medical expenses, exceptional medical hardship or extraordinary medical expenses relative to income
- Significant change in financial circumstances (job loss, divorce, death in family, disability, etc.)
- Participation in needs-based government assistance programs (e.g., Medicaid, SNAP, SSI)
- Uninsured/Underinsured status – Status does not automatically disqualify patient

Patients with insurance may still qualify if they have high out-of-pocket responsibility or financial hardship.

V. SLIDING FEE SCALE (By % of Federal Poverty Level)

QOC uses the current Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services and updates the scale annually.

Household Income (% of FPL)	Patient Responsibility	Discount Applied
0–100%	0%	100% (Full Charity Care – No Charge)
101–150%	25% of charges	75% Discount
151–200%	50% of charges	50% Discount
201–250%	75% of charges	25% Discount
251–300%	Case-by-case (up to 25% discount)	Hardship Discount
>300%	May qualify for hardship discount or payment plan	Determined individually

Note: *The sliding fee scale will be updated annually based on the current Federal Poverty Guidelines published by the U.S. Department of Health and Human Services.*

QOC may provide additional discounts beyond the minimum requirements in cases of verified financial hardship, extraordinary medical expenses or exceptional circumstances.

VI. APPLICATION PROCESS

Patients may request charity care or discounted services at any time, including before, during, or after care.

How to Apply:

- Complete the Financial Assistance Application form
- Provide proof of income (e.g., tax return, pay stub, W-2, benefits statement)
- Provide proof of household size
- Provide documentation of medical expenses or hardship if requested

QOC Responsibilities:

- Provide the application in English, Spanish, and other languages as needed
- Assist patients in completing the application
- Make reasonable efforts to verify information when documents are unavailable
- Process applications within **10 business days**
- Notify patients in writing of approval or denial
- Apply approved discounts **retroactively for up to 90 days**

Important: Care will not be denied or delayed while an application is pending.

Failure to provide documentation may result in denial; however, QOC will make reasonable efforts to verify eligibility through alternative means.

VII. PAYMENT PLANS

Patients who do not qualify for full charity care may set up an **interest-free payment plan** based on their ability to pay. Monthly payments will not exceed a reasonable percentage of household income.

What to Expect:

- Affordable monthly payments
- Flexible terms
- No interest or late fees
- May be extended or adjusted for hardship
- No aggressive collections

VIII. COMMUNICATION OF POLICY

QOC will make this policy available:

- At admission or referral
- During financial counseling
- In patient handbooks or welcome packets
- On the agency website
- In publicly accessible office areas
- In English, Spanish, and other languages appropriate to the service area or as needed.

Staff will verbally inform patients of the availability of charity care and assist them in applying. Interpreter services for other languages are available at no cost to the patient.

IX. NON-DISCRIMINATION

QOC does not discriminate in the provision of charity care, discounted services, or payment plans based on:

- Race or ethnicity
- Color
- National origin
- Religion
- Sex, gender identity, or sexual orientation
- Age
- Disability
- Marital or family status
- Veteran status
- Immigration status
- Insurance status
- Any other protected characteristic

Eligibility is based solely on financial need and medical necessity.

X. CONFIDENTIALITY

All financial and personal information submitted by the patient is:

- Kept confidential
- Used only for determining eligibility
- Protected under HIPAA and other privacy laws
- Never shared with external entities except as required by law

XI. REPORTING AND COMPLIANCE

QOC will:

- Track all charity care and discount services
- Maintain documentation for auditing purposes
- Report charity care annually to the Maryland Health Care Commission (MHCC) and other agencies as required
- Comply with **COMAR 10.24.16.08E**

XII. QUALITY AND PERFORMANCE MONITORING

As part of QOC's **Quality Assurance and Performance Improvement (QAPI)** program:

- Utilization of charity care will be reviewed to ensure access
- Barriers to care will be identified and addressed
- Trends in service needs will inform resource planning
- Policy effectiveness will be reviewed annually

XIII. GOVERNANCE AND POLICY REVIEW

- This policy will be reviewed and updated at least **annually**
- Sliding fee scale will be updated annually according to the latest FPL guidelines
- Significant changes will be approved by senior leadership or governing body
- Staff will receive training on any revisions

XIV. NO DELAY OR DENIAL OF SERVICE

QOC will **not delay, deny, or discontinue** medically necessary services due to a patient's inability to pay or due to charity/discount application status.
No patient will be referred to collections or incur negative action while an application is pending.

EXHIBIT 4A

Sliding Fee Scale Tables

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

SLIDING FEE SCALE TABLES

Effective Date: 2025

Based on the Federal Poverty Guidelines (FPG)

This Sliding Fee Scale is used to determine the level of financial assistance available to eligible clients of Quality One Care Home Health, Inc. (QOC). Discount levels are determined by household income and size, as verified through the QOC Financial Assistance Application.

INCOME ELIGIBILITY & DISCOUNT TABLE

All percentages refer to Federal Poverty Guideline (FPG) thresholds.

Household Income as % of FPG	Discount Level	Client Responsibility
0% – 200% of FPG	100% Discount (Full Charity Care)	$0 owed
201% – 300% of FPG	75% Discount	25% of charges
301% – 350% of FPG	50% Discount	50% of charges
351% – 400% of FPG	25% Discount	75% of charges
Above 400% of FPG	Standard Charges Apply – Unless Financial Hardship is documented	May qualify for Time-Payment Plan or Special Hardship Review

HOUSEHOLD INCOME TABLE – 2025 FEDERAL POVERTY GUIDELINES

(Effective January 2025 — official HHS values)

Household Size	100% FPG	200% FPG	300% FPG	400% FPG
1	$15,650	$31,300	$46,950	$62,600
2	$21,150	$42,300	$63,450	$84,600
3	$26,650	$53,300	$79,950	$106,600
4	$32,150	$64,300	$96,450	$128,600
5	$37,650	$75,300	$112,950	$150,600
6	$43,150	$86,300	$129,450	$172,600
7	$48,650	$97,300	$145,950	$194,600
8	$54,150	$108,300	$162,450	$216,600

For households larger than eight (8), add $5,500 for each additional person at the 100% FPG level, then multiply accordingly for higher percentages. larger than 8, add $5,140 per additional person (100% FPG baseline). Values are updated each year when HHS issues new guidelines.

PROGRAM NOTES

- Determinations are based on **gross household income** and documentation submitted.
- Clients with **special financial hardship** may request individualized review.
- Discounts apply only to medically necessary home health services.
- Probable eligibility is determined within **two business days**, as required by Maryland law.

POSTING REQUIREMENT

This chart must be posted:

- In the QOC main office
- On the official website
- In all service intake areas
- Included in client admission packets

*For questions or assistance, call QOC at **301-658-7141** or email **info@qualityonecare.com**.*

EXHIBIT 4B

Health Equity & Character & Competence Worksheet

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

HEALTH EQUITY & CHARITY CARE COMPLIANCE WORKSHEET

Applicant: Quality One Care Home Health, Inc. (QOC)
Project Type: Establishment of a Home Health Agency (HHA)
Jurisdictions Served: Baltimore City, Baltimore County, and Howard County
Regulatory Reference: COMAR 10.24.16.08E – Charity Care and Sliding Fee Scale

COMAR STANDARDS	Quote from the policy	Section citation
10.24.16.08E Charity Care and Sliding Fee Scale Each applicant for home health agency services shall have **a written policy** for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low-income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:		
1.Determination of Eligibility for Charity Care and Reduced Fees. Within **two business days following a client's initial request for charity care services**, **application for medical assistance, or both, the home health agency shall make a determination of probable eligibility** for medical assistance, charity care, and reduced fees, and **communicate** this probable eligibility determination to the client.	"QOC will make a **probable eligibility determination within two business days** of: (1) A request for charity care, (2) Submission of a financial assistance application, or (3) Submission of a Medical Assistance (Medicaid) application." During the first contact or upon referral, QOC will assess family size, insurance status, household income, and financial resources to determine probable eligibility." "Care will **not be denied or delayed** while an application is pending."	QOC Charity Care Assessment & Financial Assistance Policy — **Section V: Determination of Probable Eligibility** QOC Charity Care & Discount Policy — **Section VI: Application Process**

2.Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's **charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area** population. Notices regarding the HHA's charity care and sliding fee scale policies shall be **posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients' or clients' families concerns with payment for HHA services** and **provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.**	**Public Notice Statement:** "Quality One Care Home Health, Inc. (QOC) will make home health care available to all adult residents… Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. **Probable eligibility will be determined within two business days**." "QOC will make this policy available: at admission, during financial counseling, in patient packets, on the website, and in publicly accessible office areas, in English, Spanish, and other languages."	QOC Charity Care Public Notice — **Public Notice Statement** QOC Charity Care & Discount Policy — **Section VIII: Communication of Policy** QOC Sliding Fee Scale Tables — **Posting Requirement Section**
3.Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall **include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care but are unable to bear the full cost of services.**	**Sliding Fee Scale:** "0–200% FPG — 100% Discount (Full Charity Care) 201–300% FPG — 75% Discount 301–350% FPG — 50% Discount 351–400% FPG — 25% Discount Above 400% FPG — hardship review or time-payment plan." "QOC provides charity care to patients with income at or below 100% FPL and discounted care up to 300% FPL."	QOC Sliding Fee Scale Tables — **Income Eligibility & Discount Table** QOC Charity Care & Discount Policy — **Section V: Sliding Fee Scale** QOC Time Payment Plan Policy — **Payment Plan Terms**

4. Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, **provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve** during the most recent year for which data is available. The applicant shall demonstrate that: (a) **Its track record** in the provision of charity care services, if any, supports the credibility of its commitment; and (b) **It has a specific plan** for achieving the level of charity care to which it is committed.	"QOC will **not deny, delay, or discontinue** medically necessary care based on inability to pay." "QOC does not discriminate in the provision of charity care… based on race, ethnicity, national origin, gender, age, disability, immigration status, insurance status, or any protected characteristic." "QOC provides charity care (free care) to patients ≤100% FPL and discounted care up to 300% FPL." "Probable eligibility will be determined within two business days… Discounts may be applied retroactively for up to 90 days." "Utilization of charity care will be reviewed to ensure access… Policy effectiveness will be reviewed annually."	QOC Charity Care & Discount Policy — **Sections II, IX & XII** QOC Charity Care Assessment & Financial Assistance Policy — **Section V**

EXHIBIT 4C

Charity Care Assessment & Financial Assistance Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

Charity Care Assessment & Financial Assistance Policy

I. PURPOSE

Quality One Care Home Health, Inc. ("Quality One Care") or "QOC") is committed to ensuring that all individuals, regardless of their financial circumstances, have access to medically necessary home health services.

The purpose of this policy is to establish clear, compliant, and equitable policies for assessing and providing financial assistance, including charity care, sliding fee scale discounts, and time-payment arrangements, to eligible clients of QOC.

This policy aligns with QOC's mission of serving underserved and medically complex populations and complies with all applicable federal and state regulations, including **COMAR 10.24.16.08E**, **COMAR 10.24.01.08G(3)(f)**, COMAR 10.24.01.09 and CMS Conditions of Participation as well as all applicable federal and state regulations.

QOC will not deny, delay, or discontinue medically necessary care based on a patient's inability to pay.

II. POLICY STATEMENT

Quality One Care Home Health, Inc. (QOC) is committed to ensuring access to high-quality home health services for all adult residents of its licensed service area, including individuals who are uninsured, underinsured, or experiencing financial hardship. QOC does not discriminate based on race, color, creed, gender, age, sexual orientation, gender identity, national origin, disability, or financial status.

Clients who lack adequate insurance coverage and demonstrate inability to pay may qualify for:

- Charity care (free or reduced-cost services)
- Sliding fee scale discounts based on Federal Poverty Guidelines
- Time-payment plans allowing extended, affordable repayment options

QOC will make timely determinations of probable eligibility in accordance with MHCC regulations.

III. PUBLIC NOTIFICATION

In compliance with Maryland regulations, QOC will publicly communicate its Charity Care and Financial Assistance policies through:

- Notices posted prominently in QOC business offices,
- Information published on QOC's official website,
- Annual newspaper publication within the service region.

Required Notice Language:

"Quality One Care Home Health, Inc. (QOC) will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301-658-7141."

IV. PAYMENT EXPECTATIONS & TIME-PAYMENT PLANS

Clients who do not qualify for Medicaid, insurance reimbursement, or charity care are responsible for payment of services rendered. QOC will:

- Issue billing statements over a three-month cycle,
- Provide follow-up communication after the second billing notice,
- Offer time-payment plans with minimum monthly payments as low as $10,
- Allow repayment periods up to 18 months based on financial circumstances.

V. DETERMINATION OF PROBABLE ELIGIBILITY

QOC will make a **probable eligibility determination within two business days** of:

- A request for charity care,
- Submission of a financial assistance application,
- Submission of a Medical Assistance (Medicaid) application.

During the first contact or upon referral, QOC will assess:

- Family size,
- Insurance status,
- Household income and available financial resources.

Probable Eligibility Guidance:

1. If the client has applied for Medicaid, QOC will treat the client as Medicaid-pending unless a denial occurs.
2. If the client:
    - Lacks insurance,
    - Is not eligible for Medicaid, and
    - Demonstrates insufficient income or resources, the client will be considered probably eligible for charity care or sliding-scale discounts.

Clients will receive written communication of probable eligibility determination.

VI. FINAL ELIGIBILITY DETERMINATION

1. Final charity care eligibility must be determined by QOC. A client's self-declaration of inability to pay is not considered adequate proof.
2. Clients who have applied for Community Medicaid and completed required documentation may be accepted as “Medicaid Pending.” In these cases, no QOC charity form is required, but QOC will monitor Medicaid application progress.
3. QOC will assess total financial resources, including disposable income, assets, and ordinary living expenses.
4. QOC must confirm that no other party is legally responsible for the patient’s medical expenses.

VII. SLIDING FEE SCALE

QOC will apply sliding-scale discounts based on the most current **Federal Poverty Level (FPL)** guidelines (See Exhibit on Federal and State FPL Guidelines). Eligibility and discount tiers will be published annually and included in the client information packet.

VIII. DOCUMENTATION REQUIREMENTS

Clients applying for charity care, sliding-scale discounts, or time-payment arrangements may be required to provide:

- Proof of income (pay stubs, tax return, benefits statements),
- Household size verification,
- Medicaid denial letter (if applicable),
- Documentation of financial hardship or catastrophic events.

QOC will maintain confidentiality and handle all documentation in compliance with HIPAA and state privacy laws.

IX. STAFF RESPONSIBILITIES & TRAINING

QOC staff responsible for intake, billing, and financial assistance review shall be trained annually in:

- Eligibility determination procedures,
- Federal and state regulatory requirements,
- Communication of patient rights and available financial options.

X. RECORDKEEPING & COMPLIANCE

QOC will maintain records of:

- All applications received,
- Probable and final eligibility determinations,
- Correspondence with clients regarding financial assistance,
- Annual publication notices.

Records will be retained in accordance with MHCC, Medicare Conditions of Participation, and state recordkeeping requirements.

XI. POLICY REVIEW

This policy will be reviewed annually and updated to reflect QOC operational updates, regulatory changes, and changes to Federal Poverty Guidelines.

XII. REGULATORY AUTHORITY

This policy is established in accordance with the following Maryland laws and regulations:

- **COMAR 10.24.16** – Home Health Agency Regulations
- **COMAR 10.24.10** – Certificate of Need Procedures
- **COMAR 10.24.01.08G** – Charity Care Standards
- **Maryland Health–General §19-214.1** – Billing & Financial Assistance Notice Requirements

XIII. DEFINITIONS

Charity Care: Free or discounted services provided to eligible clients based on financial hardship.
Sliding Fee Scale: A structured discount schedule tied to Federal Poverty Level (FPL) income brackets.
Probable Eligibility: A preliminary determination made within two business days based on available information.
Financial Hardship: A circumstance in which a client lacks sufficient income or assets to pay for medically necessary care.
Medicaid Pending: Status given to a client who has applied for Medical Assistance but has not yet received a determination.

XIV. SLIDING FEE SCALE

QOC applies a transparent, annually updated sliding fee scale based on Federal Poverty Guidelines:

- **0–200% FPL:** 100% discount (free care)
- **200–300% FPL:** 75% discount
- **300–350% FPL:** 50% discount
- **350–400% FPL:** 25% discount
- **Above 400% FPL:** May be eligible for time-payment plans or special hardship review.

A full version of the Sliding Fee Schedule will be included in the QOC client information packet and posted publicly.

XV. PATIENT RIGHTS

All clients receiving services from QOC have the right to:

- Apply for charity care, sliding-scale discounts, or time-payment arrangements.
- Receive a probable eligibility determination within two business days.
- Receive written notification of approval, denial, or need for additional documentation.
- Appeal any denial of financial assistance.
- Receive medically necessary services without discrimination, delay, or retaliation.

Applying for financial assistance **will not** affect the quality, timeliness, or availability of services.

XVI. APPEALS AND RECONSIDERATION

Clients may request reconsideration of any denial within **15 days** of notification. Appeals must be submitted in writing and may include new or updated financial information.

QOC will review and respond to appeals within **10 business days** of receipt.

XVII. DOCUMENTATION & RETENTION REQUIREMENTS

QOC will retain all charity care applications, probable eligibility determinations, final eligibility decisions, appeals and associated outcomes, and all financial documentation used in determining eligibility for a minimum of seven (7) years. These records will be securely maintained in compliance with HIPAA requirements and all applicable Maryland state privacy regulations.

XVIII. ANNUAL REVIEW & APPROVAL AUTHORITY

This policy will be reviewed annually, and all revisions must be approved by the QOC Administrator and the QOC Compliance Officer. Updates will reflect regulatory changes, MHCC CON requirements, and modifications to operational practices.

IX. NON-RETALIATION ASSURANCE

QOC strictly prohibits retaliation or any adverse action against clients who request financial assistance, apply for charity care or sliding-scale discounts, or appeal a financial determination. Medical services will not be delayed or denied while a charity care application is being processed.

EXHIBIT 4D

Charity Care Public Notice

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

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Home Health, Inc
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Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328
Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

QOC Charity Care Public Notice

Quality One Care Home Health, Inc. (QOC) will make home health care available to all adult residents of its service area regardless of race, creed, gender, age, sexual orientation, national origin, or financial status. If insurance coverage is not available for reimbursement, patients or guarantors are responsible for payment. Individuals unable to pay may apply for charity care, sliding fee scale discounts, or a time-payment plan. Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance. Assistance amounts are based on Federal Income Poverty Guidelines. For information or applications, call 301-658-7141.

EXHIBIT 4E

Charity Care Application Form

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

CHARITY CARE & FINANCIAL ASSISTANCE APPLICATION FORM

This application is used to determine eligibility for Charity Care, Sliding-Scale Discounts, or Time-Payment Arrangements under the Quality One Care Home Health, Inc. (QOC) Charity Care and Financial Assistance Program.

Applicants must complete all sections and provide required documentation. Incomplete applications may delay processing.

SECTION 1 — APPLICANT INFORMATION

Name: _____

Date of Birth: ____ / ____ / _____

Social Security Number: –_____

Home Address: _____

City _____ State _____ ZIP _____

Phone (Home): _____ **Phone (Cell):** _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

U.S. Citizen: ☐ Yes ☐ No

Permanent Resident: ☐ Yes ☐ No

Employer: _____

Employer Address: _____

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

SECTION 2 — HOUSEHOLD MEMBERS

List all members of your household, including yourself.

Name	Age	Relationship	Income (Monthly)

SECTION 3 — MEDICAL ASSISTANCE / INSURANCE STATUS

Have you applied for Medicaid/Medical Assistance? ☐ Yes ☐ No

If yes, **Date Applied:** ____ / ____ / _____

Status: ☐ Pending ☐ Approved ☐ Denied

Do you receive any state or county assistance? ☐ Yes ☐ No

If Yes, Describe:

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

SECTION 4 — MONTHLY INCOME

List gross monthly income for all sources. Attach documentation for each applicable item.

Income Source	Monthly Amount
Employment	_____
Retirement/Pension	_____
Social Security	_____
Disability	_____
Public Assistance	_____
Unemployment	_____
Veterans Benefits	_____
Alimony	_____
Rental Income	_____
Self-Employment	_____
Other: _____	_____

Total Monthly Income: _____

SECTION 5 — ASSETS

Liquid Assets

Asset Type	Current Balance
Checking Account	_____
Savings Account	_____
CDs / Bonds / Money Market	_____
Other Liquid Assets	_____

Total Liquid Assets: _____

QOC Quality One Care
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Other Assets

Asset Type	Approximate Value	Loan Balance
Home	_____	_____
Automobile (Make/Year): _____	_____	_____
Second Vehicle (Make/Year): _____	_____	_____
Additional Property	_____	_____

SECTION 6 — MONTHLY EXPENSES

Expense Type	Monthly Amount
Rent/Mortgage	_____
Utilities	_____
Car Payment(s)	_____
Credit Card(s)	_____
Insurance (Car/Health)	_____
Medical Expenses	_____
Food/Other	_____

Total Monthly Expenses: _____

Do you have unpaid medical bills? ☐ Yes ☐ No

If yes, for what service(s)? _____

If you already have a payment plan, **monthly payment amount:** _____

SECTION 7 — DOCUMENTATION CHECKLIST

Please attach copies (not originals) of the following, when applicable:

- ☐ Last 3 months of pay stubs
- ☐ Employer income verification letter
- ☐ Last year's tax return (if self-employed)
- ☐ 3 months of bank statements
- ☐ Social Security / pension award letters
- ☐ Public assistance or benefit letters
- ☐ Letter of support (if another person provides housing/food)
- ☐ Medicaid denial or approval letter (if applicable)

SECTION 8 — CERTIFICATION & SIGNATURE

I certify that the information provided in this application is accurate and complete. I understand that Quality One Care Home Health, Inc. may request additional information to determine eligibility. I agree to notify QOC of any changes to my financial situation within 10 days.

Applicant Signature: _____
Date: ____ / ____ / _____
Relationship to Patient/Client (if not applicant): _____

Submit completed application and documentation to:
Quality One Care Home Health, Inc.
RE: Client Financial Services Department
Address: 9221 Colesville Road, Silver Spring, MD 20910
Phone: 301-658-7141 / Fax: 301-658-2328
Email: info@qualityonecare.com

EXHIBIT 5

Financial Tables & Statement of Assumptions

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328
Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

FINANCIAL PROJECTIONS & STATEMENT OF ASSUMPTIONS

Baltimore City, Baltimore County, and Howard County

The following financial assumptions support the projected revenues, expenses, and operating results presented in Table 4 for Quality One Care Home Health, Inc.'s proposed Medicare-certified Home Health Agency serving Baltimore City, Baltimore County, and Howard County. These projections are based on conservative, evidence-driven estimates that reflect current Maryland Health Care Commission (MHCC) utilization data, established regional reimbursement patterns, and realistic staffing and operational cost structures.

The assumptions demonstrate that the proposed project is financially feasible, sustainable, and consistent with the requirements of COMAR 10.24.16.08F, which mandates that applicants show the ability to provide high-quality home health services without creating unnecessary costs to the health care delivery system. Each assumption corresponds directly to a revenue or expense category in Table 4 and reflects the expected clinical, operational, and payer-mix characteristics of the tri-county service area.

1. Reporting Basis

- The projections are presented on a **calendar year basis (CY)** and in **current dollars**, consistent with MHCC financial reporting requirements.
- The projection period is CY 2026 (Year 1) through CY 2028 (Year 3).

2. Utilization and Volume Assumptions

- Service Area Demand: Projected visit volume is supported by historic MHCC data showing the tri-county region generated over 528,000 visits in FY 2023. QOC's Year 1 volume (1,050 visits) is conservatively projected at less than 1% of this regional total.
- RN Productivity: Projected at 2.2–3.0 visits per day, aligning with industry standards and supporting the calculated FTEs in Table 5.
- Therapist Productivity: Projected at 2.0–2.5 visits per day, aligning with industry standards.
- HHA Productivity: Projected at 4–5 hours/day depending on case mix , reflecting typical utilization of home health aide services.

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328
Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

3. Revenue Assumptions (Payer Mix, Allowances, and Charity Care)

Metric	Source / Basis of Assumption	Regulatory Alignment
Gross Patient Service Revenue (GPSR)	Based on projected visit volume and current Maryland Medicare and Medicaid reimbursement ceilings.	COMAR 10.24.16.08F(2)
Payer Mix	Aligns with MHCC Table 20 (FY 2023), confirming a Medicare-dominant population in the Baltimore Metropolitan Area (>70%).	COMAR 10.24.16.08C
Medicare Reimbursement	Based on CY 2024 Maryland-specific Home Health Prospective Payment System (HH PPS) payment levels, including the Baltimore CBSA wage index.	Consistent with actual realizable revenue experienced by comparable HHAs.
Medicaid Reimbursement	Based on Maryland Medicaid fee schedules in effect at submission.	Consistent with payment patterns of existing agencies.
Private-Pay Rates	Uses rates consistent with QOC's projected Private Pay Fee Schedule (**Exhibit 3**).	Rates are transparent and aligned with MHCC Table 20 regional averages.
Allowance for Bad Debt	Projected at approximately **0.6% of GPSR**, reflecting organizational historical experience.	Consistent with statewide norms.
Contractual Allowances	Range from **22–24% of GPSR**, calculated using the difference between gross charges and expected net PPS/fee-for-service reimbursement.	Consistent with standard adjustments for negotiated payer discounts and Medicare sequestration.
Charity Care	Projected at approximately **0.5% of GPSR**. This amount meets or exceeds the minimal levels observed in the Baltimore Metropolitan Area (MHCC Table 25).	Consistent with QOC's commitment under **COMAR 10.24.16.08E**.
Non-Operating Income	**None projected**, as QOC anticipates no grants, donations, or non-operating revenue during the projection period.	Supports a sustainable model based on core service operations.

QOC Quality One Care
Home Health, Inc
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Email: info@qualityonecare.com / Web: http://www.qualityonecare.com

4. Expense Assumptions (Staffing, Overhead, and Fixed Costs)

Expense Category	Basis of Assumption	Detail
Salaries & Wages	Based on competitive market rates for the Baltimore Metropolitan Region. RN salaries are estimated at $78,000–$90,000 annually.	Consistent with recent experience of other Maryland HHAs.
Fringe Benefits	Calculated at 22–24% of salary expense.	Covers payroll taxes, insurance, and other standard employee benefits.
Contractual Services	Includes therapy, social work, billing/claims support, and EMR technical support. Based on prevailing per-visit/per-hour rates.	Expenses are aligned with projected utilization and productivity.
Supplies	Estimated at $6,000–$12,000 annually, depending on volume. Covers nursing supplies (wound care, IV), PPE, and general clinical supplies.	Increases proportionally with service volume.
Administrative Overhead	Includes rent, utilities, insurance, recruiting, mileage, and IT support.	Increases proportionally with volume.
Bank Fees/Merchant Fees	Projected at $75–$100 per month, covering payroll processing and billing transactions.	Reflects non-clinical operating costs.
Accreditation or Dues	Projected at $4,500 annually, covering Joint Commission renewal, industry memberships, and regulatory updates.	Reflects ongoing compliance requirements.
Training & Education	Budgeted at $2,000 annually, covering initial orientation, annual competency, and clinical CE.	Consistent with state training expectations.
Depreciation	Applied using straight-line depreciation over 5 years for office equipment, IT hardware, and capitalized EMR costs.	Standard accounting practice for fixed assets.

EXHIBIT 6

Financial Capacity Documentation

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

SULLIVAN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA
MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

TO: Mohamed Matope
Quality One Care Home Health, Inc.

Date: March 25, 2025

The following items are enclosed:

☐ **E-file authorization forms for signature and tax returns for review**
E-file authorization form(s) and tax returns are in your portal. You should review the tax returns before returning the signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

a. Return via DocuSign
b. Mail to our office via First Class Mail
c. Upload signed E-file forms in your portal

☐ **Tax Reports that cannot be filed electronically/must be filed on paper with instructions for filing**
Follow the enclosed instructions. Copies of your tax report(s) are in your portal.

☐ **Client Agreement and/or Engagement Letter**
Electronically sign via DocuSign by clicking each tag and following the instructions to add your electronic signature or initials where required. Confirm your signature by clicking "FINISH". Alternatively, mail, fax, or upload to your portal. Follow any terms listed at the asterisk (*) on the Client Agreement.

☐ **Original documents and/or paper copies of tax returns**

☑ 12/31/24 Financial Statements

☐ **If you have questions, call Paul at (301) 657- 8080 extension 102.**

Remarks:

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The portal is the best way to send documents to us and receive them. To access the portal, go to esullivan.net, client portal, and enter your username and password to log in and access the applicable folder. If you need assistance navigating the portal, call our office, and one of our administrative team members can assist you.

Signed: Paul Sullivan
Karla Romero

4709 MONTGOMERY LANE, SUITE 201, BETHESDA, MD 20814 • TEL (301) 657-8080 • FAX (301) 657-9055
MEMBER AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
www.eSullivan.net • pSullivan@eSullivan.net

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

December 31, 2024

	Dec 31, 24
ASSETS	
Current Assets	
Checking/Savings	
First Citizens Bank 2213	779,563
Truist 5249	319,554
Truist 5257	500
Truist 5265	30,357
Truist 5273	1,912
Total Checking/Savings	1,131,887
Accounts Receivable	
Accounts Receivable (A/R)	(1,000,000)
Total Accounts Receivable	(1,000,000)
Other Current Assets	
Payroll Tax Receivable	71,286
Undeposited Funds	1,000,000
Total Other Current Assets	1,071,286
Total Current Assets	1,203,172
Fixed Assets	
Accum. Depreciation	(153,990)
Computers	34,279
Furnitures and Equipment	47,303
Leasehold Improvements E&M Inve	406,777
Printers	7,386
Total Fixed Assets	341,755
TOTAL ASSETS	1,544,927

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

December 31, 2024

	Dec 31, 24
LIABILITIES & EQUITY	
Liabilities	
Long Term Liabilities	
EIDL SBAD TREAS	137,779
Total Long Term Liabilities	137,779
Total Liabilities	137,779
Equity	
Capital	20,000
Contributions Mohamed	291,314
Retained Earnings	1,642,613
Net Loss	(546,779)
Total Equity	1,407,148
TOTAL LIABILITIES & EQUITY	1,544,927

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31,2024 and 2023

	Jan - Dec 24	Jan - Dec 23	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	17,235,327	16,482,073	100%
Total Income	17,235,327	16,482,073	100%
Cost of Goods Sold			
Business Telehealth	250,000	0	1%
Direct Wages	2,538,061	2,216,891	15%
Subcontractors - COS	13,379,501	12,437,863	78%
Total COGS	16,167,562	14,654,754	94%
Gross Profit	1,067,764	1,827,319	6%
Expense			
Accounting	27,809	27,379	0%
Advertising	9,000	0	0%
Auto Expenses	8,904	8,222	0%
Bank & Merchant Fees	3,326	626	0%
CHARITY	0	5,000	0%
Depreciation Expense	23,813	21,603	0%
Dues & Subscriptions	37,323	3,280	0%
Education and Training Expen...	0	870	0%
Insurance	56,464	12,665	0%
Interest Expense	0	1,434	0%
Legal & Professional Fees	92,800	94,783	1%
Office Expenses	97,594	64,264	1%
Parking	0	690	0%
Payroll Service Fees	9,282	8,302	0%
Penalties	0	124	0%
Pension Expense	44,225	52,631	0%
Rent or Lease	238,870	258,216	1%
Repair & Maintenance	98,244	68,253	1%
Salaries and Wages, Other	373,344	363,327	2%
Salary, Officer	194,220	226,000	1%
Taxes & Licenses	263,132	227,864	2%
Telephone Expenses	16,675	18,701	0%
Travel	600	5,183	0%
Utilities	13,481	14,905	0%
Total Expense	1,609,106	1,484,322	9%
Net Ordinary Income	(541,342)	342,997	(3)%
Other Income/Expense			
Other Income			
Interest Earned	52	0	0%
Total Other Income	52	0	0%

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31,2024 and 2023

	Jan - Dec 24	Jan - Dec 23	% of Income
Other Expense			
Penalties, Other	5,490	0	0%
Maryland Income Taxes	0	108,413	0%
Total Other Expense	5,490	108,413	0%
Net Other Income	(5,437)	(108,413)	(0)%
Net Income	(546,779)	234,584	(3)%

SULLIVAN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope Date: 12/14/24

Quality One Care Home Health, Inc.

The following items are enclosed:

☐ E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your portal. You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

a. Return through DocuSign
b. Mail to our office via First Class Mail
c. Upload back into your portal

☐ Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your portal.

☐ Client Agreement and/or Engagement Letter. Sign via **DocuSign, mail, fax, or upload to your Portal.** Follow any terms listed at the asterisk (*) on the Client Agreement.

☐ Complete required fields in DocuSign by agreeing to sign electronically. Click each sign tag and follow the instructions to add your electronic signature where required to sign or initial. Confirm your signature by clicking FINISH.

☑ 10/31/24 Financial Statements

☐ We can review _____ with you. Please call our office to schedule.

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The best way to send documents to us and to receive documents is through this portal. To access the portal: **Go to www.eSullivan.net -> Client Portal. Enter your email address as username, and password. Open the applicable folder once you have logged in.**

☐ Remarks:_____

Call with questions, or if you want our comments. (301) 657-8080

Signed: Paul Sullivan
Jane Huserova

4709 MONTGOMERY LANE, SUITE 201, BETHESDA, MD 20814 • TEL (301) 657-8080 • FAX (301) 657-9055
MEMBER AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
WEBSITE: www.eSullivan.net • E-MAIL: pSullivan@eSullivan.net

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of October 31, 2024

	Oct 31, 24	
ASSETS		
Current Assets		
Checking/Savings		
First Citizens Bank 2213		710,513
Truist 5249		99,154
Truist 5257		500
Truist 5265		500
Truist 5273		19,891
Total Checking/Savings		830,559
Accounts Receivable		
Accounts Receivable (A/R)		(1,000,000)
Total Accounts Receivable		(1,000,000)
Other Current Assets		
PPP Loan Payments		101,117
Prepaid Payroll Taxes		3,086
Undeposited Funds		1,000,000
Total Other Current Assets		1,104,204
Total Current Assets		934,762
Fixed Assets		
Accum. Depreciation		(149,202)
Computers		34,279
Furnitures and Equipment		34,781
Leasehold Improvements E&M Inve		342,277
Printers		7,386
Total Fixed Assets		269,521
TOTAL ASSETS		1,204,283
LIABILITIES & EQUITY		
Liabilities		
Current Liabilities		
Other Current Liabilities		
Payroll Liabilities		
401K Payable	2,776	
Payroll Liabilities - Other	212	
Total Payroll Liabilities		2,987
Total Other Current Liabilities		2,987
Total Current Liabilities		2,987
Long Term Liabilities		
EIDL SBAD TREAS		141,364
Total Long Term Liabilities		141,364

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of October 31, 2024

	Oct 31, 24
Total Liabilities	144,351
Equity	
Capital	20,000
Distributions Mohamed	214,160
Retained Earnings	1,642,613
Net Income	(816,841)
Total Equity	1,059,932
TOTAL LIABILITIES & EQUITY	1,204,283

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31, 2024 and 2023

	Jan - Oct 24	Jan - Oct 23	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	14,049,549	13,869,631	100%
Total Income	14,049,549	13,869,631	100%
Cost of Goods Sold			
Business Telehealth	250,000	0	2%
Direct Wages	2,181,160	1,912,651	16%
Subcontractors - COS	11,078,098	10,350,996	79%
Total COGS	13,509,258	12,263,648	96%
Gross Profit	540,292	1,605,983	4%
Expense			
Accounting	20,359	19,427	0%
Advertising	4,000	0	0%
Auto Expenses	10	94	0%
Bank & Merchant Fees	1,082	526	0%
CHARITY	5,000	5,000	0%
Depreciation Expense	19,025	17,858	0%
Dues & Subscriptions	7,410	2,721	0%
Education and Training Expenses	0	870	0%
Insurance	49,653	10,971	0%
Interest Expense	0	1,434	0%
Legal & Professional Fees	92,800	74,938	1%
Office Expenses	28,439	33,151	0%
Parking	720	690	0%
Payroll Service Fees	17,933	6,869	0%
Pension Expense	40,219	45,514	0%
Rent or Lease	218,115	223,680	2%
Repair & Maintenance	154,020	57,153	1%
Salaries and Wages, Other	270,753	319,012	2%
Salary, Officer	166,518	202,000	1%
Software	17,399	41,747	0%
Taxes & Licenses	215,991	201,958	2%
Telephone Expenses	14,218	14,019	0%
Travel	0	2,613	0%
Utilities	13,481	11,732	0%
Total Expense	1,357,145	1,293,974	10%
Net Ordinary Income	(816,853)	312,009	(6)%
Other Income/Expense			
Other Income			
Interest Earned	12	0	0%
Total Other Income	12	0	0%
Other Expense			
Maryland Income Taxes	0	108,413	0%
Total Other Expense	0	108,413	0%

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended October 31, 2024 and 2023

	Jan - Oct 24	Jan - Oct 23	% of Income
Net Other Income	12	(108,413)	0%
Net Income	(816,841)	203,596	(6)%

SULLIVAN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
CHRISTOPHER BAILEY, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope

Quality One Care Home Health, Inc.

Date: September 25, 2023

The following items are enclosed:

☐ E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your Electronic Mailbox (Sullivan & Company secured portal). You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

a. Upload back into your Electronic Mailbox
b. Mail to our office via First Class Mail

☐ Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your Electronic Mailbox (Sullivan & Company secured portal).

To access Electronic Mailbox: Go to www.eSullivan.net -> Client Center -> Client Portal. Enter your email address as username, and password. If you can't remember your password, click on Forgot Password and a new password will be sent to your email to retrieve. Open the applicable folder once you have logged in.

☐ Client Agreement and/or Engagement Letter. Sign and **mail, fax, or upload to your Electronic Mailbox**.
Follow any terms listed at the asterisk (*) on the Client Agreement.

☑ 06/30/23 Financial Statements

☐ Complete required fields in PandaDoc with signature included and click the Finish button in the top righthand corner to return to our office.

NEW ☐ We can review your _____ with you, via a Zoom call if helpful to you.

As a client of Sullivan & Company, CPAs, you receive an Electronic Mailbox. The best way to send documents to us and receive documents is through this Electronic Mailbox. Other than this Electronic Mailbox, First Class Mail is always available.

Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: Paul Sullivan

Jane Huserova

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WEBSITE: www.eSullivan.net • E-MAIL: pSullivan@eSullivan.net

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of June 30, 2023

	Jun 30, 23	
ASSETS		
Current Assets		
Checking/Savings		
Capital One Checking- NEW--8343		1,580,194
First Citizens Bank 2213		2,292
Total Checking/Savings		1,582,486
Accounts Receivable		
Accounts Receivable (A/R)		(1,300,000)
Total Accounts Receivable		(1,300,000)
Other Current Assets		
PPP Loan Payments		101,117
Prepaid 401K Contribution		199
Prepaid Payroll Taxes		3,776
Undeposited Funds		1,300,000
Total Other Current Assets		1,405,092
Total Current Assets		1,687,579
Fixed Assets		
Accum. Depreciation		(119,289)
Computers		34,279
Furnitures and Equipment		34,781
Leasehold Improvements E&M Inve		321,277
Printers		7,386
Total Fixed Assets		278,434
TOTAL ASSETS		1,966,013
LIABILITIES & EQUITY		
Liabilities		
Current Liabilities		
Other Current Liabilities		
Payroll Liabilities		
Health Insurance	9,376	
Total Payroll Liabilities		9,376
Total Other Current Liabilities		9,376
Total Current Liabilities		9,376
Long Term Liabilities		
EIDL SBAD TREAS		147,100
Total Long Term Liabilities		147,100
Total Liabilities		156,476

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of June 30, 2023

	Jun 30, 23
Equity	
Capital	20,000
Distributions Mohamed	(240,204)
Retained Earnings	1,425,397
Net Income	604,344
Total Equity	1,809,537
TOTAL LIABILITIES & EQUITY	1,966,013

Quality One Care Home Health Inc

Statement of Revenues and Expenses - Tax Basis

For the Period Ended June 30, 2023

	Jan - Jun 23	% of Income
Ordinary Income/Expense		
Income		
Service Revenues	8,226,326	100%
Total Income	8,226,326	100%
Cost of Goods Sold		
Direct Wages	1,151,010	14%
Subcontractors - COS	5,772,470	70%
Total COGS	6,923,480	84%
Gross Profit	1,302,846	16%
Expense		
Accounting	14,502	0%
Bank & Merchant Fees	300	0%
CHARITY	3,000	0%
Depreciation Expense	10,715	0%
Dues & Subscriptions	1,610	0%
Education and Training Expenses	600	0%
Insurance	13,083	0%
Interest Expense	1,434	0%
Legal & Professional Fees	11,136	0%
Office Expenses	30,102	0%
Payroll Service Fees	3,903	0%
Pension Expense	27,788	0%
Rent or Lease	49,608	1%
Repair & Maintenance	27,119	0%
Salaries and Wages, Other	193,672	2%
Salary, Officer	122,000	1%
Software	33,525	0%
Taxes & Licenses	117,393	1%
Telephone Expenses	9,622	0%
Travel	792	0%
Utilities	5,367	0%
Total Expense	677,269	8%
Net Ordinary Income	625,577	8%
Other Income/Expense		
Other Expense		
Maryland Income Taxes	21,233	0%
Total Other Expense	21,233	0%
Net Other Income	(21,233)	(0)%
Net Income	604,344	7%

SULLIVAN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
CHRISTOPHER BAILEY, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope

Quality One Care Home Health, Inc.

Date: September 25, 2023

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b. Mail to our office via First Class Mail

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☐ Client Agreement and/or Engagement Letter. Sign and **mail, fax, or upload to your Electronic Mailbox**.
Follow any terms listed at the asterisk (*) on the Client Agreement.

☑ 06/30/23 Financial Statements

☐ Complete required fields in PandaDoc with signature included and click the Finish button in the top righthand corner to return to our office.

NEW ☐ We can review your _____ with you, via a Zoom call if helpful to you.

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Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: Paul Sullivan
Jane Huserova

4709 MONTGOMERY LANE, SUITE 201, BETHESDA, MD 20814 • TEL (301) 657-8080 • FAX (301) 657-9055
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Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of September 30, 2023

	Sep 30, 23
ASSETS	
Current Assets	
Checking/Savings	
Capital One Checking- NEW--8343	1,277,317
First Citizens Bank 2213	13,648
Total Checking/Savings	1,290,965
Accounts Receivable	
Accounts Receivable (A/R)	(1,300,000)
Total Accounts Receivable	(1,300,000)
Other Current Assets	
PPP Loan Payments	101,117
Prepaid Payroll Taxes	3,776
Undeposited Funds	1,300,000
Total Other Current Assets	1,404,893
Total Current Assets	1,395,858
Fixed Assets	
Accum. Depreciation	(124,646)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	321,277
Printers	7,386
Total Fixed Assets	273,077
TOTAL ASSETS	1,668,935
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
401K Payable	4,139
Health Insurance	9,288
Total Payroll Liabilities	13,427
Total Other Current Liabilities	13,427
Total Current Liabilities	13,427
Long Term Liabilities	
EIDL SBAD TREAS	147,100
Total Long Term Liabilities	147,100
Total Liabilities	160,527

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of September 30, 2023

	Sep 30, 23
Equity	
Capital	20,000
Distributions Mohamed	(226,816)
Retained Earnings	1,425,397
Net Income	289,828
Total Equity	1,508,408
TOTAL LIABILITIES & EQUITY	1,668,935

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended September 30, 2023 and 2022

	Jan - Sep 23	Jan - Sep 22	% of Income
Ordinary Income/Expense			
Income			
Service Revenues	12,436,521	9,800,800	100%
Total Income	12,436,521	9,800,800	100%
Cost of Goods Sold			
Direct Wages	1,751,047	1,453,783	14%
Subcontractors - COS	9,217,308	6,975,080	74%
Total COGS	10,968,355	8,428,863	88%
Gross Profit	1,468,166	1,371,937	12%
Expense			
Accounting	17,886	10,768	0%
Advertising	0	4,300	0%
Auto Expenses	94	4,688	0%
Bank & Merchant Fees	451	685	0%
CHARITY	5,000	0	0%
Depreciation Expense	16,072	18,542	0%
Dues & Subscriptions	2,441	2,539	0%
Education and Training Expenses	600	0	0%
Insurance	15,624	23,816	0%
Interest Expense	1,434	0	0%
Legal & Professional Fees	23,348	5,987	0%
Meals Business	0	425	0%
Office Expenses	44,710	43,183	0%
Parking	690	1,250	0%
Payroll Service Fees	6,154	5,430	0%
Pension Expense	38,968	3,343	0%
Rent or Lease	134,412	195,295	1%
Repair & Maintenance	50,653	56,077	0%
Salaries and Wages, Other	285,212	75,679	2%
Salary, Officer	178,000	135,600	1%
Software	34,829	0	0%
Taxes & Licenses	187,460	148,519	2%
Telephone Expenses	13,001	10,560	0%
Travel	2,613	852	0%
Utilities	10,274	1,620	0%
Total Expense	1,069,925	749,158	9%
Net Ordinary Income	398,241	622,779	3%
Other Income/Expense			
Other Expense			
Maryland Income Taxes	108,413	71,610	1%
Total Other Expense	108,413	71,610	1%
Net Other Income	(108,413)	(71,610)	(1)%
Net Income	289,828	551,169	2%

These Financial Statements have not been subjected to an audit or review or compilation engagement procedures. For internal management use only. No assurance is provided.

SULLIVAN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
CHRISTOPHER BAILEY, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope Date: September 30, 2022

Quality One Care Home Health, Inc.

The following items are enclosed:

☐ E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your Electronic Mailbox (Sullivan & Company secured portal). You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

a. Upload back into your Electronic Mailbox
b. Mail to our office via First Class Mail

☐ Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your Electronic Mailbox (Sullivan & Company secured portal).

To access Electronic Mailbox: Go to www.eSullivan.net -> Client Center -> Client Portal. Enter your email address as username, and password. If you can't remember your password, click on Forgot Password and a new password will be sent to your email to retrieve. Open the applicable folder once you have logged in.

☐ Client Agreement and/or Engagement Letter. Sign and **mail, fax, or upload to your Electronic Mailbox**.
Follow any terms listed at the asterisk (*) on the Client Agreement.

☑ 08/31/2022 Financial Statements

☐ Complete required fields in PandaDoc with signature included and click the Finish button in the top righthand corner to return to our office.

NEW ☐ We can review your _____ with you, via a Zoom call if helpful to you.

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Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: Paul Sullivan
Jane Huserova

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Quality One Care Home Health Inc
Statement of Assets, Liabilities and Equity - Tax Basis
As of August 31, 2022

	Aug 31, 22
ASSETS	
Current Assets	
Checking/Savings	
Capital One Checking- NEW--8343	356,044
First Citizens Bank 2213	217,377
Total Checking/Savings	573,421
Accounts Receivable	
Accounts Receivable (A/R)	(1,300,000)
Total Accounts Receivable	(1,300,000)
Other Current Assets	
PPP Loan Payments	177,067
Undeposited Funds	1,300,000
Total Other Current Assets	1,477,067
Total Current Assets	750,488
Fixed Assets	
Accum. Depreciation	(87,333)
Computers	34,279
Furnitures and Equipment	34,781
Leasehold Improvements E&M Inve	321,277
Printers	7,386
Total Fixed Assets	310,389
Other Assets	
Due from Employee	5,000
Loan E&M Investment	289,500
Total Other Assets	294,500
TOTAL ASSETS	1,355,378
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Other Current Liabilities	
Payroll Liabilities	
401K Payable	3,600
Total Payroll Liabilities	3,600
Total Other Current Liabilities	3,600
Total Current Liabilities	3,600
Long Term Liabilities	
EIDL SBAD TREAS	147,100
Total Long Term Liabilities	147,100
Total Liabilities	150,700
Equity	
Capital	20,000
Distributions Mohamed	(327,815)
Retained Earnings	859,469
Net Income	653,023
Total Equity	1,204,678
TOTAL LIABILITIES & EQUITY	1,355,378

Quality One Care Home Health Inc

Statement of Revenues and Expenses - Tax Basis

For the Period Ended August 31, 2022

	Jan - Aug 22	% of Income
Ordinary Income/Expense		
Income		
Service Revenues	8,298,628	100%
Total Income	8,298,628	100%
Cost of Goods Sold		
Direct Wages	1,159,814	14%
Subcontractors - COS	5,836,029	70%
Total COGS	6,995,843	84%
Gross Profit	1,302,786	16%
Expense		
Accounting	9,886	0%
Advertising	4,300	0%
Auto Expenses	4,167	0%
Bank & Merchant Fees	635	0%
Depreciation Expense	16,481	0%
Dues & Subscriptions	2,023	0%
Insurance	27,168	0%
Legal & Professional Fees	5,987	0%
Meals Business	425	0%
Office Expenses	25,030	0%
Parking	860	0%
Payroll Service Fees	4,588	0%
Pension Expense	1,732	0%
Rent or Lease	171,040	2%
Repair & Maintenance	50,577	1%
Salaries and Wages, Other	62,812	1%
Salary, Officer	111,600	1%
Software	16,396	0%
Taxes & Licenses	123,037	1%
Telephone Expenses	8,947	0%
Travel	852	0%
Utilities	1,220	0%
Total Expense	649,762	8%
Net Ordinary Income	653,023	8%
Net Income	653,023	8%

SULLIVAN & COMPANY

CERTIFIED PUBLIC ACCOUNTANTS

PAUL F. SULLIVAN, CPA
RAJ GOENKA, CPA

MONIKA BENKOVIC, CPA
RADKA WINDT, BUSINESS SERVICES MANAGER

Letter of Transmittal

TO: Mohamed Matope

Quality One Care Home Health, Inc.

Date: 2/20/24

The following items are enclosed:

☐ E-file authorization form(s) for signature and tax returns for review. E-file authorization form(s) and tax returns have been placed in your portal. You should review the tax returns before returning signed E-file authorization form(s) to us. Return the signed E-file authorization forms to us in one of the following ways:

a. Return through DocuSign
b. Mail to our office via First Class Mail
c. Upload back into your portal

☐ Tax report(s) that cannot be filed electronically and must be filed on paper with instructions for filing. Follow the instructions attached. Copy(ies) of your tax report(s) have been placed in your portal.

☐ Client Agreement and/or Engagement Letter. Sign via **DocuSign, mail, fax, or upload to your Portal.** Follow any terms listed at the asterisk (*) on the Client Agreement.

☐ Complete required fields in DocuSign by agreeing to sign electronically. Click each sign tag and follow the instructions to add your electronic signature where required to sign or initial. Confirm your signature by clicking FINISH.

☑ 12/31/23 Financial Statements

☐ We can review _____ with you. Please call our office to schedule.

As a client of Sullivan & Company, CPAs, you receive a secure client portal. The best way to send documents to us and to receive documents is through this portal. To access the portal: **Go to www.eSullivan.net -> Client Portal. Enter your email address as username, and password. Open the applicable folder once you have logged in.**

☐ Remarks: _____

Call with questions, or if you want our comments. (301) 657-8080

Signed: Paul Sullivan
Jane Huserova

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Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of December 31, 2023

	Dec 31, 23	
ASSETS		
Current Assets		
Checking/Savings		
Capital One Checking- NEW--8343	1,411,769	
First Citizens Bank 2213	9,994	
Total Checking/Savings	1,421,764	
Accounts Receivable		
Accounts Receivable (A/R)	(1,300,000)	
Total Accounts Receivable	(1,300,000)	
Other Current Assets		
PPP Loan Payments	101,117	
Prepaid Payroll Taxes	3,086	
Undeposited Funds	1,300,000	
Total Other Current Assets	1,404,204	
Total Current Assets	1,525,967	
Fixed Assets		
Accum. Depreciation	(130,177)	
Computers	34,279	
Furnitures and Equipment	34,781	
Leasehold Improvements E&M Inve	342,277	
Printers	7,386	
Total Fixed Assets	288,546	
TOTAL ASSETS	1,814,513	
LIABILITIES & EQUITY		
Liabilities		
Current Liabilities		
Other Current Liabilities		
Payroll Liabilities		
401K Payable	2,908	
Health Insurance	1,891	
Total Payroll Liabilities	4,800	
Total Other Current Liabilities	4,800	
Total Current Liabilities	4,800	
Long Term Liabilities		
EIDL SBAD TREAS	147,100	
Total Long Term Liabilities	147,100	
Total Liabilities	151,900	

Quality One Care Home Health Inc

Statement of Assets, Liabilities and Equity - Tax Basis

As of December 31, 2023

	Dec 31, 23
Equity	
Capital	20,000
Distributions Mohamed	(17,367)
Retained Earnings	1,425,397
Net Income	234,584
Total Equity	1,662,613
TOTAL LIABILITIES & EQUITY	1,814,513

Quality One Care Home Health Inc

Statements of Revenues and Expenses - Tax Basis

For the Periods Ended December 31, 2023 and 2022

	Jan - Dec 23	Jan - Dec 22	% Change
Ordinary Income/Expense			
Income			
Service Revenues	16,482,073	13,840,361	19%
Total Income	16,482,073	13,840,361	19%
Cost of Goods Sold			
Direct Wages	2,216,891	1,751,452	27%
Subcontractors - COS	12,437,863	9,517,067	31%
Total COGS	14,654,754	11,268,518	30%
Gross Profit	1,827,319	2,571,843	(29)%
Expense			
Accounting	27,379	17,694	55%
Advertising	0	4,300	(100)%
Auto Expenses	8,222	7,260	13%
Bank & Merchant Fees	626	870	(28)%
CHARITY	5,000	0	100%
Depreciation Expense	21,603	37,722	(43)%
Dues & Subscriptions	3,280	3,337	(2)%
Education and Training Expenses	870	0	100%
Insurance	12,665	29,511	(57)%
Interest Expense	1,434	0	100%
Legal & Professional Fees	94,783	5,977	1,486%
Meals Business	0	425	(100)%
Office Expenses	64,264	63,202	2%
Parking	690	1,250	(45)%
Payroll Service Fees	8,302	7,416	12%
Penalties	124	0	100%
Pension Expense	52,631	14,981	251%
Rent or Lease	258,216	244,073	6%
Repair & Maintenance	68,253	77,807	(12)%
Salaries and Wages, Other	363,327	348,760	4%
Salary, Officer	226,000	195,600	16%
Taxes & Licenses	227,864	191,148	19%
Telephone Expenses	18,701	12,968	44%
Travel	5,183	852	509%
Utilities	14,905	3,361	344%
Total Expense	1,484,322	1,268,513	17%
Net Ordinary Income	342,997	1,303,330	(74)%
Other Income/Expense			
Other Expense			
Maryland Income Taxes	108,413	95,480	14%
Total Other Expense	108,413	95,480	14%
Net Other Income	(108,413)	(95,480)	(14)%
Net Income	234,584	1,207,850	(81)%

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EXHIBIT 7

RSA Qualification Documents

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

Includes RSA Historical Payor Mix & Utilization Summary

Documentation of RSA* Applicant's Qualifications to Establish a Home Health Agency in Maryland
*Maryland Residential Service Agency Providing Skilled Nursing Services

Applicant: Quality One Care Home Health, Inc

Maryland RSA license #: R3057R

1. PERFORMANCE-RELATED QUALIFICATIONS: COMAR 10.24.16.06.D and 10.24.16.07 outline performance-related qualifications that an applicant must meet in order for the MHCC to accept a CON application to establish a home health agency (HHA). The performance-related qualifications vary by type of applicant. MHCC staff has developed guidelines for all types of applicants, including a Maryland residential service agency (RSA) providing skilled nursing services, to assist staff in determining whether a potential applicant meets performance-related requirements. An RSA applicant should refer to the Guideline document, which can be found on the Commission's website at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_homehealth/documents/chcf_review_guidance_stds.pdf

2. DATA SUBMISSION REQUIREMENTS: An RSA applicant may qualify to apply for a CON to establish an HHA in Maryland by demonstrating a track record of providing good quality care. An RSA applicant must submit data to the MHCC to document the ability to monitor the required quality measures and performance levels outlined in Appendix E of the Guidelines:

- Documentation of the RSA's status as accredited for the three most recent years of operation through a deeming authority recognized by Maryland's Department of Health and Mental Hygiene.
- Documentation that the RSA has provided skilled nursing services, including the specific types and utilization of skilled nursing services provided during the most recent three years of operation (**complete Table 1**; refer to Sample Worksheet E1 in Guidelines document).
- A brief description of the RSA's quality assurance program, to include identification of the quality measures monitored by the RSA that are comparable to those measures submitted by HHAs to CMS (for example, if your RSA uses a client survey, submit a copy of the survey); and
- Examples of specific quality measures tracked, and performance levels achieved during the most recent three years of operation (**complete Table 2**; refer to Sample Worksheet E2 in Guidelines document).

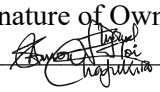
3. QUALIFICATIONS FOR ALL APPLICANTS: COMAR 10.24.16.06C provides that the MHCC will only accept a CON application from an applicant that documents the characteristics and requirements listed immediately below. An applicant must indicate whether each statement on the left side of the grid below is true or false (or not applicable), and separately provide documentation as indicated.

The Applicant:	Write response (true, false, or not applicable)
(1) Has not had its Medicare or Medicaid payments suspended within the last five years;	**True**
(2) Has not been convicted of Medicare or Medicaid fraud or abuse within the last ten years;	**True**
(3) Has received at least satisfactory findings reflecting no serious adverse citations on the most recent two survey cycles from its respective state agency, accreditation organization, or both, as applicable to the type of applicant;	**True** See JCAHO Accreditation Exhibits
(4) Has maintained accreditation through a state-recognized deeming authority, as applicable, for at least the three most recent years;	**True** See JCAHO Accreditation Exhibits
(5) Has submitted an acceptable plan of correction for any valid and serious patient-related complaint investigated over the past three years;	**True** See JCAHO Corrective Actions Exhibit
(6) Has complied with all applicable federal and State quality of care reporting requirements and performance standards;	**True** See Quality Measures Exhibit
(7) Documents availability of sufficient financial resources to implement the proposed project within the applicable timeframes set forth in the Commission's performance requirements at COMAR 10.24.01.12; 10.24.16;	See Financial Resources Exhibit
(8) Demonstrates a record of serving all applicable payer types, such as Medicare, Medicaid, private insurance, HMOs, and self-pay patients; and	See Payor Mix
(9) Affirms under penalties of perjury, that within the last ten years, no owner or senior management, or owner or senior management of any related or affiliated entity, has been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime.	**True**

ATTESTATION:

I, the undersigned, am an owner, or authorized agent of the applicant that has filed a letter of intent to establish or expand a home health agency in Maryland. I hereby affirm under the penalties of perjury that the information in this Documentation of Qualifications and attached tables is true and correct to the best of my knowledge, information, and belief.

Signature of Owner or Authorized Agent of the Potential Applicant:



Name and Title: AMON CHAFUKIRA - Program Coordinator

Date: 08/15/2025

Documentation of Qualification – RSA Applicant – Page 3

*Provide Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. – **See Exhibit 6**

Table 1: RSA Skilled Nursing Services Provided and Number of RSA Clients Served

Skilled Nursing Services Provided to RSA Clients*	CMS-Aligned Service Category	Number of RSA Clients with Skilled Nursing Services by Year			% Change 2023 vs 2022
		2023	2022	2021	
Tracheostomy Care	Respiratory Support	58	40	42	45.0%
Ventilator Care	Respiratory Support	16	9	22	77.8%
Tube Feeding Care	Nutritional Support	78	61	54	27.9%
Ostomy Care	Digestive & Excretory Support	4	3	1	33.3%
Urinary Catheter Care	Digestive & Excretory Support	8	3	2	166.7%
Medication Administration	Medication Management	78	63	57	23.8%
Wound care	Wound Management	4	6	8	-33.3%
Cardiac Care	Cardiovascular Support	3	2	4	50.0%
Post-Operative Care	Post-Surgical Care	4	7	9	-42.9%
IV Infusion	Infusion Therapy	4	6	7	-33.3%
TOTAL number of patients receiving skilled nursing services*		**76**	**68**	**64**	11.8%
% Change from Previous Year		**+11.8%**	**+6.3%**	-	-
Number of RSA Clients not receiving skilled nursing services**		**3**	**2**	**6**	50%

Table Summary

The data in Table 1 clearly demonstrates the consistent growth and increasing demand for our services, with the total number of skilled nursing clients rising from 64 in 2021 to 76 in 2023. This upward trend, including a notable 11.8% increase from 2022 to 2023, highlights our ability to effectively expand our reach and meet the needs of the community. The numbers also reflect our agency's growing specialization in complex care.

The significant increase in clients for both Tracheostomy Care and Tube Feeding Care shows that we are addressing a vital need for high-acuity services in our service area. Furthermore, the consistently low number of clients who do not receive skilled nursing services confirms that we are maintaining a strong focus on our core business and expertise.

Quality One Care Quality Assurance Program Description

Quality One Care Home Health, Inc. operates a robust Quality Assurance and Performance Improvement (QAPI) program that we've carefully designed to align with both Maryland Residential Service Agency (RSA) guidelines and the quality standards of a Home Health Agency (HHA) as set by CMS. Our program's main objective is to continuously monitor and enhance the quality, safety, and client satisfaction of our home care services.

We have a systematic approach to quality assurance that includes actively tracking a number of key measures. These measures are specifically chosen to be comparable to those submitted by HHAs to CMS, and they give us clear data on how we are performing.

1. Key Quality Measures

Quality One Care routinely monitors a number of quality measures to make sure that our services are in compliant with CMS’s HHA outcome and Process Measures. These measures include:

- Tracheostomy Suctioning Technique Compliance (Client/Family Demonstration)
- Feeding Tube Insertion Accuracy (Client/Family Demonstration)
- Hand Hygiene Compliance (Client/Family)
- Home Equipment Maintenance and Cleaning Compliance (Staff Audit)
- Home Oxygen Safety Training Completion Rate (Client/Family)
- Fall Reduction Education Completion Rate (Client)
- Safe Medication Administration Education (Client)
- Hazard Vulnerability Assessment Completion (Client)
- Overall Customer Satisfaction: "Needs Met by Staff"

As reflected in our performance tables, we track each measure annually. We're proud that many of our measures show consistent performance or improvement over the last three years, with a majority achieving 95% or higher compliance. This data helps us confirm that our efforts are making a real difference in the lives of our clients.

2. Tools and Documentation

To support our program, we rely on a variety of tools and documentation. We conduct annual client satisfaction and skills demonstration surveys that mirror CMS-aligned instruments, including Likert-style and checkboxes which uses a combination of qualitative and quantitative questions to gather valuable and impactful feedback. We also perform structured staff audits and maintain meticulous education logs to ensure our processes and training are effective.

3. Performance Tracking

We track our performance using internal dashboards that are reviewed monthly, with comprehensive trend analysis conducted at our quarterly quality review meetings. This proactive approach allows us to quickly identify any potential deficiencies and implement corrective action plans. These plans often include staff retraining, updated procedures, or re-education for our clients and their families, ensuring our services are always improving.

Table 2. Quality Measures by Measure Type and Performance Level achieved

Type of Quality Measure	Measure Type	Performance Level Achieved		
		2023	2022	2021
Tracheostomy Suctioning Technique Compliance (Client/Family Demonstrated)	Outcome (CMS QM)	98%	99%	99%
Feeding Tube Insertion Demonstration (Client/Family Accuracy)	Outcome	98%	97%	99%
Hand Hygiene Compliance (Client/Family)	Outcome (CMS QM)	90%	80%	85%
Home Equipment Maintenance/Cleaning Compliance (Staff Audit)	Outcome	95%	95%	98%
Home Oxygen Safety Training Completion Rate (Clients/Family)	Process	100%	100%	100%
Fall Reduction Education Completion Rate (Clients)	Process (CMS QM)	100%	100%	100%
Safe Medication Administration Education (Clients)	Process	100%	100%	97%
Hazard Vulnerability Assessment Completion (Clients)	Process	95%	87%	78%
Overall Customer Satisfaction — "Needs Met by Staff" (Annual Survey Result)	Experience of Care	98%	98%	97%

Notes:

- All quality metrics above were monitored continuously and reviewed quarterly by the agency's Quality Assurance & Performance Improvement (QAPI) Committee.
- Outcome data was collected via RN supervisory audits, in-home demonstrations, and compliance checklists. Experience of care data was obtained through annual client satisfaction surveys.
- **"CMS QM"** marks metrics that are aligned with measures that are also tracked by the Centers for Medicare & Medicaid Services
- **Hand Hygiene Compliance:** The improvement in 2023 was a direct result of our "Clean Hands Matter" training initiative launched in Q4 of 2022.
- **Hazard Vulnerability Assessment:** Our year-over-year improvement reflects a strengthened internal process to ensure all clients receive a comprehensive assessment.

Table 3. Currrent QOC RSA Client Payor Mix

Payor	**Percentage**
Medicare	0%
Medicare Advantage	0%
Medicaid	90%
Medicaid MCO	1% (Includes University of Maryland Health Partners)
Blue Cross	1% (Includes BlueCross BlueShield)
Other Commercial Insurance	7% (Physicians Health – 3.5%, CareFirst – 1.5%, Cigna – 1%)
Self-Pay (Private Pay)	1%
Other (Specify)	1% (County Public School System: MCPS, CCPS, FCPS)
Total	**100%**

EXHIBIT 8

State Licensure & Certification

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

Maryland
DEPARTMENT OF HEALTH
Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

April 14, 2023

Quality One Care Home Health, Inc.
Mohamad Matope, Director
9221 Colesville Road
Silver Spring, MD 20910

Dear Mr. Matope,

This is to acknowledge the receipt and approval of a change of address for your agency, and an updated license as a Health Care Staff Agency.

The enclosed license is non-expiring, unless revoked. It is your authority to operate a Health Care Staff Agency under the Maryland Department of Health, Code of Maryland Regulations (COMAR) 10.07.03.

This State license is to be displayed in a conspicuous place, at or near the entrance of your office, plainly visible and easily read by the public. If questions arise, please contact our Office by calling (410) 402-8094.

Sincerely,

Glenda Roberts

Glenda Roberts, Administrative Officer III
Developmental Disabilities/Allied Health Unit
Office of Health Care Quality

Enclosure: Non-expiring License

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

7120 SAMUEL MORSE DRIVE
SECOND FLOOR
COLUMBIA, MARYLAND 21046

License No.: HCS800389

Issued to: Quality One Home Health Care, Inc.
9221 Colesville Road
Silver Spring, MD 20910

Type of License Issued:
HEALTH CARE STAFF AGENCY

Date Issued: April 14, 2023

Expiration: **NON-EXPIRING**

Provides In:

HEALTH CARE STAFF FACILITIES

This license is granted pursuant to the Health-General Article, Title 19, Subtitle 20, Annotated Code of Maryland, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Patricia Tomasko, MD, MPH
Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXH # 10

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

7120 SAMUEL MORSE DRIVE
SECOND FLOOR
COLUMBIA, MARYLAND 21046-3422

License No: R3057R

Issued to: Quality One Care Home Health Inc
9221 Colesville Road
Silver Spring, MD 20910

Type of Agency: **RESIDENTIAL SERVICE AGENCY**

Date Issued: July 1, 2018

Service(s) Provided: Skilled Nursing and Aides; Level Three: Complex Care Provided by a Registered Nurse (RN)/Licensed Practical Nurse and RN Supervision of Aides

Population: Adults and Pediatrics

Other: REPLACEMENT LICENSE; CHANGE OF ADDRESS

Authority to operate in this State is granted to the above entity pursuant to the Health-General Article, Section 19-4A et Seq., Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration: NON-EXPIRING

Patricia Tomasko May, MD

Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No: R3057

Issued to: Quality One Care Home Health Inc
d/b/a Quality One Care Home Health, Inc
12510 Prosperity Drive Suite 320
Silver Spring, MD 20904

Type of Facility or Community Program:
RESIDENTIAL SERVICE AGENCY

Date Issued: July 1, 2018

Service(s) Provided: Skilled Nursing and Aides; Level of Care: Complex Care Provided by RN/LPN and RN Supervision of Aides

Other: N/A

Authority to operate in this State is granted to the above entity pursuant to the Health-General Article, Section 19-4A et Seq.,. Annotated Code of Maryland and is subject to any and all statutory provisions including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration: NON-EXPIRING

Patricia Tombro May MD
Executive Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

July 9, 2012

Ms. Elizabeth Puryear
Quality One Care Home Health Inc
10318 Castle Hedge Terrace
Silver Spring, MD 20902

Dear Ms. Puryear:

Your application as a Medical Assistance Provider for the Home and Community Based Services Waiver for Older Adults has been received and reviewed by representatives of the Maryland Department of Aging (MDoA) and the Medical Assistance Program at the Department of Health and Mental Hygiene.

You have been approved to provide for the following waiver services and procedure codes effective **June 19, 2012**:

1. Personal Care – Agency PC Aide without Medication Administration – Procedure Code – W0202
2. Personal Care – Agency PC with Medication Administration – Procedure Code – W0203
3. Personal Care Nurse Monitoring – Procedure Code W0204
4. Personal Care Agency Respite Care – Procedure Code W0206

The provider number assigned to you is **5209013-00**. This provider number is assigned the specific procedure codes that allow you to bill for only the services for which you have been approved. This provider number cannot be interchanged with any other provider number (s) that you may have. MDoA will also receive a copy of your provider number. Your **NPI# (National Provider Identification) # is: 55209013-00 some correspondence may request this number.** No bills for waiver services will be paid for dates of service prior to the above effective date.

Enclosed is your new provider number, information about the waiver program, including the governing regulations, waiver transmittals, reportable event policy procedure information and billing instructions. **Billing claims should be submitted to the following address, unless you are otherwise notified by your local Department of Aging:**

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

September 6, 2013

Mr. Mohamed Matope, R.N.
Quality One Care Home Health, Inc.
10318 Castle Hedge Terrace
Silver Spring, MD 20902

RE: Provider Enrollment
Residential Service Agency (RSA)
Provider Type 53
Provider #: 420641000 (Approved)

Dear Mr. Matope:

The Division of Nursing Services (DONS) has approved Quality One Care Home Health, Inc.'s ("Quality One") request to enroll as a provider in the EPSDT: Private Duty Nursing (PDN) Program. Provider Enrollment will be notified to approve Quality One's provider number.

In an effort to improve our training sessions, the DONS' has enclosed a Provider Feedback Form. Please review this form and answer the questions and comments as you see fit. This form should be submitted to my attention no later than **Friday, October 4, 2013.**

Department of Health & Mental Hygiene
Division of Nursing Services
201 W. Preston Street, Room
Baltimore, MD 21201

Please keep in mind to include all of Quality One's policy revisions in your manuals. This will assist your agency when being audited at a later date.

EXHIBIT 9

Insurance Certificate

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

1100 Virginia Drive, Suite 250
Fort Washington, PA 19034-3278
Phone:1-888-288-3534 Fax:1-847-953-0134
Website:www.nso.com

12/06/24

Quality One Care Home Health Inc.
9221 Colesville Rd
Silver Spring, MD 20910-1657

Dear Mohamed Matope:

Enclosed is the replacement certificate of insurance that you requested.

If you have any questions or need assistance, please call us toll free at 1-888-288-3534. Our Customer Service Representatives are available weekdays from 8:00 a.m. to 6:00 p.m., EST.

Sincerely,

Customer Service

Enclosure

Q032

HEALTHCARE PROVIDERS SERVICE
ORGANIZATION PURCHASING GROUP

Certificate of Insurance

OCCURRENCE PROFESSIONAL LIABILITY POLICY FORM

Print Date: 12/06/2024

The application for the Policy and any and allsupplementary information, materials, and statements submitted therewith shall be maintained on file by us or our Program Administrator and will be deemed attached to and incorporated into the Policy as if physically attached.

PRODUCER	BRANCH	PREFIX	POLICY NUMBER	POLICY PERIOD
018098	970	HPG	0615736333	From: 12/06/24 to 12/06/25 at 12:01 AM Standard Time

Named Insured and Address:

Quality One Care Home Health Inc.
9221 Colesville Rd
Silver Spring, MD 20910-1657

Program Administered by:

Nurses Service Organization
1100 Virginia Drive, Suite 250
Fort Washington, PA 19034
1-888-288-3534
www.nso.com

Medical Specialty:	Code:
Nursing Firm	80964
Excludes Cosmetic Procedures	

Insurance Provided by:

American Casualty Company of Reading, Pennsylvania
151 N. Franklin Street
Chicago, IL 60606

Professional Liability $ 1,000,000 **each claim** $ 6,000,000 **aggregate**

Your professional liability limits shown above include the following:

* Good Samaritan Liability * Malplacement Liability * Personal Injury Liability
* Sexual Misconduct Included in the PL limit shown above subject to $ 25,000 aggregate sublimit

Coverage Extensions

License Protection	$ 25,000	per proceeding	$ 25,000	aggregate
Defendant Expense Benefit	$ 1,000	per day limit	$ 25,000	aggregate
Deposition Representation	$ 10,000	per deposition	$ 10,000	aggregate
Assault Includes Workplace Violence Counseling	$ 25,000	per incident	$ 25,000	aggregate
Medical Payments	$ 25,000	per person	$ 100,000	aggregate
First Aid	$ 10,000	per incident	$ 10,000	aggregate
Damage to the Property of Others	$ 10,000	per incident	$ 10,000	aggregate
Enterprise Privacy Protection - Claims Made Retroactive Date: 12/06/2015(Defense inside limits)	$ 25,000	per incident	$ 25,000	aggregate
Media Expense	$ 25,000	per incident	$ 25,000	aggregate
Employment Practices Liability - Claims Made Retroactive Date: 12/06/2019(Defense Only)	$ 25,000	per incident	$ 25,000	aggregate

General Liability

General Liability	$1,000,000 each claim / $6,000,000 aggregate
Fire & Water Legal Liability	Included in the GL limit shown above subject to $250,000 aggregate sublimit
Personal Liability	Excluded

Total $ 5,972.00

Base Premium $5,972.00

Policy Forms and Endorsements (Please see attached list of policy forms and endorsements)

Chairman of the Board **Secretary**

Keep this Certificate of Insurance in a safe place. It and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full. To activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Coverage Change Date: **Endorsement Date:** Master Policy: 188711433

CNA93692 (11-2018)

POLICY FORMS & ENDORSEMENTS

The following are the policy forms and endorsements that apply to your current professional liability policy.

COMMON POLICY FORMS & ENDORSEMENTS

FORM #	FORM NAME
G-121500-D (04-08)	Common Policy Conditions
G-121501-C (07-01)	Occurrence Policy Form
CNA82011 (04-15)	Related Claims Endorsement
G-145184-A (06-03)	Policyholder Notice - OFAC Compliance Notice
G-147292-A (03-04)	Policyholder Notice - Silica, Mold & Asbestos Disclosure
CNA81753 (03-15)	Coverage & Cap on Losses from Certified Acts Terrorism
CNA81758MD (01-21)	Notice - Offer of Terrorism Coverage & Disclosure of Premium
GSL13424 (05-09)	Services to Animals
GSL13425 (05-09)	Business Owner Coverage Extension Endorsement
GSL15564 (10-09)	Sexual Misconduct Sublimits of Liability Professional Liability & Sexual Misconduct Exclusion
GSL15565 (03-10)	Healthcare Providers Professional Liability Assault Coverage
GSL17101 (02-10)	Exclusion of Specified Activities Reuse of Parenteral Devices and Supplies
CNA80052 (09-14)	Distribution or Recording of Material or Information in Violation of Law Exclusion Endorsement
CNA94164 (11-18)	Amendment Definition of Claim Endorsement
CNA79802MD (08-14)	Maryland Policyholder Notice
G-123846-C19 (01-02)	Maryland Cancellation and Non-Renewal
CNA79516MD (11-14)	Enterprise Privacy Protection
CNA79575 (07-14)	Exclusion of Cosmetic Procedures
CNA89026 (05-17)	Media Expense Coverage
CNA93658 (08-18)	Employment Practices Liability Coverage - Defense Only
G-121504-C (07-01)	General Liability Form
G-123827-B (07-01)	Additional Insured General Liability
G-123828-B (07-01)(04)	Certificate Holder
GSL13428 (05-09)	DBA or Specified Endorsements

PLEASE REFER TO YOUR CERTIFICATE OF INSURANCE FOR THE POLICY FORMS & ENDORSEMENTS SPECIFIC TO YOUR STATE AND YOUR POLICY PERIOD.

For NJ residents: The PLIGA surcharge shown on the Certificate of Insurance is the NJ Property & Liability Insurance Guaranty Association.

For KY residents: The Surcharge shown on the Certificate of Insurance is the KY Firefighters and Law Enforcement Foundation Program Fund and the Local Tax is the KY Local Government Premium Tax. As required by 806 Ky. Admin Regs. 2:100, this Notice is to advise you that a surcharge has been applied to your insurance premium and is separately itemized on the Declarations page or billing instrument attached to your policy, as required KRS. §136.392.

For WV residents: The surcharge shown on the Certificate of Insurance is the WV Premium Surcharge.

For FL residents:

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/6/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Ryan Probst	
Affinity Insurance Service, Inc. 1100 Virginia Drive, Suite 250 Fort Washington, PA 19034-3278	PHONE (A/C, No, Ext): 1-888-288-3534	FAX (A/C, No):
	E-MAIL ADDRESS: customer.service@nsocover.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A :	
INSURED	INSURER B :	
Quality One Care Home Health Inc. 9221 Colesville Rd Silver Spring, MD 20910 null	INSURER C :	
	INSURER D :	
	INSURER E : American Casualty Company of Reading, PA	20427
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ **(Mandatory in NH)**	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
E	Professional Liability			0615736333	12/06/2024	12/06/2025	Liability (Each claim) 1,000,000 Liability (Aggregate) 6,000,000	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Proof of Coverage

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Affinity Insurance Service, Inc.

EXHIBIT 12

Discharge Planning Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

QOC Admission and Discharge Policy

I. PURPOSE

The purpose of this policy is to ensure that all patients referred to or receiving services from Quality One Care Home Health, Inc. ("QOC") are admitted and discharged in a consistent, patient-centered, clinically appropriate, and legally compliant manner. This policy guides the full continuum of care—from referral to admission through discharge—to ensure:

- Equitable access to care
- High-quality, evidence-based service delivery
- Safe and efficient transitions between care settings
- Protection of patient rights
- Compliance with Medicare Conditions of Participation (42 CFR 484), COMAR 10.24.16.08, COMAR 10.24.01.08G(3), and Joint Commission standards

QOC is committed to serving **adult and pediatric patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay.

II. SCOPE

This policy applies to:

- All clinical and administrative staff involved in the referral, intake, admission, care delivery, discharge, documentation, or coordination of services
- All patient populations (adult, pediatric, high-acuity, chronic, post-acute, palliative, etc.)
- All disciplines (RN, LPN, PT, OT, ST, MSW, Home Health Aide)
- All payer types (Medicare, Medicare Advantage, Medicaid, Medicaid Waiver, commercial insurance, workers' compensation, private pay, charity care/discounted care)

III. POLICY STATEMENT

QOC will provide timely, appropriate, and patient-centered admission and discharge processes that:

- Prioritize safety, quality, and continuity of care
- Ensure access to services regardless of ability to pay (see Charity/Discount Policy)
- Actively involve patients, families, and caregivers in all decisions
- Maintain compliance with all regulatory requirements
- Coordinate care with physicians, hospitals, and community providers

- Prevent inappropriate/unsafe discharge or abandonment of patients
- Support the highest possible clinical outcomes and patient satisfaction
- Begin discharge planning at admission and update throughout the episode of care
- Follow CMS and COMAR requirements for documentation and notification

IV. DEFINITIONS

Admission:
The formal acceptance of a patient for home health services based on medical necessity, physician order, eligibility, and agency capacity.

Discharge:
The completion or termination of home health services, either due to goal attainment, transition of care, patient choice, physician order, or specific clinical or safety reasons.

Interdisciplinary Team (IDT):
Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists, Speech Therapists, Medical Social Workers, Home Health Aides, and administrative or clinical leadership collaborating on patient care.

Plan of Care (POC):
Comprehensive treatment plan ordered and approved by a physician in accordance with Medicare requirements (CMS Form 485 or electronic equivalent).

Homebound Status:
CMS criterion for Medicare patients indicating that leaving home requires considerable effort or assistance (not required for pediatric or certain Medicaid populations).

High-Acuity Patient:
A patient requiring complex clinical management (e.g., ventilator, tracheostomy, IV infusion, complex wound care, enteral feeding).

Medically Necessary Services:
Services required to treat illness, injury, or disability, ordered by a physician, and provided by qualified clinicians.

Patient Rights:
The legal and ethical rights afforded to all patients, detailed in QOC's Patient Rights & Responsibilities Policy (provided at admission).

V. ADMISSION PRINCIPLES

QOC admits patients in a manner that ensures:

- Timely access to medically necessary care
- Patient and family involvement in decision-making
- Equitable access regardless of payor, diagnosis, disability, or complexity
- Clinical appropriateness and safety
- Compliance with physician orders and regulatory requirements
- Immediate initiation of discharge planning to ensure continuity of care

QOC will **not** refuse admission based solely on:

- High-acuity or complexity of condition
- Disability or cognitive impairment
- Age (including pediatric or geriatric)
- Ability or inability to pay (see Charity Care Policy)
- Payor type (including Medicaid, Medicare, and uninsured)
- Geographic location within approved service area (Frederick, Carroll, Washington, Allegany, Garrett Counties)

VI. ADMISSION CRITERIA

A patient will be admitted when **all of the following apply**:

1. Clinical Eligibility

- The patient requires **skilled services** (nursing or therapy) as defined by CMS or payor
- The service is **medically necessary** to treat an illness or condition
- The patient's needs can be **safely met at home**
- The patient (or legal guardian) provides **informed consent**

2. Physician Involvement

- A **physician or allowed practitioner** (MD, DO, NP, PA) orders home health services
- The physician agrees to **review and sign the Plan of Care (POC)**
- The physician collaborates with QOC throughout the episode

3. Payor Eligibility

QOC accepts:

- Medicare
- Medicare Advantage
- Medicaid & Medicaid Waiver
- Commercial insurance
- Worker's compensation
- Private pay
- Veterans programs
- Charity care/discounted care (when eligible)

Inability to pay is NEVER a reason to deny admission.

4. Service Area

Patient must reside in one of **five Western Maryland counties**:

- Frederick
- Carroll
- Washington
- Allegany
- Garrett

5. Homebound Status (Medicare-specific)

- Medicare patients must meet CMS homebound criteria unless exempt
- Pediatric, Medicaid waiver, or private insurance patients may not need to be homebound

6. Agency Capability

QOC must have the qualified staff, equipment, and resources to meet patient's needs safely and effectively.

VII. SPECIAL POPULATIONS SERVED

A. High-Acuity Patients

QOC accepts medically complex patients requiring:

- Tracheostomy care
- Ventilator support (invasive or non-invasive)
- Enteral or parenteral feeding
- IV infusion therapy
- Complex wound care
- PICC/central line management
- Ostomy care
- Post-operative care
- Chronic disease management (CHF, COPD, diabetes, dementia, oncology, etc.)

B. Pediatric Patients

QOC admits infants, children, and adolescents with:

- Congenital or genetic disorders
- Neuromuscular or neurological impairments
- Tracheostomy or ventilator dependence
- Feeding tube or nutritional support
- Failure to thrive
- Post-NICU/PICU transition
- Technology dependence or ongoing skilled needs

Pediatric admission includes:

- Consent from parent/legal guardian
- Collaboration with pediatric specialists or primary care provider
- Consideration of school or daycare coordination
- Age-appropriate safety and developmental assessment
- Inclusion of family training and education

C. Behavioral and Cognitive Considerations

QOC admits patients with cognitive or behavioral health conditions **when care can be delivered safely**.

QOC may involve social work, behavioral health providers, or caregivers as needed to ensure safety and cooperation.

VIII. REFERRAL & INTAKE PROCESS

QOC receives referrals from:

- Hospitals and discharge planners
- Skilled nursing and rehab facilities
- Physicians and specialists
- Case managers
- Medicaid waiver programs
- Insurance plans/managed care organizations
- Schools or pediatric programs
- Families or self-referrals

Intake Staff Responsibilities:

- Collect clinical information, demographics, and insurance details
- Confirm physician order or request one
- Screen for skilled need and appropriateness
- Verify service area eligibility
- Identify urgency (routine vs. priority vs. same day)
- Communicate with clinical management for high-acuity cases
- Explain services, patient rights, and financial policies
- Initiate benefits verification and authorization

No patient will be denied admission due to incomplete paperwork at referral.
Intake staff will assist patients/families in gathering necessary documentation.

IX. CLINICAL REVIEW & APPROVAL

An RN or Clinical Director reviews every referral to determine:

- Clinical appropriateness
- Required discipline(s)
- Complexity and staffing needs
- Safety considerations
- Need for special equipment or supplies
- Any potential risk factors
- Need for interdisciplinary team collaboration

The **Director of Nursing** and/or **Administrator** must approve any high-acuity or unusual cases to ensure staffing and resource readiness.

X. RAPID ADMISSION & HOSPITAL COORDINATION

To support hospital throughput and reduce readmissions:

- Standard admission begins **within 48 hours** of referral
- **Same-day or next-day** start of care for urgent or high-priority patients
- QOC may conduct **hospital or facility pre-discharge visits**
- QOC collaborates directly with hospital case managers or physicians
- QOC accepts referrals **7 days/week**
- QOC maintains an **on-call nurse** for urgent clinical coordination

This rapid, flexible admission model supports MHCC goals for timely post-acute transitions.

XI. INITIAL ASSESSMENT

A **comprehensive, in-home assessment** is performed by an RN or qualified therapist and includes:

- Physical exam and clinical status
- Functional, cognitive, and psychosocial assessment
- Medication reconciliation
- Pain and symptom management
- Fall risk evaluation
- Home safety and environmental review
- Social determinants of health (transportation, support, financial)
- Patient and caregiver education needs
- Cultural or language needs
- Emergency and contingency plans

For Medicare patients: OASIS assessment is completed as required.

XII. PLAN OF CARE (POC)

Following assessment, the clinician develops a patient-centered Plan of Care that includes:

- Diagnoses and clinical goals
- Types and frequency of services
- Interventions and treatment plan
- Equipment, supplies, or technology needs
- Safety measures and caregiver training
- Discharge planning considerations
- Interdisciplinary coordination

The POC is:

- Reviewed, approved, and signed by the physician (CMS Form 485 or EHR equivalent)
- Reviewed every 60 days or sooner if the condition changes
- Updated based on patient progress and/or new orders

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

DISCHARGE POLICY

I. Discharge Planning

- Discharge planning starts **at admission** and is updated at every IDT review.
- The clinician discusses likely discharge goals, criteria, and needs with the **patient/caregiver and physician**; updates the plan of care as the condition evolves.
- Planning prioritizes **safety**, **continuity**, **patient goals/preferences**, and **timely transition** to the appropriate level of care.

II. Discharge Criteria

A patient may be discharged when one or more apply:

1. **Goals achieved / no further skilled need**
   - Wound closed; medication stabilized; therapy goals met.
2. **Maximum practical benefit reached**
   - Plateau despite appropriate interventions; transition to maintenance/outpatient.
3. **Patient choice / refusal / transfer**
   - Patient elects to stop services or move to another HHA/SNF/assisted living/hospice.
4. **Physician order to discontinue home health**
   - Document order and clinical rationale.
5. **Hospitalization or death**
   - If no return expected, complete discharge; if return expected, place on hold per payor rules.
6. **Unsafe environment / staff safety risk** *(last resort)*
   - After reasonable mitigation (family conference, MSW involvement, care plan adjustments), physician notified; safe alternative arranged.
7. **Nonadherence that makes care unsafe or ineffective** *(last resort)*
   - After documented education, problem-solving, and MD involvement, determine if alternate setting/provider is safer.

Important: QOC **does not discharge** simply because care is complex, costly, time-consuming, or because reimbursement is low/denied.

III. Discharge Protections & Patient Rights

- Patients are informed of rights at admission (see **Patient Rights & Responsibilities Policy**).
- QOC ensures **no abandonment**: a **safe alternative** (another provider or level of care) is offered/arranged whenever possible.

- Language/communication needs are accommodated; teach-back used to confirm understanding of discharge instructions.

IV. Medicare Requirements (NOMNC & Appeals)

For Medicare/MA patients:

- Provide the **Notice of Medicare Non-Coverage (NOMNC)** within required timeframes prior to planned discharge.
- Inform patients of their **right to appeal** through the QIO; continue services as required pending decision.
- Document timing, delivery, and patient understanding of NOMNC and any appeals.
- Coordinate with the plan/QIO and physician during appeal; maintain safe care until determination.

V. Discharge Notification & Orders

- **Planned discharges:**
  - Notify patient/family **verbally and in writing**; document consent/understanding.
  - Notify and obtain **physician order** prior to discharge (unless patient refuses services).
  - Give **advance notice** (generally ≥48 hours) when feasible.
- **Urgent discharges (safety/behavioral risk):**
  - Notify physician **immediately**; document risks and mitigation; ensure safe transition where possible.

VI. Transfer to Another Agency/Level of Care

- With patient consent, QOC coordinates transfer to another HHA, SNF, IRF, LTACH, outpatient clinic, hospice, or community program.
- QOC provides a **warm handoff**: direct clinician-to-clinician communication whenever possible, and timely transmission of the discharge/transfer summary and relevant records.

VII. Discharge Summary

Complete within 48 hours of discharge (matches your prior policy). Summary includes:

- Reason for discharge and type (planned, transfer, refusal, hospitalization, death)
- Patient condition/status at discharge (clinical, functional, psychosocial)
- Services provided and **goals achieved/not achieved** with rationale
- **Medications** at discharge; outstanding orders/monitoring needs
- Education provided; caregiver competence/teach-back confirmed

- **Equipment/supplies** in home; vendor contacts
- Referrals made (e.g., outpatient PT, wound clinic, MSW, community resources)
- **Follow-up appointments** (PCP/specialist) and who scheduled them
- Physician notification and final orders
- NOMNC/appeal information (when applicable)
- Contact information for questions post-discharge

VIII. Continuity of Care & Post-Discharge Follow-up

- Provide written discharge instructions (plain language; patient's preferred language).
- Send discharge summary and key documents to the **physician/next provider** promptly.
- **Follow-up calls**:
  - **Day 3** to confirm safety, meds, wound/therapy plan, equipment in place.
  - **Day 7** to reassess status, barriers, and address problems—helps reduce readmissions.
- For high-risk patients (e.g., CHF, COPD, complex wounds), consider an extra check-in within **24–48 hours**.

IX. Documentation Standards

- Document all notifications, patient/caregiver education, physician communications, NOMNC/appeal steps, and handoffs.
- File the discharge summary and related artifacts in the **EHR within 48 hours**.
- Use standardized checklists to ensure completeness and consistency.

X. Roles & Responsibilities

- **Primary Clinician (RN or lead therapist):** coordinates discharge plan; completes summary; educates patient/caregiver.
- **Physician/Allowed Practitioner:** reviews progress; issues discharge/transfer orders; collaborates on plan.
- **Therapists (PT/OT/ST):** update functional status, equipment needs, and outpatient plans.
- **Medical Social Worker:** addresses psychosocial barriers; links to community resources; assists with safe disposition.
- **Home Health Aide:** provides input on daily function/self-care; reinforces education.
- **Intake/Scheduling/Billing:** finalize logistics, benefits, and notify payor as needed.

XI. Quality & Compliance Integration

- Admission timeliness, unplanned discharges, appeals, readmissions within 30 days, and post-discharge call completion are tracked in **QAPI**.

- **Case reviews** are performed on discharges related to safety/nonadherence to ensure appropriate mitigation steps were taken and no abandonment occurred.
- Trends inform staff education, process improvement, and resource allocation.

XII. Policy Governance

- Reviewed at least **annually**; updated to maintain compliance with **CMS Conditions of Participation (42 CFR 484.50 & 484.58)**, **COMAR 10.24.16.08 A/B/G/I/K**, and **Joint Commission** standards.
- Staff receive training on any changes; compliance is monitored via chart audits and QAPI metrics.

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

APPEALS, DOCUMENTATION, QUALITY, GOVERNANCE

I. Patient Appeals & Grievances

Patients have the right to voice concerns without fear of retaliation.
QOC maintains a **formal grievance and appeal process** consistent with Medicare Conditions of Participation and QOC's **Patient Rights & Responsibilities Policy.**

Patients may appeal:

- Denial of admission
- Proposed discharge or reduction in services
- Quality concerns
- Staff behavior or communication
- Any aspect of their care

Appeal process:

1. Patient/family may submit verbally or in writing.
2. QOC leadership reviews within **5 business days.**
3. A written response is provided with findings and resolution.
4. Unresolved issues may be escalated to **external agencies** (e.g., MDH, MHCC, CMS, Joint Commission).

For **Medicare beneficiaries:**

- QOC will provide the **Notice of Medicare Non-Coverage (NOMNC)** before discharge.
- Patients have the right to a **fast appeal** through the **Quality Improvement Organization (QIO)**.
- QOC will comply with all QIO determinations and continue care as required during appeals.

II. Documentation Requirements

QOC maintains complete and accurate records for all admissions and discharges in accordance with CMS, COMAR, and Joint Commission requirements. Documentation includes:

- Referral and intake data
- Initial and comprehensive assessments
- Home safety and environmental evaluations
- Plan of Care (physician-signed and updated)

- Interdisciplinary notes and communications
- Discharge planning activities
- Physician notifications and orders
- NOMNC and appeal documentation (if applicable)
- Final discharge summary (completed within **48 hours**)
- Referrals and handoff documentation
- Patient education and follow-up contact

All documentation is securely maintained in the Electronic Health Record (EHR).

III. Quality Assurance & Performance Improvement (QAPI) Integration

QOC uses admission and discharge data to monitor and improve performance.
The following indicators are reviewed regularly:

Admission-related Metrics:

- Time from referral to admission (48-hour target / same-day options)
- Admission delays and root causes
- High-acuity and pediatric admissions

Discharge-related Metrics:

- Discharge reasons by category (goals met, patient refusal, transfer, safety)
- Unplanned discharges
- 30-day hospital readmission rates
- Discharge documentation timeliness (<48 hours)
- Post-discharge follow-up completion (Day 3 and Day 7)
- Medicare appeals and outcomes

Quality & Patient Experience:

- Patient/caregiver satisfaction
- Continuity of care outcomes
- Identified barriers to care
- Staff competency and training needs
- Opportunities for improvement

Actions from QAPI may include:

- Staff education or re-training
- Process changes
- Policy updates
- Resource allocation
- Collaboration with referral partners

IV. Staff Training & Competencies

All staff involved in referral, admission, service delivery, and discharge are trained on:

- This Admission & Discharge Policy
- Patient Rights & Responsibilities
- CMS Conditions of Participation
- COMAR 10.24.16 standards
- Documentation requirements
- Communication protocols
- Cultural competence and health equity
- Pediatric and high-acuity care processes (as applicable)

Training is provided:

- During orientation
- Annually
- As needed based on QAPI findings or regulatory changes

Competency is validated through:

- Skills checklists
- Direct observation
- Chart audits
- Performance reviews

V. Policy Review & Governance

This policy is reviewed **annually** by:

- Director of Nursing / Clinical Director
- Administrator / Executive Leadership
- QAPI Committee
- Compliance Officer (if applicable)

EXHIBIT 10

Accreditation Documentation (JCAHO)

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

August 14, 2024

Elizabeth M Luanda
Chief Executive Officer
Quality One Care Home Health, Inc.
9221 Coleville Road
Silver Spring, MD 20910

Joint Commission ID #: 519232
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed: 8/8/2024

Dear Ms. Luanda:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual noted below:

Comprehensive Accreditation Manual for Home Care

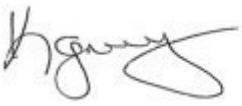
This accreditation cycle is effective beginning June 8, 2024, and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on the Find Accredited Organizations page of our website.

Congratulations on your achievement.

Sincerely,



Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations

Quality One Care Home Health, Inc.

Silver Spring, MD

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

June 8, 2024

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #519232

Print/Reprint Date: 08/15/2024

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

EXH # 1C

July 13, 2021

Elizabeth M Luanda, CEO
Quality One Care Home Health, Inc.
9221 Codeville Rd.
Silver Spring, MD 20910

Joint Commission ID #: 519232
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 7/9/2021

Dear Ms. Luanda:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning June 26, 2021 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

Quality One Care Home Health, Inc.

Silver Spring, MD

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

June 26, 2021

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #519232

Print/Reprint Date: 07/14/2021

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

June 25, 2018

Elizabeth M Luanda
CEO
Quality One Care Home Health, Inc.
12510 Prosperity Dr., Suite 320
Silver Spring , MD 20904

Joint Commission ID #: 519232
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 6/25/2018

Dear Ms. Luanda:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- **Comprehensive Accreditation Manual for Home Care**

This accreditation cycle is effective beginning June 23, 2018 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten or lengthen the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G.Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

Quality One Care Home Health, Inc.

Silver Spring, MD

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Home Care Accreditation Program

June 25, 2018

Accreditation is customarily valid for up to 36 months.

Craig W. Jones, FACHE
Chair, Board of Commissioners

ID #519232
Print/Reprint Date: 06/26/2018

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

EXHIBIT 10A

JCAHO Corrective Actions

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

Final Accreditation Report

Quality One Care Home Health, Inc.
9221 Coleville Rd.
Silver Spring, MD 20910

Organization Identification Number: 519232
Unannounced Full Event: 6/7/2024 - 6/7/2024

Program Surveyed
Home Care

Final Report: Posted 6/7/2024

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

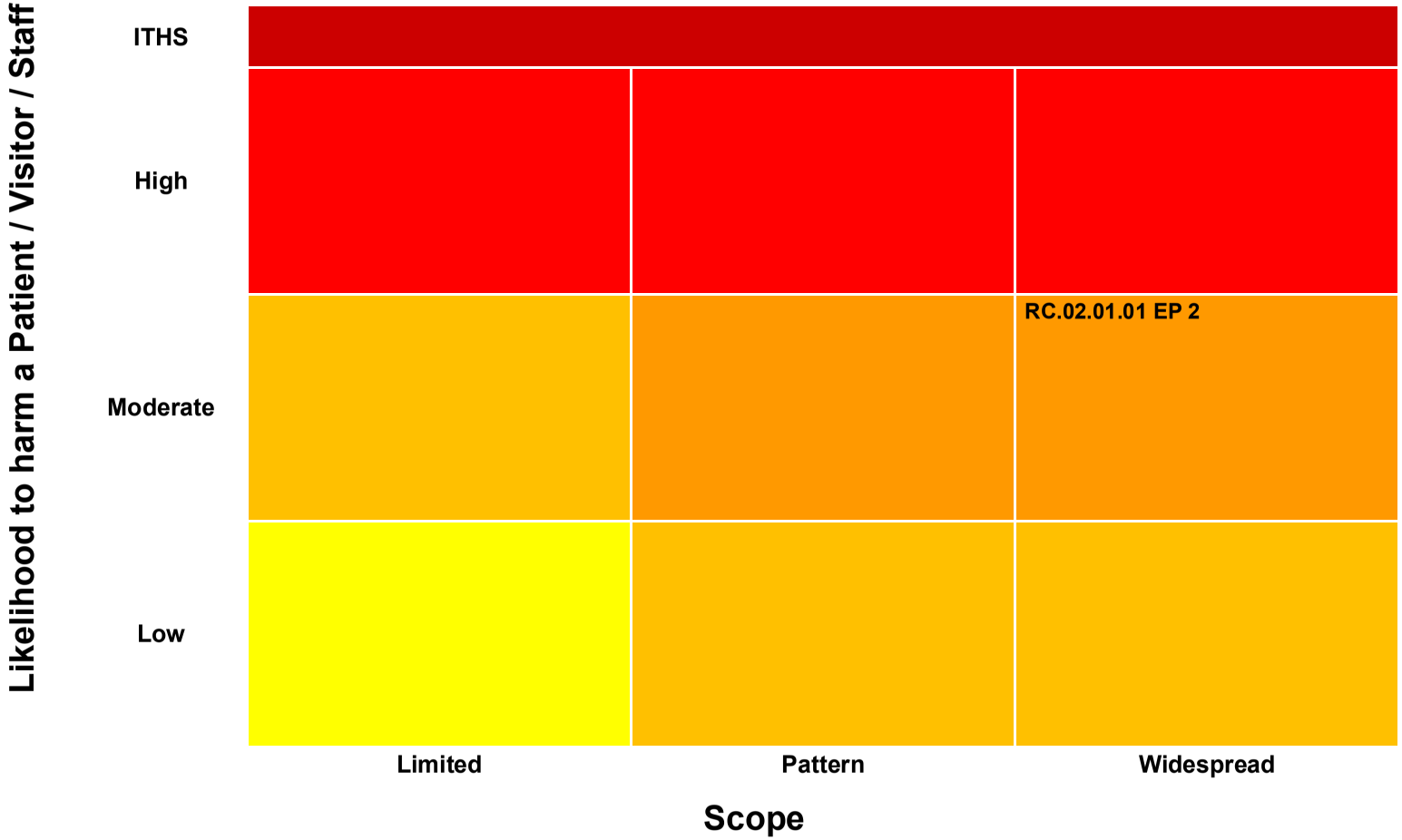
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	06/07/2024 - 06/07/2024	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Home Care

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
RC.02.01.01	2	Moderate / Widespread	✓

The Joint Commission
SAFER™ Matrix
Program: Home Care



The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation
RC.02.01.01	2	Moderate Widespread	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)	1) Observed in Record Review at Quality One Care Home Health, Inc. (9221 Coleville Rd., Silver Spring, MD) site . In 4 of 4 patient records reviewed, the surveyor noted the medical record was missing documentation regarding the treatment the nurses were providing. For Example HV#1,2 RR#1 and 2 the nurses would document care was provided and nurse had not documented what type of care was provided. For example G-tube care provided and there was no documentation of the care was. Confirmed by the DON

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care

Standard	EP	Standard Text	EP & Addendum Text
			and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Final Accreditation Report

Quality One Care Home Health, Inc.
9221 Coleville Rd.
Silver Spring, MD 20910

Organization Identification Number: 519232
60-day Evidence of Standards Compliance Submitted: 8/8/2024

ESC Programs Reviewed
Home Care

Final Report: Posted 8/14/2024

The Joint Commission
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The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	8/8/2024	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
RC.02.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care

Standard	EP	Standard Text	EP & Addendum Text
			and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

Final Accreditation Report

Quality One Care Home Health, Inc.
9221 Codeville Rd.
Silver Spring, MD 20910

Organization Identification Number: 519232
60-day Evidence of Standards Compliance Submitted: 7/9/2021

ESC Programs Reviewed
Home Care

Final Report: Posted 7/13/2021

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	7/9/2021	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
NPSG.03.06.01	Compliant
PC.02.01.03	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
NPSG.03.06.01	3	Maintain and communicate accurate patient medication information.	Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)
PC.02.01.03	1	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	Prior to providing care, the organization obtains or renews orders (verbal or written) from a physician or allowed practitioner in accordance with professional standards of practice and law and regulation.

Joint Commission Health Care Organization

Organization ID: 519232-Quality One Care Home Health, Inc.
9221 Codeville Rd. Silver Spring, MD 20910

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 7/8/2021

Home Care Accreditation Program NPSG.03.06.01 EP 3
Likelihood: Moderate Scope: Pattern

Standard Text: Maintain and communicate accurate patient medication information.

EP Text: Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies.Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)

Finding(s): 1) Observed in Individual Tracer at Quality One Care Home Health, Inc. (9221 Codeville Rd., Silver Spring, MD) site .
In 1 of 2 home visits conducted, In 1 of 2 home visits conducted, the surveyor noted the clinician had not to conducted an effective medication evaluation on a follow-up visit. For example HV#1 the patient was taken Motrin for pain and Nystatin ointment for dry skin. and these medications was not on the agency medication profile. Aquaphor was discontinued when the Nystatin started and remained on the profile. Confirmed by the LVN

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

During the inspection one of the patient's PRN medication were not listed on the MAR , this error was contributed by two main reasons:

1- Nurses did not follow agency's policy of comparing medication list on the Plan of Care and Medication Administration Record (MAR) during their shifts .

2- RN supervisor did not conduct proper medication reconciliation during their monthly supervisory visits.

Q. All corrective actions identified below must be completed prior to submission

The following measures/ systemic changes have been put in place to ensure the alleged deficient practice doesn't reoccur.

A- The Agency will re-educate all RN supervisors regarding on the proper procedure of conducting monthly nurse supervisory visits. This will include but not limited to the following procedures:

a - Developing a list of current medication

b - Developing and ensuring an updated current plan of care (Form 485) and Medication Administration Record (MAR)

c - During the supervisory visits RN supervisor will physically pull out all patient's actual medication bottles and compare it against the pharmacy label on the medication bottles, MAR, and Plan of Care, to ensure that there is no discrepancy.

B - All Nurses will be re-educated on the agency policy and procedure on reporting new, unused and discontinued medication to the agency immediately once discovered.

C - The DON/DESIGNEE will conduct monthly random audits of all active patients charts or 10% of patient's charts as census increases to ensure that proper medication reconciliation is properly done by the RN supervisors during their visits. Any negative patterns will be presented the Quality Assurance Committee for tracking and trending purposes with follow-up actions taken and implemented as need arises.

Q. All corrective actions described above were completed by

Jul 08, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The DON/DESIGNEE will conduct monthly random audits of all active patients charts or 10% of patient's charts as census increases to ensure that proper medication reconciliation is properly done by the RN supervisors during their visits. Any negative patterns will be presented the Quality Assurance Committee for tracking and trending purposes with follow-up actions taken and implemented as need arises.

Q. What is the frequency of the monitoring activities?

Monthly and quarterly.

Q. What data will be collected from these activities?

Medication error report and medication reconciliation results

Q. To who, and how often, will this data be reported?

RN supervisor will perform medication reconciliation monthly supervisory visits and report the findings each month to the DON. DON will report the data to the Quality Assurance Nurse every month.

Home Care Accreditation Program PC.02.01.03 EP 1
Likelihood: Moderate Scope: Limited

Standard Text: The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.

EP Text: Prior to providing care, the organization obtains or renews orders (verbal or written) from a physician or allowed practitioner in accordance with professional standards of practice and law and regulation.

Finding(s): 1) Observed in Record Review at Quality One Care Home Health, Inc. (9221 Codeville Rd., Silver Spring, MD) site .
In 1 of 4 patient records reviewed, In 1 of 4 patient records reviewed, the surveyor noted the prior to providing care, the organization had not obtained orders (verbal or written) from a physician. For example HV #1 the order for perform trach care was missing how to perform the care. Flush G tube with 30 ml before feedings and 60 ml after feedings was missing what the flush was to be. Confirmed by the DON

Assigning Accountability

The Director of Nursing is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Final Accreditation Report

Quality One Care Home Health, Inc.
12510 Prosperity Dr., Suite 320
Silver Spring, MD 20904

Organization Identification Number: 519232
60-day Evidence of Standards Compliance Submitted: 6/25/2018

ESC Programs Reviewed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	6/25/2018	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
NPSG.15.02.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
NPSG.15.02.01	5	Identify risks associated with home oxygen therapy such as home fires.	Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance. Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.

Quality One Care Home Health, Inc.

Organization ID: 519232

12510 Prosperity Dr., Suite 320Silver Spring, MD 20904

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 8/24/2018

OME Standard NPSG.15.02.01 Identify risks associated with home oxygen therapy such as home fires.

Findings: EP 5 Likelihood to Cause Harm: Moderate Scope: Limited
Observed in Individual Tracer at Quality One Care Home Health, Inc. (12510 PROSPERITY DR SUITE # 320, Silver Spring, MD) site. In 1 of 2 home visits conducted, did not implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. For example, the back up oxygen tanks were not secured in HV#1. This finding was confirmed with the Administrator.

Elements of Performance:

5. Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance. Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.

Assigning Accountability – Title:

Mohamed Matope RN (ADMINISTRATOR)

Corrective Actions:

DME company was notified on 6/22/18 to bring Oxygen standers to the patient's house for all oxygen cylinders. The oxygen cylinders have been placed on the standers and has been properly stored hereby ensuring safety for client and staff. Staff was in-serviced on in home safety oxygen storage and handling. RN supervisors will ensure proper oxygen cylinder storage during monthly supervisory visits.

Corrective Actions Completed Date:

6/24/2018

Sustain Compliance – Procedures:

RN supervisor will ensure proper oxygen cylinder storage during monthly supervisory visits.Oxygen storage compliance checklist has been developed by the agency for data collection and to ensure compliance by staff

Sustain Compliance – Frequency:

The oxygen storage and handling compliance will be done monthly and data from the compliance checklist will be entered and analyzed quarterly.

Sustain Compliance – Data:

Data on oxygen storage and handling will be collected from the checklist. This data will be collected and entered by the RN supervisor during the monthly supervisory visits and will include compliance on storage, handling and placement of oxygen cylinders in the stander.

Sustain Compliance – How and whom:

The oxygen storage and handling compliance data will be reported every month to the Director of Nursing and will be analyzed quarterly by Quality Assurance and Performance improvement (QAPI) team.

EXHIBIT 11

Quality Assurance and Assurance Improvent (QAPI) Program

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

Includes QAPI Policy, Quality Measures and Surveys

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
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QOC Quality Assurance and Performance Improvement (QAPI) Program & Policy

I. PURPOSE

The purpose of the Quality Assurance & Performance Improvement (QAPI) Program is to ensure that Quality One Care Home Health, Inc. (QOC) consistently delivers safe, effective, patient-centered, high-quality home health services and continuously improves clinical outcomes, patient experience, and operational performance across all service areas and patient populations.

This QAPI Program is designed to:

- Fully comply with **CMS Conditions of Participation (42 CFR §484.65)**
- Meet the **Maryland State Health Plan standards (COMAR 10.24.16.08 – Quality)**
- Satisfy **COMAR 10.24.01.08G(3)(f) – Quality Review Criteria**
- Align with **Joint Commission Home Care Accreditation Standards**
- Support QOC's mission to provide **evidence-based, high-performing, equitable care**

QOC is committed to serving **adult and pediatric patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay.

II. POLICY STATEMENT

QOC maintains an agency-wide, data-driven QAPI Program that is:

- Ongoing and proactive
- Led by administrative and clinical leadership
- Supported by all staff and disciplines
- Focused on measurable quality indicators and patient outcomes
- Linked to strategic goals, regulatory standards, and patient needs
- Driven by data, patient feedback, staff input, and regulatory requirements
- Designed to continuously improve performance, prevent problems and sustain excellence

III. SCOPE

This QAPI Program applies to:

- All departments and disciplines
- All clinical programs (skilled nursing, therapy, high-acuity care, pediatric care, chronic disease programs, etc.)
- All service lines and locations (existing and new)
- All payor types (Medicare, Medicaid, commercial, private pay, etc.)
- All patient populations (adult, pediatric, medically complex, underserved)
- All aspects of operations that impact care quality and patient experience

III. GOVERNANCE & RESPONSIBILITY

1. Governing Body

The Governing Body (or Administrator/Executive Leadership) holds ultimate responsibility for:

- QAPI design, implementation, and results
- Allocating adequate resources (staff, time, data systems, training)
- Approving QAPI goals and Performance Improvement Projects (PIPs)
- Reviewing QAPI quarterly and annual reports
- Holding leadership accountable for outcomes
- Ensuring QAPI aligns with strategic priorities and regulatory obligations

2. QAPI Committee

The QAPI Committee meets **at least quarterly** and includes:

- Administrator / Executive Director
- Director of Nursing / Clinical Director
- Therapy Supervisor(s)
- Quality Improvement Coordinator / QAPI Nurse
- Medical Director or physician advisor (as needed)
- Representatives from nursing, therapy, MSW, and home health aides
- Representatives from intake/scheduling/billing as appropriate

Responsibilities:

- Analyze quality data and trends
- Review patient outcomes and satisfaction
- Evaluate compliance with clinical standards and regulatory measures
- Identify opportunities for improvement

- Select and monitor PIPs
- Develop and track corrective action plans
- Report findings to the Governing Body

3. Management & Supervisors

Department leaders are responsible for:

- Monitoring discipline-specific quality indicators
- Educating and supervising staff
- Ensuring protocol compliance
- Implementing corrective actions
- Reporting issues to the QAPI Committee

4. All Staff Members

All employees participate in QAPI by:

- Delivering high-quality care
- Reporting incidents, near misses, and concerns
- Following policies and best practices
- Participating in training and improvement projects
- Supporting a culture of safety, accountability, and excellence

QAPI is embedded in daily operations — not a separate function.

V. QAPI PROGRAM STRUCTURE

QOC's QAPI Program includes four required components as defined by CMS:

1. Performance Measurement

Systematic collection and analysis of data in:

- Clinical outcomes
- Patient safety events
- Operational efficiency
- Patient experience & satisfaction
- Staff competency and retention
- Regulatory compliance

2. Performance Improvement Activities

When opportunities or problems are identified, QOC:

- Conducts root cause analysis (RCA)
- Develops and implements corrective actions
- Re-measures performance
- Ensures sustained improvement

3. Performance Improvement Projects (PIPs)

Data-driven, interdisciplinary projects that focus on:

- High-risk, high-volume, or problem-prone processes
- Critical quality concerns or strategic priorities
- Patient safety, access, or outcome improvements

4. Continuous Feedback & Integration

QAPI activities lead to:

- Policy and procedure updates
- Staff training
- Operational changes
- Technology enhancements
- Resource allocation
- Long-term strategic planning

VI. QUALITY INDICATORS & DATA SOURCES

QOC collects both quantitative and qualitative data, including:

Clinical Outcomes (examples):

- Wound healing rates
- Improvement in functional ability
- Pain management effectiveness
- Medication reconciliation accuracy
- CHF/COPD/diabetes outcomes
- OASIS outcome measures
- High-acuity case success metrics (vent/trach/IV)

Patient Safety:

- Falls and fall-related injuries
- Infection rates (wound, line sepsis, etc.)
- Adverse events or medical errors
- Hospitalizations and ED visits (especially 30-day readmissions)
- Timeliness of interventions and follow-up

Operational Performance:

- Time from referral to admission (48-hour standard)
- Same-day or next-day start of care rate
- Visit frequency compliance
- Missed or canceled visits
- Staff productivity and caseload
- Scheduling efficiency

Patient Experience:

- Patient satisfaction surveys (98% historical performance)
- Family/caregiver feedback
- Complaint/grievance tracking
- Net promoter scores (if used)

Staff & Workforce:

- Staff retention and turnover
- Competency validation results
- Training completion rates
- Staff satisfaction and culture assessments

Regulatory Compliance:

- CMS process measures (e.g., timely initiation of care)
- State requirements (COMAR)
- Joint Commission standards
- Documentation audit results

VII. HEALTH EQUITY & ACCESS MONITORING

QOC actively monitors access and outcomes to ensure care is **equitable and effective** across:

- Geographic areas
- Age groups (including pediatric vs adult)
- Disability or functional status
- Socioeconomic status / payor type
- Race / ethnicity / language
- Medically underserved or rural populations

When disparities are identified, QOC implements targeted interventions (e.g., outreach, staff education, telehealth expansion, partnerships with local providers).

VIII. USE OF TECHNOLOGY & DATA ANALYTICS

QOC leverages technology to enhance quality:

- **Electronic Health Record (EHR)** with integrated clinical alerts, documentation audits, and outcomes tracking
- **Clinical dashboards** to monitor real-time performance
- **Telehealth and remote monitoring** to support high-acuity, rural, and chronic care populations
- **Data analytics tools** to identify trends, predict risks, and support early intervention
- **Secure communication platforms** to coordinate interdisciplinary care and reduce delays

Technology supports **faster decisions, better coordination, and improved patient safety.**

IX. PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

A. Purpose of PIPs

Performance Improvement Projects are **targeted, data-driven initiatives** aimed at improving specific aspects of care with the greatest impact on:

- Patient outcomes
- Safety
- Access
- Satisfaction
- Regulatory compliance
- Strategic goals

B. Criteria for Selecting PIPs

PIPs are initiated when:

- Quality data reveals below-target performance
- A process is high-risk or high-volume
- A problem is persistent or trending negatively
- Regulatory requirements indicate focus
- Staff, patient, or caregiver feedback identifies issues
- Strategic priorities or innovation opportunities arise

C. Examples of PIPs QOC May Conduct:

- Reduce 30-day hospital readmission rates (CHF, COPD, wound infections)
- Improve admission timeliness (48-hour or same-day starts)
- Strengthen medication reconciliation accuracy
- Improve caregiver education and competency in high-acuity cases
- Increase wound healing rates
- Decrease missed or canceled visits
- Enhance pediatric tracheostomy or ventilator care outcomes
- Improve documentation completeness and timeliness
- Increase patient satisfaction scores beyond 98%

D. PIP Methodology

Each PIP follows a structured improvement model:

1. Define the problem with data
2. Establish measurable goals/outcomes
3. Form an interdisciplinary PIP team
4. Conduct root cause analysis (e.g., fishbone, 5 Whys)
5. Develop and implement interventions
6. Measure progress regularly
7. Modify interventions as needed
8. Sustain successful improvements
9. Report to QAPI Committee and Governing Body

E. Minimum Requirement

At least **one PIP at all times**, as required by CMS.
QOC typically conducts **multiple PIPs simultaneously** to drive improvement across key areas.

X. USE OF QAPI TO DRIVE RESOURCES & STAFFING

QOC uses QAPI findings to inform:

- Staffing levels and caseload distribution
- Specialized clinical training needs
- Recruitment of high-acuity and pediatric specialists
- Investment in telehealth, remote monitoring, and data systems
- Scheduling and workflow optimization
- Budget allocation for quality initiatives
- Development or expansion of specialty programs

Quality drives operational decision-making at QOC.

XI. VALUE-BASED CARE & INNOVATION

QOC aligns QAPI with **Home Health Value-Based Purchasing (HHVBP)** measures, including:

- Improvement in ambulation
- Improvement in self-care
- Medication management
- Hospital readmission reduction
- Patient experience (satisfaction and communication)
- Timely initiation of care

QOC also uses QAPI to:

- Adopt evidence-based best practices
- Pilot new care models (e.g., advanced chronic care programs)
- Scale successful initiatives across all service areas
- Drive efficiency without sacrificing care quality

QOC views QAPI as an engine for innovation, not just compliance.

XII. PATIENT SAFETY & RISK MANAGEMENT

QOC uses a comprehensive safety program that includes:

- Incident and near-miss reporting (non-punitive culture)
- Investigation and root cause analysis (RCA)
- Corrective action implementation
- Regular safety rounds (field observations, case reviews)
- Fall and injury prevention strategies
- Medication safety protocols

- Infection surveillance and control
- Emergency preparedness drills
- Staff safety training and reporting mechanisms

High-risk events are reported to the Governing Body and monitored for trends.

XIII. STAFF EDUCATION & COMPETENCY

QAPI findings directly inform staff training, including:

- Orientation and annual competencies
- High-acuity skills (vent/trach, wound, IV, pediatric)
- Documentation accuracy
- Cultural competence and health equity
- Emergency preparedness
- Ethics and patient rights
- Regulatory changes and best practices

QOC ensures:

- Competency checklists are validated
- Staff receive ongoing education
- Performance issues lead to targeted retraining or coaching
- High performers are recognized and used as preceptors/mentors

XIV. DOCUMENTATION & REPORTING

QOC maintains comprehensive records of:

- QAPI Committee meetings
- Quarterly performance dashboards
- Data trend reports and analysis
- Identified issues and improvement actions
- PIP charters, interventions, and outcomes
- RCA findings and action plans
- Staff training related to QAPI
- Annual QAPI Program evaluation

Documentation is maintained in a secure, organized manner and is available to CMS, state surveyors, and accrediting bodies.

XV. ANNUAL QAPI PROGRAM EVALUATION

Every year, QOC conducts a formal QAPI Program Evaluation that includes:

- Review of quality indicators and trends
- Summary of PIPs conducted and outcomes
- Analysis of goals met and unmet
- Identification of emerging risks or gaps
- Assessment of resource sufficiency
- Staff competency and training needs
- New priorities for the next year
- Recommendations for policy or operational changes
- Approval by Governing Body

XVI. CULTURE OF QUALITY & CONTINUOUS IMPROVEMENT

QOC promotes a culture where:

- Quality is everyone's responsibility
- Data drives decisions
- Patient safety is non-negotiable
- Transparency is expected
- Improvement is continuous
- Success is celebrated
- Innovation is encouraged
- Patients, families, and staff are heard

QOC does not aim to be minimally compliant —
QOC strives to be a leader in clinical excellence, patient satisfaction, and operational performance.

XVII. POLICY REVIEW & APPROVAL

This QAPI Program and Policy is reviewed **at least annually** and updated to ensure continued alignment with:

- CMS Conditions of Participation (42 CFR 484.65)
- COMAR 10.24.16.08 Quality standards & Best practices in home health care
- Joint Commission requirements

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Annual Client Survey: Hand Hygiene Technique Compliance

Survey Year: ____

Client Name: _____ Date of Observation: _____

Staff Completing Form: _____

Instructions: This survey is designed to evaluate the understanding and application of proper hand hygiene practices among clients and their family members. Please complete each item by checking the appropriate box. Your participation helps us improve the quality of care provided.

1. **Education & Understanding**

   ☐ I received verbal and/or written instruction on proper handwashing techniques.

   ☐ I understand when handwashing is required (e.g., before/after care, meals, restroom use).

   ☐ I was educated on the differences between handwashing with soap and using hand sanitizer.

   ☐ I understand how hand hygiene helps prevent infections and protects my loved one.

2. **Skill Demonstration (To Be Completed with Staff Observation)**

   ☐ I demonstrated how to wash hands using soap and water, covering all hand surfaces for at least 20 seconds.

   ☐ I demonstrated how to use alcohol-based hand sanitizer appropriately when soap and water are not available.

   ☐ I performed hand hygiene before and after participating in patient care activities during the observation.

   ☐ Observed and Verified by Staff

3. **Application and Compliance**

   ☐ I am able to demonstrate proper hand washing technique.

   ☐ I have access to clean water, soap, and paper towels at home.

   ☐ I use hand hygiene consistently during daily routines and caregiving.

   ☐ I encourage other caregivers/family members to follow hand hygiene protocols.

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4. **Feedback**

☐ I feel confident in my ability to maintain good hand hygiene.

☐ I would benefit from additional training or materials on hand hygiene.

☐ I am satisfied with the training provided by the agency.

5. Additional Comments (Optional)

_____

_____

_____

_____

_____

Client/Family Member Name: _____

Signature: _____

Date: _____

Staff Reviewer Initials: _____

Date Reviewed: _____

***Confidentiality Notice:**

This survey is confidential and used solely to evaluate and improve our educational services. Your feedback helps us ensure safety and compliance.

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Annual Client Survey: Tracheostomy Suctioning Techniques

Survey Year: ____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: ☐ Client ☐ Family Member ☐ Other (Specify): _____

Instructions:

Please review the following items with the client or family caregiver. Check each box that applies. This form should be completed during initial training and reviewed annually or as needed.

1. **Understanding of Suctioning Equipment Use**
   - ☐ Able to identify suction machine and its parts
   - ☐ Can assemble suction equipment correctly
   - ☐ Demonstrates knowledge of appropriate suction pressure settings
   - ☐ Understands when and how often to suction
2. **Demonstration of Proper Technique**
   - ☐ Performs hand hygiene before and after suctioning
   - ☐ Uses appropriate Personal Protective Equipment (PPE)
   - ☐ Measures catheter insertion depth accurately
   - ☐ Suctions tracheostomy tube correctly (using circular motion, ≤ 10 seconds per pass)
   - ☐ Allows sufficient recovery time between suction passes
3. **Safety and Emergency Readiness**
   - ☐ Recognizes signs of respiratory distress
   - ☐ Knows when to stop suctioning and call for medical help
   - ☐ Keeps spare tracheostomy supplies readily available
   - ☐ Able to describe steps for accidental decannulation

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4. **Post-Suctioning Care**

   ☐ Cleans suction catheter or uses disposable appropriately

   ☐ Properly discards waste and used supplies

   ☐ Ensures tracheostomy ties are secure

   ☐ Monitors for secretions, bleeding, or skin breakdown around the stoma

5. **Client/Family Confidence**

   ☐ Verbalizes understanding of procedure

   ☐ Demonstrates confidence in performing suctioning independently

   ☐ Agrees to contact nurse if unsure or if changes are noticed

Nurse/Staff Reviewer Initials: _____

Client/Family Signature: _____

Date of Completion: _____

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Annual Client Survey: Medication Management Education

Survey Year: ____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: ☐ Client ☐ Family Member ☐ Other (Specify): _____

PART 1: Medication Education

1. Were you educated on how to take your medications safely?
   ☐ Yes ☐ No ☐ Not sure
2. Do you understand the purpose of each medication you are currently taking?
   ☐ Yes, completely ☐ Somewhat ☐ No
3. Were written instructions (e.g., medication list or schedule) provided to you?
   ☐ Yes ☐ No ☐ Not Sure
4. Were you informed about potential side effects of your medications?
   ☐ Yes ☐ No ☐ Not Applicable
5. Do you know what to do or who to contact if you experience side effects?
   ☐ Yes ☐ No ☐ Unsure

PART 2: Medication Management Support

6. Do you use a pill organizer or reminder system (e.g., phone alert, caregiver)?
   ☐ Yes ☐ No ☐ Not Needed
7. Did someone assist you with medication setup (sorting pills, creating schedule, etc.)?
   ☐ Yes ☐ No ☐ Not Applicable
8. Have your nurses or caregivers reviewed your medication list with you regularly?
   ☐ Yes, every visit ☐ Sometimes ☐ No
9. Do you feel confident managing your medications independently or with help?
   ☐ Yes ☐ No ☐ I need more training
10. How satisfied are you with the medication education provided?
    ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied
11. Would you like additional support or follow-up regarding your medications?
    ☐ Yes ☐ No

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PART 3: Feedback and Suggestions

12. How would you rate the clarity and usefulness of the medication management education you received?

☐ Very clear and helpful

☐ Somewhat helpful

☐ Not helpful

☐ I did not receive education

13. Do you have any suggestions on how we can improve our medication management education and support?

_____

_____

_____

_____

_____

Signature: _____

Staff Reviewer Initials: _____

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Annual Client Survey: Home Oxygen Safety

Survey Year: ____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: ☐ Client ☐ Family Member ☐ Other (Specify): _____

PART 1: Oxygen Safety Training Completion

1. Did you (or your caregiver) receive education from a nurse or respiratory therapist on how to safely use and store oxygen at home?

   ☐ Yes ☐ No ☐ Not Sure

2. Was this training provided at the start of care or during your first oxygen setup visit?

   ☐ Yes ☐ No ☐ Don't Remember

3. Were written materials (handouts, checklists, or posters) provided to you on oxygen safety?

   ☐ Yes ☐ No ☐ Not Sure

4. Were you educated on the importance of avoiding smoking or open flames near oxygen?

   ☐ Yes ☐ No ☐ Don't Remember

5. Did the staff check where and how the oxygen tanks were stored in your home?

   ☐ Yes ☐ No ☐ Not Applicable

PART 2: Confidence and Knowledge Retention

6. On a scale of 1 to 5, how confident do you feel about safely using and storing oxygen in your home?

   ☐ 1 – Not Confident

   ☐ 2 – Somewhat Confident

   ☐ 3 – Neutral

   ☐ 4 – Confident

   ☐ 5 – Very confident

7. Do you know what to do in case of an oxygen-related emergency or equipment failure?

   ☐ Yes ☐ No ☐ Not Sure

8. Do you know how to clean and maintain your oxygen equipment (if applicable)?

   ☐ Yes ☐ No ☐ N/A – Maintenance handled by provider

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PART 3: Feedback and Suggestions

9. Do you believe the training you received was:

   ☐ Easy to understand

   ☐ Too basic

   ☐ Too complicated

   ☐ Not applicable to your situation

10. Do you have any suggestions for improving how we provide oxygen safety training?

_____

_____

_____

_____

_____

Signature: _____

Staff Reviewer Initials: _____

***Confidentiality Notice:**

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Annual Client Survey: Fall Prevention

Survey Year: ____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: ☐ Client ☐ Family Member ☐ Other (Specify): _____

PART 1: Fall Prevention Education Completion

1. Did you receive education from a nurse or therapist on how to prevent falls at home?
   ☐ Yes ☐ No ☐ Not Sure
2. Was this training provided during your admission or within the first few days of service?
   ☐ Yes ☐ No ☐ Don't Remember
3. Were you given written materials (handouts or visual aids) on fall prevention?
   ☐ Yes ☐ No ☐ Not Sure
4. Did the staff discuss common household hazards that increase fall risk (e.g., loose rugs, poor lighting, uneven surfaces)? ☐ Yes ☐ No ☐ Not Sure
5. Did the nurse or staff make recommendations for home modifications (e.g., grab bars, non-slip mats, clutter removal)? ☐ Yes ☐ No ☐ Not Applicable

PART 2: Confidence and Fall History

6. Have you or your caregiver made changes to your home environment to reduce fall risks?
   ☐ Yes ☐ No ☐ In Progress ☐ Not Applicable
7. On a scale of 1 to 5, how confident do you feel about avoiding falls in your home?
   ☐ 1 – Not Confident
   ☐ 2 – Somewhat Confident
   ☐ 3 – Neutral
   ☐ 4 – Confident
   ☐ 5 – Very confident
8. Since beginning care with our agency, have you experienced any falls?
   ☐ No falls ☐ One fall ☐ More than one fall ☐ Prefer not to say

QOC Quality One Care
Home Health, Inc
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PART 3: Feedback and Suggestions

9. How would you rate the clarity and usefulness of the fall prevention education you received?

   ☐ Very clear and helpful

   ☐ Somewhat helpful

   ☐ Not helpful

   ☐ I did not receive education

10. Do you have any suggestions on how we can improve our fall prevention education and support?

_____

_____

_____

_____

_____

Signature: _____

Staff Reviewer Initials: _____

***Confidentiality Notice:**

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Annual Client Survey: Feeding Tube Insertion Demonstration

Survey Year: ____

Client Name: _____ Date of Observation: _____

Staff Completing Form: _____

Instructions: This survey is designed to assess your understanding and ability to demonstrate safe and accurate feeding tube insertion. Please complete the checklist below. Your feedback helps us maintain and improve our quality of care.

1. **Feeding Tube Insertion Demonstration**

Please check the box for each step that you or your caregiver feel confident in performing correctly after receiving education/training:

☐ Washed hands thoroughly before the procedure

☐ Verified the correct placement of the tube before use

☐ Flushed the tube with the appropriate solution prior to feeding

☐ Administered the correct formula and volume as directed

☐ Maintained proper positioning during and after the feeding

☐ Recognized signs of tube displacement or complications

☐ Cleaned the insertion site and equipment properly

☐ Documented feedings or reported to the nurse as instructed

☐ Felt comfortable asking questions or requesting help

☐ Understood the emergency steps in case of aspiration or blockage

2. **Overall Understanding and Confidence**

Please check the box that best represents your experience:

☐ I feel very confident performing this task independently

☐ I feel somewhat confident but may need occasional help

☐ I do not feel confident and need additional training

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3. Additional Comments (Optional)

_____

_____

_____

_____

_____

Client/Parent/Guardian Name: _____

Signature: _____

Date: _____

Staff Reviewer Initials: _____

Date Reviewed: _____

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Annual Staff Audit: Home Equipment Maintenance/Cleaning Compliance

Audit Year: ____

Client Name: _____ Date of Visit: _____

Staff Completing Form: _____

Instructions: This form should be completed by field staff conducting home visits. Please review each applicable equipment item for maintenance, cleanliness, and functionality. Select all that apply. Signature required at the end.

1. **Equipment Inventory (Check all present in the home)**
   - ☐ Oxygen Concentrator
   - ☐ Nebulizer
   - ☐ Suction Machine
   - ☐ Feeding Pump
   - ☐ Pulse Oximeter
   - ☐ Wheelchair / Walker
   - ☐ Bed Rails / Hospital Bed
   - ☐ Other (Specify): _____

2. **Maintenance Compliance (Check all that apply)**
   - ☐ All equipment is clean and free of visible dust, mold, or residue.
   - ☐ Equipment is stored in a safe, accessible location.
   - ☐ Power cords and tubing are free from damage or frays.
   - ☐ Disposable parts (filters, masks, tubes) have been replaced on schedule.
   - ☐ Manufacturer's guidelines for cleaning/maintenance are being followed.
   - ☐ No foul odors, rust, or leakage detected.
   - ☐ Client/family was reminded about routine equipment checks.

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3. **Corrective Actions (if applicable)**

   ☐ Client/family was educated on cleaning schedule

   ☐ Malfunctioning equipment was reported to agency or DME vendor

   ☐ Maintenance issue resolved during visit

   ☐ Follow-up visit scheduled

   ☐ Not applicable

4. **Comments / Observations**

   _____

   _____

   _____

   _____

   _____

Staff Signature: _____

Date: _____

Reviewer Initials: _____

Date Reviewed: _____

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Hazard Vulnerability Assessment Completion Survey

Audit Year: ____

Client Name: _____ Date of Visit: _____

Nurse/Staff Completing Assessment: _____

1. **Hazard Identification (Check all that apply in the client's home environment)**
   - ☐ Fire hazards (e.g., faulty wiring, unattended candles, overloaded outlets)
   - ☐ Slip/trip hazards (e.g., loose rugs, cluttered walkways, wet floors)
   - ☐ Inadequate lighting (especially near stairways or bathrooms)
   - ☐ Unsecured medical equipment or tubing
   - ☐ Poor ventilation or exposure to smoke/allergens
   - ☐ Hazardous chemicals or substances accessible to children/vulnerable adults
   - ☐ Pets that may pose fall risks or cause allergic reactions
   - ☐ Lack of functioning smoke or carbon monoxide detectors
   - ☐ Unsafe storage of medication or sharp objects
   - ☐ Unclear emergency exits or blocked paths
   - ☐ Other (Specify): _____

2. **Client Education Topics Reviewed (Check all completed)**
   - ☐ Emergency preparedness (fire, medical, evacuation plan)
   - ☐ Proper use and storage of medical equipment
   - ☐ Fall prevention strategies
   - ☐ Safe medication handling and disposal
   - ☐ Environmental safety and cleanliness
   - ☐ When and how to call emergency services
   - ☐ Infection control measures (e.g., hand hygiene, disinfection)
   - ☐ Other: _____

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3. **Client/Family Understanding**

   ☐ Client/family understood hazard risks

   ☐ Client/family verbalized understanding of mitigation strategies

   ☐ Client/family demonstrated safe practices

4. **Recommendations Made**

   _____

   _____

   _____

   _____

   _____

Nurser/Staff Signature: _____

Date: _____

Reviewer Initials: _____

Date Reviewed: _____

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Annual Client Satisfaction Survey

Survey Year: ____

Client Name: _____ Date of Survey Completion: _____

Survey Completed By: ☐ Client ☐ Family Member ☐ Legal Representative ☐ Other: _____

Instructions:

Please review each statement below and check the box that best reflects your level of satisfaction. Your feedback is confidential and helps us improve our services.

How do you feel?	Very Satisfied	Satisfied	Neutral	Dissatisfied
Staff are respectful and professional	☐	☐	☐	☐
Staff arrive on time for scheduled visits	☐	☐	☐	☐
Communication with the agency is easy and responsive	☐	☐	☐	☐
My care plan is explained clearly and updated as needed	☐	☐	☐	☐
I feel safe and cared for by the staff	☐	☐	☐	☐
My needs are met in a timely and respectful manner	☐	☐	☐	☐
I am informed about my medications and treatments	☐	☐	☐	☐
The agency addresses my complaints or concerns promptly	☐	☐	☐	☐
Agency and staff are knowledgeable and professional	☐	☐	☐	☐
I am satisfied with the overall quality of services received	☐	☐	☐	☐

1. **Do you feel receiving services in your home?**

   ☐ Yes ☐ No ☐ Maybe

2. **Overall, how satisfied are you with the services provided by Quality One Care?**

   ☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Dissatisfied ☐ Very Dissatisfied

3. **What do you like most about our services?**

   _____

   _____

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4. **What could we do to improve our care or services?**

_____

_____

_____

_____

_____

5. **Additional comments or suggestions**

_____

_____

_____

_____

_____

Client/Representative Signature: _____

Date: _____

Staff Reviewer Initials: _____

Date Reviewed: _____

***Confidentiality Notice:**

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QOC Quality One Care
Home Health Inc.

HAND HYGIENE / GLOVE USE OBSERVATION FORM

YEAR_2024 Location: ☒Home ☐Lab ☐Office Completed by: **RN SUPERVISOR**

MONTHS	**JANUARY --- APRIL**																			
NUMBER OF NURSES OBSERVED	40 Nurses																			
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Hand Hygiene (use of alcohol foam hand rub or washing hands with soap and water for at least 15 seconds)																				
Before touching a patient	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Before clean and aseptic procedures, including medication ,suction, G-tube care, tracheostomy care, personal care, wound care,etc.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
After touching the patient	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Before and after contacting equipment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
After removing gloves or other personal protective equipment (PPE)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Proper donning and removing glove	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
After equipment contact upon exiting patient's room**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glove Use																				
Whenever potential for hand contact with blood/body substance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gloves removed right after use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

QOC Quality One Care
Home Health Inc.

HAND HYGIENE OBSERVATIONS REPORT

NUMBER OF HAND HYGIENE PERFORMED: 40
PERIOD JANUARY - APRIL 2021
Compliance: 95 % **Goal: 85%** **Goal Met ☐Yes ☐No**

GOAL
National Average 75%
State Average 80%
Agency Goal 85%

QOC Quality One Care
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OXYGEN CYLINDER STORAGE COMPLIANCE OBSERVATION FORM

Month/Year_____ Location: ☐Home Completed by: _____

STAFF TITLE																				
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
OXYGEN CYLINDER STORAGE:																				
Cylinder stored in well-ventilated area																				
Cylinder placed in the stander																				
Cylinder stored in a manner to prevent hazard by tipping, falling or rolling.																				
Cylinder stored upright																				
Cylinders are 20 feet away from combustible or flammable substance																				

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OXYGEN CYLINDER STORAGE COMPLIANCE OBSERVATION FORM

This report should include the 3 month period of data collection.

Period:

Compliance: **Goal:** **Goal Met** ☐**Yes** ☐**No**

RN, LPN			**HHA/CNA/ PCA**			**Total**		
Yes	No		Yes	No		Yes		
		+			+		=	

GOAL
Agency Goal 98%

Formula

$$\textbf{Compliance} = \frac{\textbf{Oxygen storage/handling compliance}}{\textbf{Number of activities)}} \textbf{ X 100}$$

QOC Quality One Care Home Health Inc.

OXYGEN SAFETY TRAINING

PT NAME:	DOB:	DATE: **1/10/2022**
O2 RELATED DIAGNOSIS:	CODE STATUS: Choose an item.	
ALLERGIES:		

IS THIS:
☐ Initial Teaching ☐Reassessment
OXYGEN SUPPLY USED AT HOME:
☐Compressed oxygen cylinders, or "green tanks" ☐Oxygen concentrators ☐Liquid oxygen systems

MEANS OF OXYGEN DELIVERY:
☐Nasal cannula ☐Ventilator ☐Mask ☐Trach collar

TEACHING PROVIDED
☐Placing No smoking Oxygen in Use signs
☐Handling and storage of oxygen cylinders
☐Hazards of smoking with oxygen in use
☐Importance of securing electric devices to prevent short-circuit sparks.
☐Danger of using volatile, flammable materials near the patient using oxygen

TEACHING PROVIDED TO: ☐Patient ☐Mom ☐Dad ☐Family member ☐Other
TYPE OF TEACHING: ☐Instructed ☐Supervised ☐Independent ☐Return demonstration.
TEACHING TOOLS: ☐Verbal ☐Video ☐Demonstration ☐Printed material ☐other:
RESPONSE TO TEACHING ☐Good ☐Fair ☐Poor ☐anxious ☐Cannot cope.

VERBAL /UNDERSTAND ☐ Yes ☐ No
NEED FURTHER SUPERVISION IN:
NEED FURTHER INSTRUCTION IN:
PLAN FOR NEXT TRAINING:

DATE:

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EQUIPMENT CLEANING LOG

NAME OF THE PATIENT_____**DOB**_____

EQUIPMENT TO CLEAN /CHANGED	HOW OFTEN	DATE CLEANED	PROPER CLEANSER USED Yes/No	EQUIPMENT WAS CHECKED Yes /No	EQUIPMENT FUNCTION WELL Yes/No	INITIALS
Suction machine	Once a week					
Suction canister	Once a week					
Suction Tubing	Once a week					
Ventilator	Once a week					
Ventilator Tubing	Once a week					
Vent. Water Chamber	Once a week					
CPAP/BIPAP	Once a week					
CPAP/BIPAP tubing	Once a week					
Monitors	Once a week					
Nebulizer	Once a week					
Aerosol Tubing	Once a week					
Oxygen Tank	Once a week					
Oxygen Tubing	Once a week					
Oxygen Concentrator	Once a week					
Tracheostomy Tube	Once a week					
Feeding Pump	Once a week					
IV infusion pump	Once a week					
Wheel chair	Once a month					
Patient bed &furniture	Once a month					
Hoyer lift	Once a month					
Refrigerator	Once a month					
Medication cart	Once a month					
Toys	Once a month					

NAME	INITIALS	NAME	INITIALS

QOC Quality One Care
Home Health Inc.

FALL REDUCTION PROGRAM

Reducing the risk of patient harm from falls is one of the National Patient Safety Goals established by the Joint Commission. Quality one care (QOC) has implemented a fall reduction program that provides guidelines for staff involved in the care of patients in the agency. The program not only limits the number of falls but also to minimize injury resulting from falls. Some key components of QOC's fall reduction program are:

- Fall Risk Assessment for each patient
- Environmental Assessment
- Staff education and training
- Education for patient & family
- Review of patient medications
- Individualized patient care plan
- Post-Fall Assessments
- Evaluation

QOC will measure the effectiveness of the program quarterly

The agency's comprehensive fall reduction program includes restraint-free tools to:

- Identify high fall risk patients
- Alert caregivers of a potential fall
- Hip protectors and floor cushions to reduce the risk of fall-related injuries
- Patient Safety tools to reduce the hazards within the patient's environment

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FALL-REDUCTION PROGRAM EVALUATION

RISK CONTROL MEASURES	YES/NO	CORRECTIVE ACTION
RISK ASSESSMENT PROCESS 1. 1.Is every client evaluated for risk of falling, utilizing a fall-assessment tool that considers the following factors, among others: • Previous fall history and associated injuries? • Gait and balance disturbances? • Foot and leg problems? • Reduced vision? • Medical conditions and disabilities? • Cognitive impairment? • Bowel and bladder dysfunction? • Special toileting requirements? • Use of multiple prescription and over-the-counter medications? • Need for mechanical and/or human assistance? • Environmental hazards? 2. Are higher-risk clients identified, including those who experience recurrent falls or have multiple risk factors? 3. Are higher-risk clients referred to their physician for a more thorough assessment 4. Is a home safety check conducted prior to commencement of services? 5. If safety problems are detected in the home, are corrective actions recommended to the client as part of the service agreement? 6. Are direct care staff members involved in the initial client assessment, as well as ongoing reassessment efforts? 7. Are services regularly assessed and modified in response to changes in the client's condition? 8. Are clients and families informed of salient risk factors, as well as basic safety strategies? 9. Are all assessment findings documented and incorporated into the client's plan of care		

FALL-REDUCTION PROGRAM EVALUATION

RISK CONTROL ANALYSIS	YES/NO	CORRECTIVE ACTION
STAFF EDUCATION 1. Are educational in-service programs offered to direct care staff on a regular basis, and are attendance records kept? 2. Do staff educational programs focus on skills training, such as how to use gait belts and assist with transfers? 3. Do educational offerings examine the root causes of falls, as well as their prevention? 4. Are staff members instructed to assess and document the client's condition at each visit, and also to: • Report any changes to the supervisor and family in a clear and timely manner? • Perform frequent home safety checks? • Reinforce fall-reduction tactics with clients and family? • Encourage clients to ask for assistance with risky tasks? • Keep accurate, detailed records of client encounters **POST-FALL ANALYSIS** 1. Are all clients fall reviewed for quality assurance purposes, including analysis of root causes and tracking of trends? 2. Does the post-fall analysis require caregivers to describe the circumstances of the fall, and also to: • Identify major causal factors, both personal and environmental? • Indicate the client's functional status before and after the fall? • Suggest interventions to prevent or mitigate future falls? 3. Is the post-fall analysis thoroughly documented, and are findings incorporated into quality assurance and/or incident reporting programs		

FALL RISK ASSESSMENT:

The fall risk assessment serves as the basis for care planning. The agency will conduct the fall risk assessment on each patient at start of care, when there is a change in patient's condition, and at re-certification.

Morse Fall Risk Assessment is an official fall risk assessment scales utilizes by Quality One Care Inc. (QOC).It is made up of six subscales:

1. History of falls
2. Secondary diagnosis
3. Ambulatory aid
4. IV or heparin lock
5. Gait
6. Mental status

SEE ATTACHED MORSE FALL RISK ASSESSMENT/MORSE FALL RISK ASSESSMENT TOOL

EDUCATION:

In order to promote patient and family participation in the fall reduction and safety plan, the Fall Risk and Prevention procedure is introduced upon admission. Using the Morse Fall Scoring system. Besides admission, patients are reassessed based on change of status, transfer, or after a fall occurs.

The identified fall risk factors and interventions are reviewed with the patient and family. This is to help them understand why they are at risk for falls and increase their compliance with key interventions.

The goal of the agency is to assess and improve patients' knowledge of risks for fall, and how to prevent falls. The agency will use different teaching methods and tools that are appropriate to the patient/family level of understanding.

The education is documented and revised as patient status changes

Education Topics include the following

1. Impaired balance and gait
2. Vision
3. Medications
4. Environment
5. Chronic conditions

ENVIRONMENTAL ASSESSMENT

QOC understands that environmental assessment is effective in falls reduction. On initial assessment, the agency examines the physical environment to determine whether the home is safe for the patients. The agency will educate its nursing staff the importance of maintaining a safe environment for all its patients; assist with identifying patients who are high risk for fall; provide the tools to educate patient/families of the potential risk for falls and outline strategies to develop individualized plan of care to reduce fall. Often, some modifications are necessary to accommodate the functional abilities of the patients.

All patients are considered at risk of falling and simple prevention strategies have been put in place to ensure the risk of fall is minimized. A safe environment will be maintained for all patients. Standard safety measures have been put place for all patients regardless of identified risk, these include:

1. Patients are nursed in an appropriate bed
2. Orientate all patients and parents to room
3. Keep beds with brakes on
4. Side rails are raised for appropriate age and patient groups
5. Appropriate non slip footwear for ambulating patients
6. Maintain adequate lighting in child's room; low level lighting at night.
7. Keep floors clear of clutter including equipment and toys
8. Secure and supervise all children with a safety belt or harness in wheelchairs, highchairs, strollers, infant seats and any specialist seating)
9. Bathroom assist unsteady patients with ambulation
10. Place necessary items a patient may need within reach (drinking water, phone, etc)
11. Ensure equipment is well maintained and serviced appropriately (such as wheelchairs and commodes)

BACKGROUND

B. *Patient Fall risk factors (check all that apply):*

- ☐ Impaired mobility
- ☐ Impaired mentation
- ☐ Impaired / altered elimination patterns (nocturia, urgency, frequency, diarrhea, incontinence, laxative, bowel prep)
- ☐ Impaired communication / sensory (vision, hearing, neuropathy)
- ☐ Impaired vital signs (fever, slow or fast heart rate, low blood pressure)
- ☐ Prior fall history
- ☐ Medication NOTE: If pertinent, attach copy of MAR for previous 12-hours
  - ☐ Anticonvulsant ☐ Anti-anxiety agent
  - ☐ Psychotropic ☐ Hypnotic/Sleep aid
  - ☐ Pain Medication ☐ Diuretic
  - ☐ Notable medication change within the past 2 days
  - Other:
- ☐ Diagnosis-related
  - ☐ Hypotension ☐ Hypoglycemia
  - ☐ TIA/Syncope ☐ Parkinson's
  - ☐ History of CVA or paralysis
  - ☐ Orthopedic condition
  - Other:

ASSESSMENT

Vital Signs: T_____ P_____ R _____ B/P_____ Oxygen Sat: _____
Neurochecks if evidence/suspicion of head injury: _____

If diabetic, do glucometer. Result:_____

Pain Level: _____ Describe any NEW onset pain:
_____

Injury (describe findings):

- ☐ None
- ☐ Minor:_____ _____
- ☐ Major:_____
- ☐ Death:_____

RECOMMENDATION

What can we do to prevent this from happening again? Care plan recommendations:

- ☐ High-Fall Risk Precautions
- ☐ Frequent monitoring
- ☐ Every 2hrsToileting
- ☐ PT Evaluation
- ☐ Review of meds
- ☐ Clear path to Bathroom
- ☐ Remove clutter
- ☐ Non-slip footwear
- ☐ Hip protectors
- ☐ Improved positioning
- ☐ Other:
- ☐ Oxygen/IV tubing mgmt
- ☐ Patient/family education

Additional notes:

_____

_____

_____

_____

POST-FALL CHECKLIST

- √ **Notify physician**
- √ **Notify RN supervisor**
- √ **Assess patient for injury and document assessment findings in the nursing record**
- √ **Revise plan of care to include reduction strategies**

- √ **Filled out incident report**

POST-FALL ASSESSMENT

A post-fall assessment is a structured way to collect information after a fall. The patient will be carefully and systematically assessed for injuries. All findings will be documented in the nursing record, and an incident report will be filled.

The post-fall assessment focuses on immediate risk of injury or complications and will begins as soon as possible after the fall. It includes**:**

. General information about the fall

. Patient Assessment---vital signs; visible signs of injury (type & pain scores);

Glucometer (if diabetic); Glasgow Scale (if suspected brain injury and Morse Falls scale

. Interventions based on Morse Falls scale

. Notification of RN supervisor

. Activation of EMS response team for emergency situation

The desired outcome of the post-fall assessment is to:

Specify root cause

Specify type of fall

Identify actions to prevent reoccurrence

Change plan of care

Involve patient/family in learning about the fall occurrence

Prevent repeat fall

PLAN OF CARE

POLICY

An individualized plan of care tailored to the client's risk factors will be developed by QOC. This is done after completion of the fall risk assessment and will be based on the assessment of the client's needs, strengths, limitations and goals.

PROCEDURE

The plan of care will match the identified client's risk factors such as mobility challenges, medication, mental status, and continence needs.

The plan of care identifies particular kinds of risks specific to a client and interventions to mitigate those risks.

The plan of care guides staff on how to reduce falls. Fall reduction care planning is a process by which the client's risk assessment information is translated into an action plan to address the client's needs. It is an active document that ensures continuity of care and changes as the client's condition changes.

The DON/RN (Director of Nursing, Registered Nurse) develops a Plan of Care for each client following completion of the risk assessment.

The individualized plan of care is developed for patients with any of the following:

Patient has risk factors for falling (found on the risk assessment form)
Patient has fallen since admission
Patient or family are anxious about falls

Based on the results and the provisions of the Plan of Care, the DON will select the appropriate staff that meet the skills and experience qualification needed to provide the specific needs of the client. To maintain full compliance with the requirements of this policy, the following is addressed as applicable to each client:

A. The client's plan of care is based on assessments of the client's health, function, and psychosocial condition.
B. The assessment of a client is provided:
    a. Before the client receives services from the agency
    b. When there is a change in client's condition
    c. At recertification
C. The agency shall ensure that the care plan developed for the client at a minimum addresses:
    (a) The services to be provided to the client, which are based on the assessment of the client
    (b) When and how often the services are to provided
    (c) How and by whom the services are to be provided
    (d) Long-range and short-range goals for the client
    (e) Physical needs, including safety measures to protect against fall and injury
D. The client's plan of Care shall be reviewed by a registered nurse.

REVIEW OF MEDICATION

The agency reviews and evaluates medication-related fall risk on admission and at regular intervals. QOC has identified common ways medications contribute to falls. Such as:

Sedation
Impaired balance/coordination/reaction time
Orthostatic hypotension
Parkinsonism
Cognitive changes

The agency has developed a screening tool to help identify the reactions of medication, and a medication related risk factors for fall (Table 1)

SCREENING MEDICATION FALL RISK

TABLE 1

Drug	**Reaction**
Ant diabetic agents	Hypoglycemia
Cardiovascular agents	Orthostatic hypotension, dizziness, syncope, bradycardia
Psychotropic agents	Psychomotor impairment, sedation, orthostatic hypotension, confusion
Analgesics	Sedation, Confusion
Metoclopramide	Psychomotor impairment, sedation
Anticonvulsants	Sedation, psychomotor impairment, confusion
Antihistamines	Sedation, confusion, blurred vision

The agency has also developed a Medication Fall Risk Scoring to determine if a patient is at risk for falls and plan care accordingly (Table 2)

MEDICATION FALL RISK SCORE

TABLE 2

Point value (Risk Level)	**CLASS OF MEDICATION**	**REACTION**
3 (High)	Analgesics, antipsychotics, anticonvulsants, benzodiazepines	Sedation, dizziness, postural disturbances, altered gait and balance, impaired cognition
2 (Medium)	Antihypertensive, cardiac drugs, antiarrhythmic, antidepressant,	Induced orthostatic, impaired Cerebral perfusion, poor health status
1 (Low)	Diuretics	Increased ambulation, induced orthostatic
Scores >/= 6		Higher risk for fall; evaluate patient

To calculate the score, staff members have been taught add up the point value (risk level) for every medication the patient is taking. If the patient is taking more than one medication in a particular risk category, the score should be calculated by (risk level score) x (number of medications in that risk level category). For a patient at risk, the agency will use the evaluation tools to determine if medications may be tapered, discontinued, or changed to a safer alternative.

FALL REDUCTION PROGRAM EVALUATION

On evaluation, the interventions on the plan of care are noted to be effective and accurate. The agency licensed staff are providing adequate supervision and are committed to the reducing falls. Staff training on reduction of falls and identifying patients that are high risk for falls was noted to be effective.

Standard safety measures have been maintained.

The program appears to have had a protective effect. No fall or injury has been reported. Patient and patient family appears to be knowledgeable about the risk for fall and the prevention of falls.

STAFF TRAINING AND EDUCATION

The agency staff will be trained and educated on fall reduction and fall-related injuries**.** Reducing falls requires leadership commitment and a systematic approach.

The training/education will entail the following:

A. Informing staff of the need to reduce falls/fall-related injuries by:
   Communicating safety information to staff
   Incorporating fall/safety precaution into the patient care
B. Training staff on the standardized, validated tool used by the agency to identify risk factors for falls. (Morse Fall Scale is used by the agency)
C. Training is provided to staff on using the tool to ensure inter-rater reliability.
D. Informing staff of the interventions in the individualized plan of care based on identified fall and injury risks.
E. Training on implementation of the interventions
F. Training on assessment and continued reassessment of the patient
G. Training on environmental safety
H. Training on post-fall assessment and how to accurately fill the post-fall form

EXHIBIT 12

Discharge Planning Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

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QOC Admission and Discharge Policy

I. PURPOSE

The purpose of this policy is to ensure that all patients referred to or receiving services from Quality One Care Home Health, Inc. ("QOC") are admitted and discharged in a consistent, patient-centered, clinically appropriate, and legally compliant manner. This policy guides the full continuum of care—from referral to admission through discharge—to ensure:

- Equitable access to care
- High-quality, evidence-based service delivery
- Safe and efficient transitions between care settings
- Protection of patient rights
- Compliance with Medicare Conditions of Participation (42 CFR 484), COMAR 10.24.16.08, COMAR 10.24.01.08G(3), and Joint Commission standards

QOC is committed to serving **adult and pediatric patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay.

II. SCOPE

This policy applies to:

- All clinical and administrative staff involved in the referral, intake, admission, care delivery, discharge, documentation, or coordination of services
- All patient populations (adult, pediatric, high-acuity, chronic, post-acute, palliative, etc.)
- All disciplines (RN, LPN, PT, OT, ST, MSW, Home Health Aide)
- All payer types (Medicare, Medicare Advantage, Medicaid, Medicaid Waiver, commercial insurance, workers' compensation, private pay, charity care/discounted care)

III. POLICY STATEMENT

QOC will provide timely, appropriate, and patient-centered admission and discharge processes that:

- Prioritize safety, quality, and continuity of care
- Ensure access to services regardless of ability to pay (see Charity/Discount Policy)
- Actively involve patients, families, and caregivers in all decisions
- Maintain compliance with all regulatory requirements
- Coordinate care with physicians, hospitals, and community providers

- Prevent inappropriate/unsafe discharge or abandonment of patients
- Support the highest possible clinical outcomes and patient satisfaction
- Begin discharge planning at admission and update throughout the episode of care
- Follow CMS and COMAR requirements for documentation and notification

IV. DEFINITIONS

Admission:
The formal acceptance of a patient for home health services based on medical necessity, physician order, eligibility, and agency capacity.

Discharge:
The completion or termination of home health services, either due to goal attainment, transition of care, patient choice, physician order, or specific clinical or safety reasons.

Interdisciplinary Team (IDT):
Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists, Speech Therapists, Medical Social Workers, Home Health Aides, and administrative or clinical leadership collaborating on patient care.

Plan of Care (POC):
Comprehensive treatment plan ordered and approved by a physician in accordance with Medicare requirements (CMS Form 485 or electronic equivalent).

Homebound Status:
CMS criterion for Medicare patients indicating that leaving home requires considerable effort or assistance (not required for pediatric or certain Medicaid populations).

High-Acuity Patient:
A patient requiring complex clinical management (e.g., ventilator, tracheostomy, IV infusion, complex wound care, enteral feeding).

Medically Necessary Services:
Services required to treat illness, injury, or disability, ordered by a physician, and provided by qualified clinicians.

Patient Rights:
The legal and ethical rights afforded to all patients, detailed in QOC's Patient Rights & Responsibilities Policy (provided at admission).

V. ADMISSION PRINCIPLES

QOC admits patients in a manner that ensures:

- Timely access to medically necessary care
- Patient and family involvement in decision-making
- Equitable access regardless of payor, diagnosis, disability, or complexity
- Clinical appropriateness and safety
- Compliance with physician orders and regulatory requirements
- Immediate initiation of discharge planning to ensure continuity of care

QOC will **not** refuse admission based solely on:

- High-acuity or complexity of condition
- Disability or cognitive impairment
- Age (including pediatric or geriatric)
- Ability or inability to pay (see Charity Care Policy)
- Payor type (including Medicaid, Medicare, and uninsured)
- Geographic location within approved service area (Frederick, Carroll, Washington, Allegany, Garrett Counties)

VI. ADMISSION CRITERIA

A patient will be admitted when **all of the following apply**:

1. Clinical Eligibility

- The patient requires **skilled services** (nursing or therapy) as defined by CMS or payor
- The service is **medically necessary** to treat an illness or condition
- The patient's needs can be **safely met at home**
- The patient (or legal guardian) provides **informed consent**

2. Physician Involvement

- A **physician or allowed practitioner** (MD, DO, NP, PA) orders home health services
- The physician agrees to **review and sign the Plan of Care (POC)**
- The physician collaborates with QOC throughout the episode

3. Payor Eligibility

QOC accepts:

- Medicare
- Medicare Advantage
- Medicaid & Medicaid Waiver
- Commercial insurance
- Worker's compensation
- Private pay
- Veterans programs
- Charity care/discounted care (when eligible)

Inability to pay is NEVER a reason to deny admission.

4. Service Area

Patient must reside in one of **five Western Maryland counties**:

- Frederick
- Carroll
- Washington
- Allegany
- Garrett

5. Homebound Status (Medicare-specific)

- Medicare patients must meet CMS homebound criteria unless exempt
- Pediatric, Medicaid waiver, or private insurance patients may not need to be homebound

6. Agency Capability

QOC must have the qualified staff, equipment, and resources to meet patient's needs safely and effectively.

VII. SPECIAL POPULATIONS SERVED

A. High-Acuity Patients

QOC accepts medically complex patients requiring:

- Tracheostomy care
- Ventilator support (invasive or non-invasive)
- Enteral or parenteral feeding
- IV infusion therapy
- Complex wound care
- PICC/central line management
- Ostomy care
- Post-operative care
- Chronic disease management (CHF, COPD, diabetes, dementia, oncology, etc.)

B. Pediatric Patients

QOC admits infants, children, and adolescents with:

- Congenital or genetic disorders
- Neuromuscular or neurological impairments
- Tracheostomy or ventilator dependence
- Feeding tube or nutritional support
- Failure to thrive
- Post-NICU/PICU transition
- Technology dependence or ongoing skilled needs

Pediatric admission includes:

- Consent from parent/legal guardian
- Collaboration with pediatric specialists or primary care provider
- Consideration of school or daycare coordination
- Age-appropriate safety and developmental assessment
- Inclusion of family training and education

C. Behavioral and Cognitive Considerations

QOC admits patients with cognitive or behavioral health conditions **when care can be delivered safely**.

QOC may involve social work, behavioral health providers, or caregivers as needed to ensure safety and cooperation.

VIII. REFERRAL & INTAKE PROCESS

QOC receives referrals from:

- Hospitals and discharge planners
- Skilled nursing and rehab facilities
- Physicians and specialists
- Case managers
- Medicaid waiver programs
- Insurance plans/managed care organizations
- Schools or pediatric programs
- Families or self-referrals

Intake Staff Responsibilities:

- Collect clinical information, demographics, and insurance details
- Confirm physician order or request one
- Screen for skilled need and appropriateness
- Verify service area eligibility
- Identify urgency (routine vs. priority vs. same day)
- Communicate with clinical management for high-acuity cases
- Explain services, patient rights, and financial policies
- Initiate benefits verification and authorization

No patient will be denied admission due to incomplete paperwork at referral.
Intake staff will assist patients/families in gathering necessary documentation.

IX. CLINICAL REVIEW & APPROVAL

An RN or Clinical Director reviews every referral to determine:

- Clinical appropriateness
- Required discipline(s)
- Complexity and staffing needs
- Safety considerations
- Need for special equipment or supplies
- Any potential risk factors
- Need for interdisciplinary team collaboration

The **Director of Nursing** and/or **Administrator** must approve any high-acuity or unusual cases to ensure staffing and resource readiness.

X. RAPID ADMISSION & HOSPITAL COORDINATION

To support hospital throughput and reduce readmissions:

- Standard admission begins **within 48 hours** of referral
- **Same-day or next-day** start of care for urgent or high-priority patients
- QOC may conduct **hospital or facility pre-discharge visits**
- QOC collaborates directly with hospital case managers or physicians
- QOC accepts referrals **7 days/week**
- QOC maintains an **on-call nurse** for urgent clinical coordination

This rapid, flexible admission model supports MHCC goals for timely post-acute transitions.

XI. INITIAL ASSESSMENT

A **comprehensive, in-home assessment** is performed by an RN or qualified therapist and includes:

- Physical exam and clinical status
- Functional, cognitive, and psychosocial assessment
- Medication reconciliation
- Pain and symptom management
- Fall risk evaluation
- Home safety and environmental review
- Social determinants of health (transportation, support, financial)
- Patient and caregiver education needs
- Cultural or language needs
- Emergency and contingency plans

For Medicare patients: OASIS assessment is completed as required.

XII. PLAN OF CARE (POC)

Following assessment, the clinician develops a patient-centered Plan of Care that includes:

- Diagnoses and clinical goals
- Types and frequency of services
- Interventions and treatment plan
- Equipment, supplies, or technology needs
- Safety measures and caregiver training
- Discharge planning considerations
- Interdisciplinary coordination

The POC is:

- Reviewed, approved, and signed by the physician (CMS Form 485 or EHR equivalent)
- Reviewed every 60 days or sooner if the condition changes
- Updated based on patient progress and/or new orders

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DISCHARGE POLICY

I. Discharge Planning

- Discharge planning starts **at admission** and is updated at every IDT review.
- The clinician discusses likely discharge goals, criteria, and needs with the **patient/caregiver and physician**; updates the plan of care as the condition evolves.
- Planning prioritizes **safety**, **continuity**, **patient goals/preferences**, and **timely transition** to the appropriate level of care.

II. Discharge Criteria

A patient may be discharged when one or more apply:

1. **Goals achieved / no further skilled need**
   - Wound closed; medication stabilized; therapy goals met.
2. **Maximum practical benefit reached**
   - Plateau despite appropriate interventions; transition to maintenance/outpatient.
3. **Patient choice / refusal / transfer**
   - Patient elects to stop services or move to another HHA/SNF/assisted living/hospice.
4. **Physician order to discontinue home health**
   - Document order and clinical rationale.
5. **Hospitalization or death**
   - If no return expected, complete discharge; if return expected, place on hold per payor rules.
6. **Unsafe environment / staff safety risk** *(last resort)*
   - After reasonable mitigation (family conference, MSW involvement, care plan adjustments), physician notified; safe alternative arranged.
7. **Nonadherence that makes care unsafe or ineffective** *(last resort)*
   - After documented education, problem-solving, and MD involvement, determine if alternate setting/provider is safer.

Important: QOC **does not discharge** simply because care is complex, costly, time-consuming, or because reimbursement is low/denied.

III. Discharge Protections & Patient Rights

- Patients are informed of rights at admission (see **Patient Rights & Responsibilities Policy**).
- QOC ensures **no abandonment**: a **safe alternative** (another provider or level of care) is offered/arranged whenever possible.

- Language/communication needs are accommodated; teach-back used to confirm understanding of discharge instructions.

IV. Medicare Requirements (NOMNC & Appeals)

For Medicare/MA patients:

- Provide the **Notice of Medicare Non-Coverage (NOMNC)** within required timeframes prior to planned discharge.
- Inform patients of their **right to appeal** through the QIO; continue services as required pending decision.
- Document timing, delivery, and patient understanding of NOMNC and any appeals.
- Coordinate with the plan/QIO and physician during appeal; maintain safe care until determination.

V. Discharge Notification & Orders

- **Planned discharges:**
  - Notify patient/family **verbally and in writing**; document consent/understanding.
  - Notify and obtain **physician order** prior to discharge (unless patient refuses services).
  - Give **advance notice** (generally ≥48 hours) when feasible.
- **Urgent discharges (safety/behavioral risk):**
  - Notify physician **immediately**; document risks and mitigation; ensure safe transition where possible.

VI. Transfer to Another Agency/Level of Care

- With patient consent, QOC coordinates transfer to another HHA, SNF, IRF, LTACH, outpatient clinic, hospice, or community program.
- QOC provides a **warm handoff**: direct clinician-to-clinician communication whenever possible, and timely transmission of the discharge/transfer summary and relevant records.

VII. Discharge Summary

Complete within 48 hours of discharge (matches your prior policy). Summary includes:

- Reason for discharge and type (planned, transfer, refusal, hospitalization, death)
- Patient condition/status at discharge (clinical, functional, psychosocial)
- Services provided and **goals achieved/not achieved** with rationale
- **Medications** at discharge; outstanding orders/monitoring needs
- Education provided; caregiver competence/teach-back confirmed

- **Equipment/supplies** in home; vendor contacts
- Referrals made (e.g., outpatient PT, wound clinic, MSW, community resources)
- **Follow-up appointments** (PCP/specialist) and who scheduled them
- Physician notification and final orders
- NOMNC/appeal information (when applicable)
- Contact information for questions post-discharge

VIII. Continuity of Care & Post-Discharge Follow-up

- Provide written discharge instructions (plain language; patient's preferred language).
- Send discharge summary and key documents to the **physician/next provider** promptly.
- **Follow-up calls**:
  - **Day 3** to confirm safety, meds, wound/therapy plan, equipment in place.
  - **Day 7** to reassess status, barriers, and address problems—helps reduce readmissions.
- For high-risk patients (e.g., CHF, COPD, complex wounds), consider an extra check-in within **24–48 hours**.

IX. Documentation Standards

- Document all notifications, patient/caregiver education, physician communications, NOMNC/appeal steps, and handoffs.
- File the discharge summary and related artifacts in the **EHR within 48 hours**.
- Use standardized checklists to ensure completeness and consistency.

X. Roles & Responsibilities

- **Primary Clinician (RN or lead therapist):** coordinates discharge plan; completes summary; educates patient/caregiver.
- **Physician/Allowed Practitioner:** reviews progress; issues discharge/transfer orders; collaborates on plan.
- **Therapists (PT/OT/ST):** update functional status, equipment needs, and outpatient plans.
- **Medical Social Worker:** addresses psychosocial barriers; links to community resources; assists with safe disposition.
- **Home Health Aide:** provides input on daily function/self-care; reinforces education.
- **Intake/Scheduling/Billing:** finalize logistics, benefits, and notify payor as needed.

XI. Quality & Compliance Integration

- Admission timeliness, unplanned discharges, appeals, readmissions within 30 days, and post-discharge call completion are tracked in **QAPI**.

- **Case reviews** are performed on discharges related to safety/nonadherence to ensure appropriate mitigation steps were taken and no abandonment occurred.
- Trends inform staff education, process improvement, and resource allocation.

XII. Policy Governance

- Reviewed at least **annually**; updated to maintain compliance with **CMS Conditions of Participation (42 CFR 484.50 & 484.58)**, **COMAR 10.24.16.08 A/B/G/I/K**, and **Joint Commission** standards.
- Staff receive training on any changes; compliance is monitored via chart audits and QAPI metrics.

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APPEALS, DOCUMENTATION, QUALITY, GOVERNANCE

I. Patient Appeals & Grievances

Patients have the right to voice concerns without fear of retaliation.
QOC maintains a **formal grievance and appeal process** consistent with Medicare Conditions of Participation and QOC's **Patient Rights & Responsibilities Policy.**

Patients may appeal:

- Denial of admission
- Proposed discharge or reduction in services
- Quality concerns
- Staff behavior or communication
- Any aspect of their care

Appeal process:

1. Patient/family may submit verbally or in writing.
2. QOC leadership reviews within **5 business days.**
3. A written response is provided with findings and resolution.
4. Unresolved issues may be escalated to **external agencies** (e.g., MDH, MHCC, CMS, Joint Commission).

For **Medicare beneficiaries:**

- QOC will provide the **Notice of Medicare Non-Coverage (NOMNC)** before discharge.
- Patients have the right to a **fast appeal** through the **Quality Improvement Organization (QIO)**.
- QOC will comply with all QIO determinations and continue care as required during appeals.

II. Documentation Requirements

QOC maintains complete and accurate records for all admissions and discharges in accordance with CMS, COMAR, and Joint Commission requirements. Documentation includes:

- Referral and intake data
- Initial and comprehensive assessments
- Home safety and environmental evaluations
- Plan of Care (physician-signed and updated)

- Interdisciplinary notes and communications
- Discharge planning activities
- Physician notifications and orders
- NOMNC and appeal documentation (if applicable)
- Final discharge summary (completed within **48 hours**)
- Referrals and handoff documentation
- Patient education and follow-up contact

All documentation is securely maintained in the Electronic Health Record (EHR).

III. Quality Assurance & Performance Improvement (QAPI) Integration

QOC uses admission and discharge data to monitor and improve performance.
The following indicators are reviewed regularly:

Admission-related Metrics:

- Time from referral to admission (48-hour target / same-day options)
- Admission delays and root causes
- High-acuity and pediatric admissions

Discharge-related Metrics:

- Discharge reasons by category (goals met, patient refusal, transfer, safety)
- Unplanned discharges
- 30-day hospital readmission rates
- Discharge documentation timeliness (<48 hours)
- Post-discharge follow-up completion (Day 3 and Day 7)
- Medicare appeals and outcomes

Quality & Patient Experience:

- Patient/caregiver satisfaction
- Continuity of care outcomes
- Identified barriers to care
- Staff competency and training needs
- Opportunities for improvement

Actions from QAPI may include:

- Staff education or re-training
- Process changes
- Policy updates
- Resource allocation
- Collaboration with referral partners

IV. Staff Training & Competencies

All staff involved in referral, admission, service delivery, and discharge are trained on:

- This Admission & Discharge Policy
- Patient Rights & Responsibilities
- CMS Conditions of Participation
- COMAR 10.24.16 standards
- Documentation requirements
- Communication protocols
- Cultural competence and health equity
- Pediatric and high-acuity care processes (as applicable)

Training is provided:

- During orientation
- Annually
- As needed based on QAPI findings or regulatory changes

Competency is validated through:

- Skills checklists
- Direct observation
- Chart audits
- Performance reviews

V. Policy Review & Governance

This policy is reviewed **annually** by:

- Director of Nursing / Clinical Director
- Administrator / Executive Leadership
- QAPI Committee
- Compliance Officer (if applicable)

EXHIBIT 13

Staffing & Staff Development Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

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QOC Staffing Plan & Staff Development Policy

I. PURPOSE

The purpose of this policy is to ensure that Quality One Care Home Health, Inc. (QOC) maintains sufficient, qualified, and competent staff to deliver safe, high-quality, and patient-centered home health services across all current and future service areas in Maryland. This policy establishes the framework for staffing, supervision, competency, recruitment, retention, training, and workforce development in alignment with patient needs, regulatory requirements, and organizational growth. QOC will adjust staffing levels as patient volume, acuity, and geographic scope increase, with phased staffing projections detailed separately in the agency's financial and statistical planning documents.

II. AGENCY-WIDE AND STATEWIDE SCOPE

QOC has operated across multiple Maryland jurisdictions since 2009 and anticipates continued expansion statewide. This Staffing Plan and Staff Development Policy applies to all QOC locations, counties, and future service areas. It ensures consistent quality, staffing standards, and regulatory compliance throughout the organization, including for high-acuity and pediatric patients. All staff, contractors, supervisors, and leaders are expected to adhere to this policy regardless of region.

III. STAFFING PHILOSOPHY

QOC believes that staffing directly impacts patient safety, clinical outcomes, satisfaction, and organizational performance. Therefore, staffing decisions are driven by:

- Patient acuity and clinical needs, not just volume.
- Use of the most qualified clinician for each task and service.
- Consistent caregiver assignments to ensure continuity of care.
- Appropriate staff-to-patient workloads to maintain quality.
- Competency-based role assignments.
- Strong clinical supervision and accountability.
- A supportive environment that attracts and retains top talent.
- Ethical, patient-first decision-making.
- Ongoing education and professional development.
- Anticipation of future growth and service expansion.

IV. REGULATORY COMPLIANCE

This policy ensures compliance with:

- CMS Conditions of Participation for Home Health Agencies (42 CFR 484.60 – Care Planning; 484.70 – HHA Services; 484.75 – Skilled Professional Services; 484.80 – Home Health Aide Services)
- COMAR 10.07.10 (Licensure of Home Health Agencies)
- COMAR 10.24.16 (State Health Plan – Access, Quality, Staffing, and Workforce)
- Joint Commission Human Resources (HR), Leadership (LD), and Provision of Care (PC) standards
- OSHA workplace safety requirements
- Federal and state labor and employment laws
- Professional licensure and scope of practice regulations

Compliance with these standards is mandatory and monitored continuously by leadership, QAPI, and the Governing Body.

V. STAFFING DETERMINANTS

QOC uses multiple factors to determine staffing needs:

- Number of active patients
- Number of admissions and discharges
- Patient acuity, complexity, and specialized needs
- Geographic distribution of patients
- Visit frequency and care intensity
- Service mix (skilled nursing, therapy, aide, social work)
- Regulatory supervision requirements
- Staff skill mix, licensure, and competency
- Productivity benchmarks
- Availability of qualified workforce in each region
- Seasonal trends and referral patterns
- Planned growth and program expansion
- Financial sustainability and operational capacity

Staffing levels are adjusted proactively as these factors change. Formal FTE projections and phased growth models are maintained separately as part of the agency's financial and statistical plans, including Certificate of Need submissions.

VI. ORGANIZATIONAL STRUCTURE AND KEY STAFF ROLES

QOC maintains a clear organizational structure to ensure oversight, supervision, and accountability.

Leadership and Management:

- Governing Body: Holds ultimate responsibility for staffing adequacy, quality, and patient safety.
- Administrator/Executive Director: Oversees operations, staffing resources, finances, and regulatory compliance.
- Director of Nursing (DON)/Clinical Director: Responsible for clinical staffing, competency, supervision, performance, and quality.
- Clinical Supervisors/Team Managers: Manage daily assignments, patient caseloads, and staff performance; conduct supervisory visits.
- Discipline Leads (PT, OT, ST, MSW): Provide discipline-specific oversight, training, and consultation.
- Quality, QAPI, Patient Safety, and Compliance: Monitor staffing effectiveness and identify opportunities for improvement.

Clinical Staff:

- Registered Nurses (RN) – perform assessments, develop care plans, provide skilled nursing, and supervise LPNs and HHAs.
- Licensed Practical/Vocational Nurses (LPN/LVN) – provide nursing care under RN supervision.
- Physical Therapists (PT), Occupational Therapists (OT), Speech-Language Pathologists (ST) – deliver specialized therapy services.
- Medical Social Workers (MSW) – provide psychosocial support, resource coordination, and counseling.
- Home Health Aides (HHA) – deliver personal care and ADL support under RN supervision.

Support Staff:

- Intake and Referral Coordinators
- Schedulers
- Administrative Support
- Quality and Compliance Staff
- Billing and Documentation Specialists

As the agency expands, additional clinical supervisors, administrative personnel, and leadership positions will be added to support operations and maintain quality.

VII. STAFFING MODEL – INTERDISCIPLINARY, RN-LED TEAMS

QOC uses RN-led interdisciplinary teams to provide coordinated, patient-focused care. Each patient is assigned a primary RN case manager whenever possible. The primary RN coordinates services across disciplines, communicates with physicians, and ensures smooth transitions. Team members collaborate through case conferences, EMR communication, and shared care plans. High-acuity or pediatric cases may include specialty-trained clinicians and additional oversight.

This model supports:

- Comprehensive care planning
- Clinical accountability
- Interdisciplinary collaboration
- High-acuity care readiness
- Patient safety and quality outcomes
- Efficient resource use

VIII. CASELOAD AND PRODUCTIVITY STANDARDS

QOC sets realistic and safe productivity expectations based on best practices in home health.

Typical guidelines:

- RNs: 25–30 active patients or 5–6 visits/day (adjusted for acuity and travel)
- LPNs: 5–6 visits/day under RN supervision
- Therapists: 4–5 visits/day based on frequency and complexity
- MSW: 2–3 visits/day (due to assessment and resource coordination)
- HHAs: number of visits based on frequency in the care plan and geographic proximity

Caseloads are regularly adjusted based on:

- Patient acuity
- Number of skilled disciplines involved
- Geographic factors
- Travel time and rural distances
- Admission/discharge workload
- Staff experience and competency
- High-acuity or pediatric care demands

Clinical supervisors review caseloads weekly to ensure safety and quality.

IX. DIRECT VS. INDIRECT STAFFING

QOC differentiates between:

- Direct caregivers: RN, LPN, PT, OT, ST, MSW, HHA
- Indirect/support staff: Supervisors, intake, scheduling, quality, compliance, administrative support, billing

This ensures that clinical staff can focus on patient care while support staff manage logistics, coordination, and documentation processes to maximize efficiency and quality.

X. CONTINUITY OF CARE

Consistent caregiver assignments are essential to quality outcomes, patient satisfaction, and trust. Therefore:

- Each patient is assigned a primary clinician.
- A minimum of three (3) backup caregivers are identified for each patient to ensure coverage.
- Backup staffing is included in the patient's care plan.
- Staff assignments consider geography, skills, language, and patient preference.
- Changes in assignment are communicated to the patient and documented.
- The RN Supervisor monitors continuity and resolves gaps or inconsistencies.

This approach comes directly from QOC's original policy and remains a core standard of care.

XI. SUPERVISION AND AUTHORITY

- All care is supervised by an RN or appropriate clinical discipline.
- The RN Supervisor or DON has the authority to reassign patients or staff at any time to ensure safety and efficiency.
- LPNs and HHAs always work under RN supervision.
- Supervisors conduct routine and as-needed field visits and chart audits.
- Performance evaluations include clinical quality, documentation, teamwork, compliance, and patient communication.
- Staff must practice within their scope of licensure and competency.
- Supervisors address performance issues promptly and support staff development.

XII. BACKUP AND EMERGENCY STAFFING

To ensure no interruption in patient care, QOC maintains multiple layers of backup:

- Three backup caregivers per patient (as required by original policy)
- Internal float staff or cross-trained staff
- PRN/per diem staff
- Overtime as needed
- Temporary staffing agencies (used sparingly and with oversight)
- Telehealth or remote check-ins when clinically appropriate
- On-call clinical staff available 24/7 for urgent needs
- Supervisor or DON may reassign staff in emergencies

This multi-level backup system ensures continuity of care regardless of staff illness, turnover, weather, or unexpected events.

XIII. STAFFING FOR HIGH-ACUITY AND SPECIALTY PATIENTS

QOC provides services for patients of all ages and levels of complexity, including high-acuity and pediatric populations. The agency maintains specialty-trained nurses and therapists who possess advanced competencies in tracheostomy and ventilator management, enteral and parenteral nutrition, complex wound care, infusion therapy, and chronic disease management. Pediatric clinicians are educated in growth, developmental monitoring, family teaching, and pediatric safety.
High-acuity and pediatric cases are assigned to staff whose competencies are validated and who receive ongoing education and supervision from the Director of Nursing or a qualified clinical lead. Staffing ratios for these cases are deliberately smaller to preserve patient safety and clinical effectiveness.

XIV. RECRUITMENT STRATEGY

QOC employs a structured, statewide recruitment program designed to attract, screen, and hire qualified personnel who share the agency's mission and values.
Key elements include:

- **Local recruitment** within each service county to support community employment and continuity.
- Partnerships with colleges, universities, and professional associations to build a pipeline of nursing and therapy graduates.
- Targeted outreach to experienced home health professionals and specialty nurses.

- Competitive wages and benefits, flexible scheduling, and hybrid work options where appropriate.
- Credential verification and pre-employment competency review for all licensed and certified personnel.
- Recruitment based on projected service demand, patient acuity, and census trends derived from QOC's financial and statistical plans.

XV. RETENTION AND EMPLOYEE ENGAGEMENT

Retention is essential to quality and cost control. QOC promotes workforce stability by:

- Maintaining open communication between staff and leadership.
- Providing manageable caseloads and balanced productivity standards.
- Offering continuing education, certification support, and tuition assistance.
- Recognizing employee achievements through awards and evaluations.
- Encouraging career advancement through internal promotion and mentoring.
- Conducting annual staff satisfaction surveys and using results to guide improvement initiatives.
- Maintaining competitive compensation aligned with regional market data.

XVI. TRAINING AND COMPETENCY PROGRAM

QOC maintains a comprehensive training system in compliance with CMS, COMAR, and Joint Commission standards. All staff complete orientation and competency validation prior to patient contact, followed by annual re-evaluation.
Training includes:

- Home health regulations, documentation standards, and HIPAA compliance.
- Infection control and emergency preparedness.
- Patient rights, safety, and cultural competence.
- High-acuity and pediatric specialty modules.
- Clinical skills validation for each discipline.
- Ongoing in-service education reflecting QAPI findings and emerging best practices.
  Training records are retained and audited by the Quality and Compliance Department.
  Competency gaps are corrected through individualized education or supervision plans.

XVII. TECHNOLOGY AND TELEHEALTH SUPPORT

QOC leverages technology to enhance staffing efficiency and patient outcomes.

- A secure electronic health record (EHR) system supports scheduling, documentation, and quality tracking.
- Telehealth tools enable clinical follow-ups, monitoring, and supervision when permitted by payors.
- Mobile platforms allow field staff to access patient data in real time.
- Technology performance is reviewed quarterly to ensure reliability and privacy compliance.

XVIII. CONTINGENCY STAFFING AND EMERGENCY READINESS

To ensure uninterrupted services, QOC maintains contingency plans that include:

- PRN and on-call staff pools across all service areas.
- Cross-trained personnel capable of filling multiple roles.
- Cooperative agreements with reputable staffing vendors for emergency use.
- Deployment of telehealth and supervisory check-ins during weather or disaster events.
- A 24-hour on-call system supervised by clinical leadership.
  These procedures are integrated into the agency's Emergency Preparedness Plan.

XIX. STAFFING EFFECTIVENESS MONITORING

QOC continuously evaluates staffing effectiveness through quantitative and qualitative indicators such as:

- Patient outcomes and satisfaction.
- Staff retention and turnover.
- Overtime, missed-visit, and vacancy rates.
- Referral acceptance and timeliness of admission.
- Readmission and hospitalization rates.
  Findings are analyzed monthly by leadership and quarterly through the QAPI Committee and Governing Body. Corrective actions may include workload adjustments, targeted hiring, or process redesign. Trends are compared with state and national benchmarks.

XX. INTEGRATION WITH QAPI AND PATIENT SAFETY

Staffing data, performance indicators, and incident trends feed directly into QOC's Quality Assurance and Performance Improvement (QAPI) and Patient Safety Programs.

- Staffing-related concerns trigger performance improvement projects as appropriate.
- QAPI committees review data on caseload balance, staff competency, and patient satisfaction.
- Root-cause analysis is conducted for any adverse events linked to staffing or supervision.
- Results are communicated to staff, and education or process changes are implemented.

XXI. LEADERSHIP AND GOVERNING BODY ACCOUNTABILITY

The Administrator and Director of Nursing are responsible for ensuring adequate staffing at all times, supported by Human Resources, Quality, and Finance. They submit quarterly reports on staffing adequacy, turnover, and quality outcomes to the Governing Body.
The Governing Body reviews these reports, approves major staffing changes, and verifies that the agency has the human and financial resources to meet patient needs across all jurisdictions.
Leadership accountability for staffing is tied to performance evaluation and strategic planning.

XXII. ANNUAL STAFFING PLAN REVIEW AND UPDATE

This policy is reviewed annually and revised as needed to reflect:

- Changes in patient census or acuity.
- Geographic expansion or new service lines.
- Workforce availability and market trends.
- QAPI and compliance findings.
- Updates to regulatory or accreditation standards.
  Adjustments are approved by the Administrator, Director of Nursing, and Governing Body and documented in the annual strategic and financial plans.

XXIII. CONCLUSION

This Staffing Plan and Staff Development Policy establishes QOC's statewide framework for maintaining a qualified, competent, and compassionate workforce. It ensures that staffing decisions are data-driven, responsive to patient needs, and consistent with regulatory and accreditation standards. QOC's leadership remains committed to continuous improvement, workforce sustainability, and the delivery of safe, high-quality, patient-centered care across all Maryland jurisdictions.

EXHIBIT 14

Clinical Staffing and Competency Policy

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

QOC Quality One Care
Home Health, Inc
9221 Colesville Road, Silver Spring, MD 20910
PH: 301 658-7141 / Fax: 301 658-2328

QOC Clinical Staffing and Competency Policy

I. PURPOSE

The purpose of this policy is to ensure that Quality One Care Home Health, Inc. (QOC) maintains a sufficient number of qualified, competent, and adequately staffed interdisciplinary team capable of safely delivering skilled home health services, including high-acuity and pediatric care to all patients across all service areas, in compliance with CMS, COMAR, and Joint Commission standards. This policy establishes standards for staffing levels, recruitment, training, competency validation, supervision, performance evaluation, and workforce stability.

II. SCOPE

Applies to all clinical and paraprofessional staff:

- Registered Nurses (RN)
- Licensed Practical Nurses (LPN)
- Physical, Occupational, and Speech Therapists (PT/OT/ST)
- Medical Social Workers (MSW)
- Home Health Aides (HHA, CNA, GNA)
- Clinical supervisors and leadership
- Contract, PRN, and temporary staff (held to the same standards)
-

III. POLICY STATEMENT

QOC will:

- Recruit and retain qualified staff based on patient acuity, geography, and volume.
- Ensure every clinician meets licensure, competency, and training standards.
- Provide comprehensive orientation, ongoing education, and annual competency validation.
- Maintain safe caseloads and staff-to-patient assignments.
- Use data and QAPI findings to guide staffing, training, and resource allocation.
- Ensure strong leadership, supervision, and interdisciplinary collaboration.
- Maintain surge and contingency staffing capabilities.
- Support staff well-being, retention, and professional growth.
- Comply with CMS CoPs, COMAR, and Joint Commission standards.

IV. STAFFING MODEL & RATIOS

QOC uses a **flexible, patient-centered, acuity-based staffing model** rather than fixed ratios. Staffing is adjusted according to:

- Patient acuity (routine vs high acuity)
- Service line (nursing, therapy, pediatric, specialty programs)
- Visit frequency
- Geographic distribution
- Travel time and rural access
- Staff capacity and availability
- Hospital referral patterns and growth

Staffing is based on:

- Patient acuity and complexity
- Geographic distribution
- Required disciplines
- Visit frequency
- Specialty program demand (vent, trach, wound, IV, pediatric)
- Caseload limits per clinician
- Travel time and rural access

Typical caseload guidelines:

- RN: 20–25 active patients (lower for high-acuity or pediatric)
- LPN: 25–30 visits/week under RN supervision
- Therapists (PT/OT/ST): 25–30 visits/week depending on complexity
- MSW: As needed based on referral volume
- HHA: Assigned by hours and needs of each patient

High-acuity, pediatric, and complex patients are assigned LOWER caseloads to ensure safety and quality.

V. LEADERSHIP & REPORTING STRUCTURE

- **Administrator / Executive Director**
  Overall leadership, compliance, staffing resources.
- **Director of Nursing (Clinical Director)**
  Responsible for clinical quality, staffing levels, competency, supervision, high-acuity oversight.
- **Clinical Supervisors / Team Leads (RN/Therapy)**
  Direct supervision of field staff, case conferencing, competency checks, scheduling support.
- **Interdisciplinary Care Teams**
  RN + Therapists + MSW + HHA + Physician collaboration.

Clear chain of command and escalation process for clinical issues.

VI. CLINICAL ROLES AND QUALIFICATIONS

Registered Nurse (RN)

- Licensed in Maryland
- Performs initial assessment, OASIS, care coordination, supervision
- Trained in high-acuity care (vent, trach, wound, IV)
- Serves as case manager

Licensed Practical Nurse (LPN)

- Licensed in Maryland
- Provides skilled nursing under RN supervision
- Competency in medication administration, wound care, vital signs

Therapists (PT, OT, ST)

- Licensed in Maryland
- Conduct evaluations and develop therapy plans
- Specialized certifications encouraged (e.g. neuro, lymphedema)

Medical Social Worker (MSW)

- Licensed graduate social worker (LGSW or LCSW-C)
- Assesses psychosocial needs, connects to community resources

Home Health Aides (HHA/CNA/GNA)

- Certified (CNA/GNA) per Maryland requirements
- Complete QOC-specific competency before assignment
- Supervised by an RN or therapist

VII. RECRUITMENT & HIRING STANDARDS

All hires/staff must:

- Hold active Maryland licensure/certification
- Pass criminal background check and OIG exclusion screen
- Provide verification of education, work history and references
- Demonstrate clinical competency
- Complete health screening and meet immunization requirements
- Meet driving and insurance requirements (field staff)
- Provide evidence of liability and auto insurance (field staff)
- Demonstrate competency appropriate to role

High-acuity staff (vent, trach, IV, complex wound) require prior experience OR complete specialized training before assignment.

VIII. ORIENTATION & ONBOARDING

All staff receive and complete a structured orientation that includes:

- QOC mission, policies, documentation standards
- CMS & COMAR regulatory overview
- Joint Commission standards
- Scope of practice and clinical expectations
- EMR/EHR training
- Patient rights & ethics
- Cultural competence and health equity
- Infection control & emergency preparedness
- Field safety and home environment protocols
- High-acuity and pediatric training (if applicable)
- Shadow visits and supervised field training

Completion of orientation and competency validation is required prior to independent field work.

IX. COMPETENCY VALIDATION

Competency is assessed:

- At hire (initial validation)
- At orientation completion
- Annually (at minimum)
- When job duties change
- After incident or retraining

Methods include:

- Direct observation
- Simulation/return demonstration
- Written or verbal exams
- Clinical documentation review
- Case studies / scenario-based validation

Specialty skills validated include:

- Ventilator and tracheostomy care
- IV / central line management
- Complex wound care / negative pressure therapy
- Enteral feeding
- Pediatric assessment and care
- OASIS / documentation accuracy
- Emergency response

Competency tracking system maintains up-to-date records and triggers renewal reminders.

X. SUPERVISION & OVERSIGHT

RNs supervise LPNs and HHAs.
Therapists supervise therapy assistants.
Clinical managers conduct ride-alongs, chart reviews, case conferences.

Supervisors conduct:

- Case conferences
- Field supervision and ride-alongs
- Documentation audits
- Clinical coaching and support

Interdisciplinary Case Conferences

- Regularly scheduled
- Focus on high-risk/high-acuity cases
- Involve RN, therapist, MSW, aide, physician as needed
- Review goals, progress, barriers, and discharge planning

XII. PERFORMANCE EVALUATIONS

All staff receive **annual performance evaluations** that include:

- Clinical competency review
- Documentation quality
- Patient outcomes
- Patient/caregiver feedback
- Timeliness and reliability
- Professional conduct
- QAPI-related metrics
- Goal setting and growth plan

Underperformance results in coaching, retraining, or performance improvement plans. High performers may become preceptors, mentors, or team leads.

XIII. SURGE, COVERAGE, & CONTINGENCY STAFFING

To maintain continuity and access, QOC:

- Maintains PRN/on-call staff
- Cross-trains clinicians across service lines
- Develops regional float pool
- Uses telehealth for monitoring or check-ins
- Reassigns staff based on acuity and geography
- Coordinates with partner agencies for emergency backup (if needed)
- Activates incident command structure during disasters (per Emergency Preparedness Plan)

This prevents care delays, missed visits, and burnout.

X. STAFF TRAINING & DEVELOPMENT

Ongoing education includes:

- Annual mandatory competencies
- High-acuity training (vent, trach, wound, IV)
- Pediatric care
- Chronic disease management
- Cultural competence
- Communication and de-escalation
- Regulatory changes (CMS/COMAR updates)
- QAPI-driven training (based on performance data)
- Leadership development for supervisors

QOC supports professional growth and encourages certification.

XI. WORKFORCE RETENTION & SUPPORT

QOC maintains high retention through:

- Competitive compensation and benefits
- Flexible scheduling and geographic assignment
- Reasonable caseload expectations
- Supportive clinical leadership
- Strong mentorship and preceptor program
- Open-door communication
- Recognition programs and advancement opportunities
- Burnout prevention and mental health support

Stable, experienced staff = higher quality care.
Low turnover = strong patient relationships and continuity.

XV. QAPI & DATA-INFORMED STAFFING

Staffing decisions are driven by data from the QAPI Program:

- Caseload and productivity reports
- Patient acuity trends
- High-acuity case volume
- Geographic gaps in coverage
- Patient satisfaction feedback
- Missed visit rates

- Readmission or adverse event analysis
- Training and competency needs

QAPI informs:

- Hiring priorities
- Specialty training
- Resource allocation
- Staffing adjustments
- Operational improvements

Staffing is dynamic, not static.

XIII. CONTRACTED/PRN STAFF

All Contract/PRN staff must:

- Meet ALL QOC hiring standards
- Receive orientation and competency validation
- Be supervised and included in QAPI and training
- Be held to same performance standards
- Follow all QOC policies and documentation standards
- Participate in supervision and QAPI as appropriate

No double standards. Contract = employee-level quality.

XIV. COMPLIANCE

This policy ensures compliance with:

- CMS Conditions of Participation (42 CFR 484.60, 484.75, 484.80)
- COMAR 10.24.16.08K – Staffing Plan
- Maryland Nurse Practice Act
- Joint Commission HR, Competency & Supervision standards
- OSHA and infection control standards

XV. POLICY REVIEW & APPROVAL

Reviewed annually or as needed based on:

- QAPI findings
- Regulatory changes
- Patient population changes
- Expansion of services or geography
- Staffing pattern analysis
- Strategic planning

EXHIBIT 15

Federal Poverty Level Guidelines

Quality One Care Home Health, Inc.

Baltimore–Howard Region HHA Project

Includes QAPI Policy, Quality Measures and Surveys

2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	7,825.00	11,737.50	15,650.00	19,562.50	20,345.00	20,814.50	21,127.50	21,597.00	23,475.00	27,387.50	28,170.00	28,952.50
2	10,575.00	15,862.50	21,150.00	26,437.50	27,495.00	28,129.50	28,552.50	29,187.00	31,725.00	37,012.50	38,070.00	39,127.50
3	13,325.00	19,987.50	26,650.00	33,312.50	34,645.00	35,444.50	35,977.50	36,777.00	39,975.00	46,637.50	47,970.00	49,302.50
4	16,075.00	24,112.50	32,150.00	40,187.50	41,795.00	42,759.50	43,402.50	44,367.00	48,225.00	56,262.50	57,870.00	59,477.50
5	18,825.00	28,237.50	37,650.00	47,062.50	48,945.00	50,074.50	50,827.50	51,957.00	56,475.00	65,887.50	67,770.00	69,652.50
6	21,575.00	32,362.50	43,150.00	53,937.50	56,095.00	57,389.50	58,252.50	59,547.00	64,725.00	75,512.50	77,670.00	79,827.50
7	24,325.00	36,487.50	48,650.00	60,812.50	63,245.00	64,704.50	65,677.50	67,137.00	72,975.00	85,137.50	87,570.00	90,002.50
8	27,075.00	40,612.50	54,150.00	67,687.50	70,395.00	72,019.50	73,102.50	74,727.00	81,225.00	94,762.50	97,470.00	100,177.50
9	29,825.00	44,737.50	59,650.00	74,562.50	77,545.00	79,334.50	80,527.50	82,317.00	89,475.00	104,387.50	107,370.00	110,352.50
10	32,575.00	48,862.50	65,150.00	81,437.50	84,695.00	86,649.50	87,952.50	89,907.00	97,725.00	114,012.50	117,270.00	120,527.50
11	35,325.00	52,987.50	70,650.00	88,312.50	91,845.00	93,964.50	95,377.50	97,497.00	105,975.00	123,637.50	127,170.00	130,702.50
12	38,075.00	57,112.50	76,150.00	95,187.50	98,995.00	101,279.50	102,802.50	105,087.00	114,225.00	133,262.50	137,070.00	140,877.50
13	40,825.00	61,237.50	81,650.00	102,062.50	106,145.00	108,594.50	110,227.50	112,677.00	122,475.00	142,887.50	146,970.00	151,052.50
14	43,575.00	65,362.50	87,150.00	108,937.50	113,295.00	115,909.50	117,652.50	120,267.00	130,725.00	152,512.50	156,870.00	161,227.50

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	31,300.00	35,212.50	39,125.00	43,037.50	46,950.00	50,862.50	54,775.00	58,687.50	62,600.00	78,250.00	93,900.00	109,550.00
2	42,300.00	47,587.50	52,875.00	58,162.50	63,450.00	68,737.50	74,025.00	79,312.50	84,600.00	105,750.00	126,900.00	148,050.00
3	53,300.00	59,962.50	66,625.00	73,287.50	79,950.00	86,612.50	93,275.00	99,937.50	106,600.00	133,250.00	159,900.00	186,550.00
4	64,300.00	72,337.50	80,375.00	88,412.50	96,450.00	104,487.50	112,525.00	120,562.50	128,600.00	160,750.00	192,900.00	225,050.00
5	75,300.00	84,712.50	94,125.00	103,537.50	112,950.00	122,362.50	131,775.00	141,187.50	150,600.00	188,250.00	225,900.00	263,550.00
6	86,300.00	97,087.50	107,875.00	118,662.50	129,450.00	140,237.50	151,025.00	161,812.50	172,600.00	215,750.00	258,900.00	302,050.00
7	97,300.00	109,462.50	121,625.00	133,787.50	145,950.00	158,112.50	170,275.00	182,437.50	194,600.00	243,250.00	291,900.00	340,550.00
8	108,300.00	121,837.50	135,375.00	148,912.50	162,450.00	175,987.50	189,525.00	203,062.50	216,600.00	270,750.00	324,900.00	379,050.00
9	119,300.00	134,212.50	149,125.00	164,037.50	178,950.00	193,862.50	208,775.00	223,687.50	238,600.00	298,250.00	357,900.00	417,550.00
10	130,300.00	146,587.50	162,875.00	179,162.50	195,450.00	211,737.50	228,025.00	244,312.50	260,600.00	325,750.00	390,900.00	456,050.00
11	141,300.00	158,962.50	176,625.00	194,287.50	211,950.00	229,612.50	247,275.00	264,937.50	282,600.00	353,250.00	423,900.00	494,550.00
12	152,300.00	171,337.50	190,375.00	209,412.50	228,450.00	247,487.50	266,525.00	285,562.50	304,600.00	380,750.00	456,900.00	533,050.00
13	163,300.00	183,712.50	204,125.00	224,537.50	244,950.00	265,362.50	285,775.00	306,187.50	326,600.00	408,250.00	489,900.00	571,550.00
14	174,300.00	196,087.50	217,875.00	239,662.50	261,450.00	283,237.50	305,025.00	326,812.50	348,600.00	435,750.00	522,900.00	610,050.00

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)

Dollars Per Month

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	652.08	978.13	1,304.17	1,630.21	1,695.42	1,734.54	1,760.63	1,799.75	1,956.25	2,282.29	2,347.50	2,412.71
2	881.25	1,321.88	1,762.50	2,203.13	2,291.25	2,344.13	2,379.38	2,432.25	2,643.75	3,084.38	3,172.50	3,260.63
3	1,110.42	1,665.63	2,220.83	2,776.04	2,887.08	2,953.71	2,998.13	3,064.75	3,331.25	3,886.46	3,997.50	4,108.54
4	1,339.58	2,009.38	2,679.17	3,348.96	3,482.92	3,563.29	3,616.88	3,697.25	4,018.75	4,688.54	4,822.50	4,956.46
5	1,568.75	2,353.13	3,137.50	3,921.88	4,078.75	4,172.88	4,235.63	4,329.75	4,706.25	5,490.63	5,647.50	5,804.38
6	1,797.92	2,696.88	3,595.83	4,494.79	4,674.58	4,782.46	4,854.38	4,962.25	5,393.75	6,292.71	6,472.50	6,652.29
7	2,027.08	3,040.63	4,054.17	5,067.71	5,270.42	5,392.04	5,473.13	5,594.75	6,081.25	7,094.79	7,297.50	7,500.21
8	2,256.25	3,384.38	4,512.50	5,640.63	5,866.25	6,001.63	6,091.88	6,227.25	6,768.75	7,896.88	8,122.50	8,348.13
9	2,485.42	3,728.13	4,970.83	6,213.54	6,462.08	6,611.21	6,710.63	6,859.75	7,456.25	8,698.96	8,947.50	9,196.04
10	2,714.58	4,071.88	5,429.17	6,786.46	7,057.92	7,220.79	7,329.38	7,492.25	8,143.75	9,501.04	9,772.50	10,043.96
11	2,943.75	4,415.63	5,887.50	7,359.38	7,653.75	7,830.38	7,948.13	8,124.75	8,831.25	10,303.13	10,597.50	10,891.88
12	3,172.92	4,759.38	6,345.83	7,932.29	8,249.58	8,439.96	8,566.88	8,757.25	9,518.75	11,105.21	11,422.50	11,739.79
13	3,402.08	5,103.13	6,804.17	8,505.21	8,845.42	9,049.54	9,185.63	9,389.75	10,206.25	11,907.29	12,247.50	12,587.71
14	3,631.25	5,446.88	7,262.50	9,078.13	9,441.25	9,659.13	9,804.38	10,022.25	10,893.75	12,709.38	13,072.50	13,435.63

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	2,608.33	2,934.38	3,260.42	3,586.46	3,912.50	4,238.54	4,564.58	4,890.63	5,216.67	6,520.83	7,825.00	9,129.17
2	3,525.00	3,965.63	4,406.25	4,846.88	5,287.50	5,728.13	6,168.75	6,609.38	7,050.00	8,812.50	10,575.00	12,337.50
3	4,441.67	4,996.88	5,552.08	6,107.29	6,662.50	7,217.71	7,772.92	8,328.13	8,883.33	11,104.17	13,325.00	15,545.83
4	5,358.33	6,028.13	6,697.92	7,367.71	8,037.50	8,707.29	9,377.08	10,046.88	10,716.67	13,395.83	16,075.00	18,754.17
5	6,275.00	7,059.38	7,843.75	8,628.13	9,412.50	10,196.88	10,981.25	11,765.63	12,550.00	15,687.50	18,825.00	21,962.50
6	7,191.67	8,090.63	8,989.58	9,888.54	10,787.50	11,686.46	12,585.42	13,484.38	14,383.33	17,979.17	21,575.00	25,170.83
7	8,108.33	9,121.88	10,135.42	11,148.96	12,162.50	13,176.04	14,189.58	15,203.13	16,216.67	20,270.83	24,325.00	28,379.17
8	9,025.00	10,153.13	11,281.25	12,409.38	13,537.50	14,665.63	15,793.75	16,921.88	18,050.00	22,562.50	27,075.00	31,587.50
9	9,941.67	11,184.38	12,427.08	13,669.79	14,912.50	16,155.21	17,397.92	18,640.63	19,883.33	24,854.17	29,825.00	34,795.83
10	10,858.33	12,215.63	13,572.92	14,930.21	16,287.50	17,644.79	19,002.08	20,359.38	21,716.67	27,145.83	32,575.00	38,004.17
11	11,775.00	13,246.88	14,718.75	16,190.63	17,662.50	19,134.38	20,606.25	22,078.13	23,550.00	29,437.50	35,325.00	41,212.50
12	12,691.67	14,278.13	15,864.58	17,451.04	19,037.50	20,623.96	22,210.42	23,796.88	25,383.33	31,729.17	38,075.00	44,420.83
13	13,608.33	15,309.38	17,010.42	18,711.46	20,412.50	22,113.54	23,814.58	25,515.63	27,216.67	34,020.83	40,825.00	47,629.17
14	14,525.00	16,340.63	18,156.25	19,971.88	21,787.50	23,603.13	25,418.75	27,234.38	29,050.00	36,312.50	43,575.00	50,837.50

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2025 Poverty Guidelines: Alaska

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	9,775.00	14,662.50	19,550.00	24,437.50	25,415.00	26,001.50	26,392.50	26,979.00	29,325.00	34,212.50	35,190.00	36,167.50
2	13,215.00	19,822.50	26,430.00	33,037.50	34,359.00	35,151.90	35,680.50	36,473.40	39,645.00	46,252.50	47,574.00	48,895.50
3	16,655.00	24,982.50	33,310.00	41,637.50	43,303.00	44,302.30	44,968.50	45,967.80	49,965.00	58,292.50	59,958.00	61,623.50
4	20,095.00	30,142.50	40,190.00	50,237.50	52,247.00	53,452.70	54,256.50	55,462.20	60,285.00	70,332.50	72,342.00	74,351.50
5	23,535.00	35,302.50	47,070.00	58,837.50	61,191.00	62,603.10	63,544.50	64,956.60	70,605.00	82,372.50	84,726.00	87,079.50
6	26,975.00	40,462.50	53,950.00	67,437.50	70,135.00	71,753.50	72,832.50	74,451.00	80,925.00	94,412.50	97,110.00	99,807.50
7	30,415.00	45,622.50	60,830.00	76,037.50	79,079.00	80,903.90	82,120.50	83,945.40	91,245.00	106,452.50	109,494.00	112,535.50
8	33,855.00	50,782.50	67,710.00	84,637.50	88,023.00	90,054.30	91,408.50	93,439.80	101,565.00	118,492.50	121,878.00	125,263.50
9	37,295.00	55,942.50	74,590.00	93,237.50	96,967.00	99,204.70	100,696.50	102,934.20	111,885.00	130,532.50	134,262.00	137,991.50
10	40,735.00	61,102.50	81,470.00	101,837.50	105,911.00	108,355.10	109,984.50	112,428.60	122,205.00	142,572.50	146,646.00	150,719.50
11	44,175.00	66,262.50	88,350.00	110,437.50	114,855.00	117,505.50	119,272.50	121,923.00	132,525.00	154,612.50	159,030.00	163,447.50
12	47,615.00	71,422.50	95,230.00	119,037.50	123,799.00	126,655.90	128,560.50	131,417.40	142,845.00	166,652.50	171,414.00	176,175.50
13	51,055.00	76,582.50	102,110.00	127,637.50	132,743.00	135,806.30	137,848.50	140,911.80	153,165.00	178,692.50	183,798.00	188,903.50
14	54,495.00	81,742.50	108,990.00	136,237.50	141,687.00	144,956.70	147,136.50	150,406.20	163,485.00	190,732.50	196,182.00	201,631.50

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	39,100.00	43,987.50	48,875.00	53,762.50	58,650.00	63,537.50	68,425.00	73,312.50	78,200.00	97,750.00	117,300.00	136,850.00
2	52,860.00	59,467.50	66,075.00	72,682.50	79,290.00	85,897.50	92,505.00	99,112.50	105,720.00	132,150.00	158,580.00	185,010.00
3	66,620.00	74,947.50	83,275.00	91,602.50	99,930.00	108,257.50	116,585.00	124,912.50	133,240.00	166,550.00	199,860.00	233,170.00
4	80,380.00	90,427.50	100,475.00	110,522.50	120,570.00	130,617.50	140,665.00	150,712.50	160,760.00	200,950.00	241,140.00	281,330.00
5	94,140.00	105,907.50	117,675.00	129,442.50	141,210.00	152,977.50	164,745.00	176,512.50	188,280.00	235,350.00	282,420.00	329,490.00
6	107,900.00	121,387.50	134,875.00	148,362.50	161,850.00	175,337.50	188,825.00	202,312.50	215,800.00	269,750.00	323,700.00	377,650.00
7	121,660.00	136,867.50	152,075.00	167,282.50	182,490.00	197,697.50	212,905.00	228,112.50	243,320.00	304,150.00	364,980.00	425,810.00
8	135,420.00	152,347.50	169,275.00	186,202.50	203,130.00	220,057.50	236,985.00	253,912.50	270,840.00	338,550.00	406,260.00	473,970.00
9	149,180.00	167,827.50	186,475.00	205,122.50	223,770.00	242,417.50	261,065.00	279,712.50	298,360.00	372,950.00	447,540.00	522,130.00
10	162,940.00	183,307.50	203,675.00	224,042.50	244,410.00	264,777.50	285,145.00	305,512.50	325,880.00	407,350.00	488,820.00	570,290.00
11	176,700.00	198,787.50	220,875.00	242,962.50	265,050.00	287,137.50	309,225.00	331,312.50	353,400.00	441,750.00	530,100.00	618,450.00
12	190,460.00	214,267.50	238,075.00	261,882.50	285,690.00	309,497.50	333,305.00	357,112.50	380,920.00	476,150.00	571,380.00	666,610.00
13	204,220.00	229,747.50	255,275.00	280,802.50	306,330.00	331,857.50	357,385.00	382,912.50	408,440.00	510,550.00	612,660.00	714,770.00
14	217,980.00	245,227.50	272,475.00	299,722.50	326,970.00	354,217.50	381,465.00	408,712.50	435,960.00	544,950.00	653,940.00	762,930.00

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2025 Poverty Guidelines: Alaska

Dollars Per Month

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	814.58	1,221.88	1,629.17	2,036.46	2,117.92	2,166.79	2,199.38	2,248.25	2,443.75	2,851.04	2,932.50	3,013.96
2	1,101.25	1,651.88	2,202.50	2,753.13	2,863.25	2,929.33	2,973.38	3,039.45	3,303.75	3,854.38	3,964.50	4,074.63
3	1,387.92	2,081.88	2,775.83	3,469.79	3,608.58	3,691.86	3,747.38	3,830.65	4,163.75	4,857.71	4,996.50	5,135.29
4	1,674.58	2,511.88	3,349.17	4,186.46	4,353.92	4,454.39	4,521.38	4,621.85	5,023.75	5,861.04	6,028.50	6,195.96
5	1,961.25	2,941.88	3,922.50	4,903.13	5,099.25	5,216.93	5,295.38	5,413.05	5,883.75	6,864.38	7,060.50	7,256.63
6	2,247.92	3,371.88	4,495.83	5,619.79	5,844.58	5,979.46	6,069.38	6,204.25	6,743.75	7,867.71	8,092.50	8,317.29
7	2,534.58	3,801.88	5,069.17	6,336.46	6,589.92	6,741.99	6,843.38	6,995.45	7,603.75	8,871.04	9,124.50	9,377.96
8	2,821.25	4,231.88	5,642.50	7,053.13	7,335.25	7,504.53	7,617.38	7,786.65	8,463.75	9,874.38	10,156.50	10,438.63
9	3,107.92	4,661.88	6,215.83	7,769.79	8,080.58	8,267.06	8,391.38	8,577.85	9,323.75	10,877.71	11,188.50	11,499.29
10	3,394.58	5,091.88	6,789.17	8,486.46	8,825.92	9,029.59	9,165.38	9,369.05	10,183.75	11,881.04	12,220.50	12,559.96
11	3,681.25	5,521.88	7,362.50	9,203.13	9,571.25	9,792.13	9,939.38	10,160.25	11,043.75	12,884.38	13,252.50	13,620.63
12	3,967.92	5,951.88	7,935.83	9,919.79	10,316.58	10,554.66	10,713.38	10,951.45	11,903.75	13,887.71	14,284.50	14,681.29
13	4,254.58	6,381.88	8,509.17	10,636.46	11,061.92	11,317.19	11,487.38	11,742.65	12,763.75	14,891.04	15,316.50	15,741.96
14	4,541.25	6,811.88	9,082.50	11,353.13	11,807.25	12,079.73	12,261.38	12,533.85	13,623.75	15,894.38	16,348.50	16,802.63

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	3,258.33	3,665.63	4,072.92	4,480.21	4,887.50	5,294.79	5,702.08	6,109.38	6,516.67	8,145.83	9,775.00	11,404.17
2	4,405.00	4,955.63	5,506.25	6,056.88	6,607.50	7,158.13	7,708.75	8,259.38	8,810.00	11,012.50	13,215.00	15,417.50
3	5,551.67	6,245.63	6,939.58	7,633.54	8,327.50	9,021.46	9,715.42	10,409.38	11,103.33	13,879.17	16,655.00	19,430.83
4	6,698.33	7,535.63	8,372.92	9,210.21	10,047.50	10,884.79	11,722.08	12,559.38	13,396.67	16,745.83	20,095.00	23,444.17
5	7,845.00	8,825.63	9,806.25	10,786.88	11,767.50	12,748.13	13,728.75	14,709.38	15,690.00	19,612.50	23,535.00	27,457.50
6	8,991.67	10,115.63	11,239.58	12,363.54	13,487.50	14,611.46	15,735.42	16,859.38	17,983.33	22,479.17	26,975.00	31,470.83
7	10,138.33	11,405.63	12,672.92	13,940.21	15,207.50	16,474.79	17,742.08	19,009.38	20,276.67	25,345.83	30,415.00	35,484.17
8	11,285.00	12,695.63	14,106.25	15,516.88	16,927.50	18,338.13	19,748.75	21,159.38	22,570.00	28,212.50	33,855.00	39,497.50
9	12,431.67	13,985.63	15,539.58	17,093.54	18,647.50	20,201.46	21,755.42	23,309.38	24,863.33	31,079.17	37,295.00	43,510.83
10	13,578.33	15,275.63	16,972.92	18,670.21	20,367.50	22,064.79	23,762.08	25,459.38	27,156.67	33,945.83	40,735.00	47,524.17
11	14,725.00	16,565.63	18,406.25	20,246.88	22,087.50	23,928.13	25,768.75	27,609.38	29,450.00	36,812.50	44,175.00	51,537.50
12	15,871.67	17,855.63	19,839.58	21,823.54	23,807.50	25,791.46	27,775.42	29,759.38	31,743.33	39,679.17	47,615.00	55,550.83
13	17,018.33	19,145.63	21,272.92	23,400.21	25,527.50	27,654.79	29,782.08	31,909.38	34,036.67	42,545.83	51,055.00	59,564.17
14	18,165.00	20,435.63	22,706.25	24,976.88	27,247.50	29,518.13	31,788.75	34,059.38	36,330.00	45,412.50	54,495.00	63,577.50

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2025 Poverty Guidelines: Hawaii

Dollars Per Year

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	8,995.00	13,492.50	17,990.00	22,487.50	23,387.00	23,926.70	24,286.50	24,826.20	26,985.00	31,482.50	32,382.00	33,281.50
2	12,160.00	18,240.00	24,320.00	30,400.00	31,616.00	32,345.60	32,832.00	33,561.60	36,480.00	42,560.00	43,776.00	44,992.00
3	15,325.00	22,987.50	30,650.00	38,312.50	39,845.00	40,764.50	41,377.50	42,297.00	45,975.00	53,637.50	55,170.00	56,702.50
4	18,490.00	27,735.00	36,980.00	46,225.00	48,074.00	49,183.40	49,923.00	51,032.40	55,470.00	64,715.00	66,564.00	68,413.00
5	21,655.00	32,482.50	43,310.00	54,137.50	56,303.00	57,602.30	58,468.50	59,767.80	64,965.00	75,792.50	77,958.00	80,123.50
6	24,820.00	37,230.00	49,640.00	62,050.00	64,532.00	66,021.20	67,014.00	68,503.20	74,460.00	86,870.00	89,352.00	91,834.00
7	27,985.00	41,977.50	55,970.00	69,962.50	72,761.00	74,440.10	75,559.50	77,238.60	83,955.00	97,947.50	100,746.00	103,544.50
8	31,150.00	46,725.00	62,300.00	77,875.00	80,990.00	82,859.00	84,105.00	85,974.00	93,450.00	109,025.00	112,140.00	115,255.00
9	34,315.00	51,472.50	68,630.00	85,787.50	89,219.00	91,277.90	92,650.50	94,709.40	102,945.00	120,102.50	123,534.00	126,965.50
10	37,480.00	56,220.00	74,960.00	93,700.00	97,448.00	99,696.80	101,196.00	103,444.80	112,440.00	131,180.00	134,928.00	138,676.00
11	40,645.00	60,967.50	81,290.00	101,612.50	105,677.00	108,115.70	109,741.50	112,180.20	121,935.00	142,257.50	146,322.00	150,386.50
12	43,810.00	65,715.00	87,620.00	109,525.00	113,906.00	116,534.60	118,287.00	120,915.60	131,430.00	153,335.00	157,716.00	162,097.00
13	46,975.00	70,462.50	93,950.00	117,437.50	122,135.00	124,953.50	126,832.50	129,651.00	140,925.00	164,412.50	169,110.00	173,807.50
14	50,140.00	75,210.00	100,280.00	125,350.00	130,364.00	133,372.40	135,378.00	138,386.40	150,420.00	175,490.00	180,504.00	185,518.00

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	35,980.00	40,477.50	44,975.00	49,472.50	53,970.00	58,467.50	62,965.00	67,462.50	71,960.00	89,950.00	107,940.00	125,930.00
2	48,640.00	54,720.00	60,800.00	66,880.00	72,960.00	79,040.00	85,120.00	91,200.00	97,280.00	121,600.00	145,920.00	170,240.00
3	61,300.00	68,962.50	76,625.00	84,287.50	91,950.00	99,612.50	107,275.00	114,937.50	122,600.00	153,250.00	183,900.00	214,550.00
4	73,960.00	83,205.00	92,450.00	101,695.00	110,940.00	120,185.00	129,430.00	138,675.00	147,920.00	184,900.00	221,880.00	258,860.00
5	86,620.00	97,447.50	108,275.00	119,102.50	129,930.00	140,757.50	151,585.00	162,412.50	173,240.00	216,550.00	259,860.00	303,170.00
6	99,280.00	111,690.00	124,100.00	136,510.00	148,920.00	161,330.00	173,740.00	186,150.00	198,560.00	248,200.00	297,840.00	347,480.00
7	111,940.00	125,932.50	139,925.00	153,917.50	167,910.00	181,902.50	195,895.00	209,887.50	223,880.00	279,850.00	335,820.00	391,790.00
8	124,600.00	140,175.00	155,750.00	171,325.00	186,900.00	202,475.00	218,050.00	233,625.00	249,200.00	311,500.00	373,800.00	436,100.00
9	137,260.00	154,417.50	171,575.00	188,732.50	205,890.00	223,047.50	240,205.00	257,362.50	274,520.00	343,150.00	411,780.00	480,410.00
10	149,920.00	168,660.00	187,400.00	206,140.00	224,880.00	243,620.00	262,360.00	281,100.00	299,840.00	374,800.00	449,760.00	524,720.00
11	162,580.00	182,902.50	203,225.00	223,547.50	243,870.00	264,192.50	284,515.00	304,837.50	325,160.00	406,450.00	487,740.00	569,030.00
12	175,240.00	197,145.00	219,050.00	240,955.00	262,860.00	284,765.00	306,670.00	328,575.00	350,480.00	438,100.00	525,720.00	613,340.00
13	187,900.00	211,387.50	234,875.00	258,362.50	281,850.00	305,337.50	328,825.00	352,312.50	375,800.00	469,750.00	563,700.00	657,650.00
14	200,560.00	225,630.00	250,700.00	275,770.00	300,840.00	325,910.00	350,980.00	376,050.00	401,120.00	501,400.00	601,680.00	701,960.00

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

2025 Poverty Guidelines: Hawaii

Dollars Per Month

Household/ Family Size	50%	75%	100%	125%	130%	133%	135%	138%	150%	175%	180%	185%
1	749.58	1,124.38	1,499.17	1,873.96	1,948.92	1,993.89	2,023.88	2,068.85	2,248.75	2,623.54	2,698.50	2,773.46
2	1,013.33	1,520.00	2,026.67	2,533.33	2,634.67	2,695.47	2,736.00	2,796.80	3,040.00	3,546.67	3,648.00	3,749.33
3	1,277.08	1,915.63	2,554.17	3,192.71	3,320.42	3,397.04	3,448.13	3,524.75	3,831.25	4,469.79	4,597.50	4,725.21
4	1,540.83	2,311.25	3,081.67	3,852.08	4,006.17	4,098.62	4,160.25	4,252.70	4,622.50	5,392.92	5,547.00	5,701.08
5	1,804.58	2,706.88	3,609.17	4,511.46	4,691.92	4,800.19	4,872.38	4,980.65	5,413.75	6,316.04	6,496.50	6,676.96
6	2,068.33	3,102.50	4,136.67	5,170.83	5,377.67	5,501.77	5,584.50	5,708.60	6,205.00	7,239.17	7,446.00	7,652.83
7	2,332.08	3,498.13	4,664.17	5,830.21	6,063.42	6,203.34	6,296.63	6,436.55	6,996.25	8,162.29	8,395.50	8,628.71
8	2,595.83	3,893.75	5,191.67	6,489.58	6,749.17	6,904.92	7,008.75	7,164.50	7,787.50	9,085.42	9,345.00	9,604.58
9	2,859.58	4,289.38	5,719.17	7,148.96	7,434.92	7,606.49	7,720.88	7,892.45	8,578.75	10,008.54	10,294.50	10,580.46
10	3,123.33	4,685.00	6,246.67	7,808.33	8,120.67	8,308.07	8,433.00	8,620.40	9,370.00	10,931.67	11,244.00	11,556.33
11	3,387.08	5,080.63	6,774.17	8,467.71	8,806.42	9,009.64	9,145.13	9,348.35	10,161.25	11,854.79	12,193.50	12,532.21
12	3,650.83	5,476.25	7,301.67	9,127.08	9,492.17	9,711.22	9,857.25	10,076.30	10,952.50	12,777.92	13,143.00	13,508.08
13	3,914.58	5,871.88	7,829.17	9,786.46	10,177.92	10,412.79	10,569.38	10,804.25	11,743.75	13,701.04	14,092.50	14,483.96
14	4,178.33	6,267.50	8,356.67	10,445.83	10,863.67	11,114.37	11,281.50	11,532.20	12,535.00	14,624.17	15,042.00	15,459.83

Household/ Family Size	200%	225%	250%	275%	300%	325%	350%	375%	400%	500%	600%	700%
1	2,998.33	3,373.13	3,747.92	4,122.71	4,497.50	4,872.29	5,247.08	5,621.88	5,996.67	7,495.83	8,995.00	10,494.17
2	4,053.33	4,560.00	5,066.67	5,573.33	6,080.00	6,586.67	7,093.33	7,600.00	8,106.67	10,133.33	12,160.00	14,186.67
3	5,108.33	5,746.88	6,385.42	7,023.96	7,662.50	8,301.04	8,939.58	9,578.13	10,216.67	12,770.83	15,325.00	17,879.17
4	6,163.33	6,933.75	7,704.17	8,474.58	9,245.00	10,015.42	10,785.83	11,556.25	12,326.67	15,408.33	18,490.00	21,571.67
5	7,218.33	8,120.63	9,022.92	9,925.21	10,827.50	11,729.79	12,632.08	13,534.38	14,436.67	18,045.83	21,655.00	25,264.17
6	8,273.33	9,307.50	10,341.67	11,375.83	12,410.00	13,444.17	14,478.33	15,512.50	16,546.67	20,683.33	24,820.00	28,956.67
7	9,328.33	10,494.38	11,660.42	12,826.46	13,992.50	15,158.54	16,324.58	17,490.63	18,656.67	23,320.83	27,985.00	32,649.17
8	10,383.33	11,681.25	12,979.17	14,277.08	15,575.00	16,872.92	18,170.83	19,468.75	20,766.67	25,958.33	31,150.00	36,341.67
9	11,438.33	12,868.13	14,297.92	15,727.71	17,157.50	18,587.29	20,017.08	21,446.88	22,876.67	28,595.83	34,315.00	40,034.17
10	12,493.33	14,055.00	15,616.67	17,178.33	18,740.00	20,301.67	21,863.33	23,425.00	24,986.67	31,233.33	37,480.00	43,726.67
11	13,548.33	15,241.88	16,935.42	18,628.96	20,322.50	22,016.04	23,709.58	25,403.13	27,096.67	33,870.83	40,645.00	47,419.17
12	14,603.33	16,428.75	18,254.17	20,079.58	21,905.00	23,730.42	25,555.83	27,381.25	29,206.67	36,508.33	43,810.00	51,111.67
13	15,658.33	17,615.63	19,572.92	21,530.21	23,487.50	25,444.79	27,402.08	29,359.38	31,316.67	39,145.83	46,975.00	54,804.17
14	16,713.33	18,802.50	20,891.67	22,980.83	25,070.00	27,159.17	29,248.33	31,337.50	33,426.67	41,783.33	50,140.00	58,496.67

Note: Each individual program--e.g., SNAP, Medicaid--determines how to round various multiples of the poverty guidelines, what income is to be included, and how the eligibility unit is defined. For more information about the poverty guidelines visit: http://aspe.hhs.gov/poverty.

Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Maryland
DEPARTMENT OF LABOR

Division of Workforce Development and Adult Learning (DWDAL)

Policy Issuance

PI 2025-09 2025 Federal Poverty Guidelines & 2025 Lower Living Standard Income Level | July 14 2025

TO	Division of Workforce Development and Adult Learning (DWDAL) staff
FROM	DWDAL Maryland Department of Labor (MD Labor)
SUBJECT	2025 Federal Poverty Guidelines and 2025 Lower Living Standard Income Level (LLSIL)
PURPOSE	To provide the U.S. Department of Health and Human Services 2025 federal poverty guidelines and the U.S. Department of Labor's updated annual LLSIL levels for 2025.
ACTION	Local Workforce Development Area (Local Area) Directors, American Job Center (AJC) Reemployment Program Directors, and central office managers will ensure all employees are aware of and receive copies of this policy. DWDAL policies are available on the MD Labor website.
EXPIRATION	Until Cancelled.
QUESTIONS	Lauren Gilwee Director, Policy DWDAL 410.767.2268 laurene.gilwee@maryland.gov Javonte McDonald Director, Office of Workforce Development DWDAL 410.767.2110 javonte.mcdonald@maryland.gov
PREPARED BY	Margaret Drew, Policy Analyst, DWDAL, MD Labor

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CANCELLATIONS

All previous policies on Federal Poverty Guidelines and Lower Living Standard Income Levels (LLSIL) remain active for program participants during that policy's effective date. These policies may be archived and available at: http://www.labor.maryland.gov/employment/mpi/.

GENERAL INFORMATION

The Workforce Innovation and Opportunity Act (WIOA) was signed into law on July 22, 2014 and went into effect July 1, 2015. WIOA supersedes the Workforce Investment Act of 1998 (WIA) and amends the Adult Education and Family Literacy Act, the Wagner Peyser Act, and the Rehabilitation Act of 1973. By design, the workforce system established under WIOA is integrated to help both businesses and jobseekers. WIOA envisions connecting businesses with job seekers through meaningful partnerships among workforce, education, human services, and economic development entities to ensure optimum results and leveraging of resources. The law addresses the needs of job seekers by establishing a workforce system that helps them access employment, education, training, and support services to succeed in the labor market. Through the American Job Centers (AJCs), WIOA works to address employer needs by matching them to the skilled workers they need to compete in the global economy.

Title I of WIOA requires the United States Secretary of Labor to update and publish the Lower Living Standard Income Level (LLSIL) guidelines tables annually. States must use these tables as described in the law, including for youth eligibility determinations. WIOA defines the term "low income individual" as one who qualifies under various criteria, including an individual who receives, or received for a prior six-month period, income that does not exceed the higher level of the poverty line or 70 percent of the LLSIL.

This policy provides the annual LLSIL for 2025 for the Maryland Department of Labor's (MD Labor) Division of Workforce Development and Adult Learning (DWDAL). MD Labor created this policy in response to the United States Department of Labor (USDOL) releasing LLSIL guidelines through the Federal Register. USDOL determines LLSIL figures by calculating the percentage change in the most recent Consumer Price Index for All Urban Consumers for an area, then applying this calculation to each of the previous year's LLSIL figures. Tables 4 and 5 on USDOL's Lower Living Standard Income Level Guidelines webpage represent these changes. Additionally, the calculations reference the U.S. Department of Health and Human Services (HHS)'s current 2025 poverty guidelines.

MD Labor determined LLSIL levels for each county based on either census tract or on metropolitan status, as determined by Bureau of Labor Statistics Office of Management and Budget Bulletin No. 18-03, "Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas." MD Labor may update LLSIL designations annually as HHS and USDOL figures change.

This policy is effective May 13, 2025.

2025 Federal Poverty Guidelines

The following chart provides the 2025 Poverty Guidelines, as given by HHS.

2025 Poverty Guidelines	
Size of Family	**Poverty Guideline**
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150

NOTE: For family units with more than 8 members, add $5,500 for each additional person.[1]

[1] Department of Health and Human Services: Annual Update of the HHS Poverty Guidelines: https://www.dol.gov/sites/dolgov/files/ETA/llsil/pdfs/HHS-Poverty-Guidelines_2025-FRN.pdf.

2025 Lower Living Standard Income Level

WIOA stipulates that 70 percent of the LLSIL value shall be used for certain WIOA programs, including the youth program and the Indian and Native American Program. The following chart provides Maryland's LLSIL standards by family size, Local Workforce Development Area (Local Area), and county.

2025 LLSIL – 70%, by Family Size

Area	Family Size						
	1	**2**	**3**	**4**	**5**	**6**	**If 7+, Add**
Anne Arundel Co.	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Baltimore City	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Baltimore Co	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Carroll Co.	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Frederick Co.	14,608*	23,939	32,859	40,559	47,869	55,982	8,113
Howard Co.	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Lower Shore							
Somerset Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Wicomico Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Worcester Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Montgomery Co.	14,608*	23,939	32,859	40,559	47,869	55,982	8,113
Prince George's Co.	14,608*	23,939	32,859	40,559	47,869	55,982	8,113
Southern MD							
Calvert Co.	14,608*	23,939	32,859	40,559	47,869	55,982	8,113
Charles Co.	14,608*	23,939	32,859	40,559	47,869	55,982	8,113
St. Mary's Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Susquehanna							
Cecil Co.	13,396*	21,948	30,129	37,191	43,895	51,328	7,433
Harford Co.	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Upper Shore							
Caroline Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Dorchester Co.	11,746*	19,242*	26,410*	32,601	38,472	44,992	6,520
Kent Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Talbot Co.	11,746*	19,242*	26,410*	32,601	38,472	44,992	6,520
Queen Anne's Co.	14,998*	24,578	33,737	41,643	49,148	57,479	8,331
Western MD							
Allegany Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Washington Co.	12,205*	19,998*	27,448	33,888	39,995	46,777	6,782
Garrett Co.	11,746*	19,242*	26,410*	32,601	38,472	44,992	6,520
Effective May 2025							

**Poverty level is greater than the LLSIL figures.*

REFERENCES

LAW

- Workforce Innovation and Opportunity Act (WIOA), 29 U.S.C. § 3101 et. seq (2015);

USDOL GUIDANCE

- Bureau of Labor Statistics Office of Management and Budget Bulletin No. 18-03, "Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas"
- Annual Update of the HHS Poverty Guidelines, Federal Register, January 17, 2025, Vol. 90, No. 11, Pages 5917-5918
- Workforce Innovation and Opportunity Act 2025 Lower Living Standard Income Level (LLSIL), Federal Register, May 13, 2025, Vol. 90, No. 91, Pages 20318-20319
- USDOL Lower Living Standard Income Level Guidelines

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