Applicant: Integrated Community Services (ICS), Inc.

Responses to Certificate of Need Completeness Questions

March 3rd, 2026

Re: Integrated Community Services (ICS), Inc- Certificate of Need Application
Establishment of a New Home Health Care Agency Matter Nos.: 26-R4-2483, 26-R4-2484, 26-R4-2485, 26-R4-2486

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

Populations and Services

1. What are the primary health conditions of the individuals who will receive services from ICS?

ICS Response:

The individuals ICS proposes to serve in Maryland will primarily be elderly, disabled, and medically complex patients with chronic cardiovascular, metabolic, renal, respiratory, mobility, and cognitive conditions.

These populations require coordinated skilled nursing, personal care assistance, chronic disease management, fall prevention, and care transition services to maintain stability in the community and reduce avoidable institutional utilization.

ICS's established clinical pathways and care coordination infrastructure are specifically designed to meet the needs of these high-risk populations that will be directly implemented in the Maryland program.

Fees and Time Payment Plan

2. Provide a copy of the policy governing time payment options and explain how the plan operates.

ICS Response:

Attached as Exhibit 9 is the policy governing time payment options, including detailed information regarding how the plan operates

Charity Care and Sliding Fee Scale

3. How will information about charity care and sliding fee scale policies be disseminated an nually to reach the agency's service population?

ICS Response:

ICS will disseminate information regarding its Charity Care and Sliding Fee Scale policies on an annual basis using multiple methods designed to effectively reach its service population. Dissemination methods will include annual publication in a local newspaper, prominent posting of notices in the agency's business office and on its website, and inclusion of written information in patient admission packets prior to the initiation of services.

In addition, ICS will ensure that its dissemination practices are fully aligned with all applicable Maryland requirements and regulatory guidance and will periodically review and update its outreach methods as necessary to maintain accessibility, effectiveness, and ongoing compliance.

All information will be provided in a clear, understandable format appropriate for the service area population. Agency staff will be available to address patient and family questions regarding charity care eligibility, sliding fee scale options, and payment responsibilities during intake and prior to the start of services to ensure informed decision-making.

4. Provide supporting documentation demonstrating the amount of charity care provided by ICS in prior years, including quantitative data, and evidence supporting the claim that ICS has met or exceeded county-level home health agency (HHA) charity care averages in accordance with COMAR 10.24.16.08.

ICS Response:

Integrated Community Services (ICS) maintains a Board-approved Charity Care Policy consistent with regulatory standards for home health agencies and provides medically necessary services to eligible patients regardless of ability to pay.

Historical Charity Care Performance

FY2023

- $38,625.31 in approved charity care
- 3 charity care patients
- 199 charity care visits
- Average charity care per patient: $12,875.10

FY2024

- $19,986.64 in approved charity care
- 3 charity care patients
- 145 charity care visits
- Average charity care per patient: $6,662.21

Charity care determinations were made in accordance with ICS's written policy, which incorporates documented income eligibility screening, financial hardship verification, and medical necessity review. Supporting documentation includes:

- The Board-approved Charity Care Policy

- Charity eligibility determination documentation
- Internal charity care tracking logs
- Financial records substantiating reported write-offs

These data demonstrate ICS's established infrastructure for identifying and serving financially vulnerable patients.

Compliance with COMAR 10.24.16.08

ICS is not currently licensed in Maryland; therefore, Maryland-specific charity care reporting requirements are not yet applicable. Upon approval and licensure in Maryland, ICS commits to providing charity care at a level at least equivalent to the average charity care provided by Maryland home health agencies in the applicable jurisdiction, in accordance with COMAR 10.24.16.08.

ICS will implement its Board-approved Charity Care Policy within the Maryland service area immediately upon commencement of operations. Charity care will be tracked as a percentage of total Maryland gross patient service revenue and monitored quarterly through financial oversight and QAPI review processes to ensure ongoing compliance with state benchmarks.

In addition, ICS will:

- Apply uniform income eligibility screening consistent with Maryland regulatory standards
- Maintain documentation supporting all charity care determinations
- Report charity care data in accordance with MHCC reporting requirements
- Monitor performance against the applicable Maryland HHA average and adjust service allocations as necessary to maintain compliance

Through demonstrated historical provision of free and reduced-cost care and a structured compliance framework, ICS evidences both an established commitment to serving financially vulnerable populations and the operational capacity to meet Maryland's charity care standards.

5. Submit a specific plan for achieving the committed level of charity care, including monitoring and reporting processes.

ICS Response:

ICS has developed a comprehensive written Charity Care (Uncompensated Care) and Sliding Fee Scale Policy to ensure access to home health services regardless of a patient's ability to pay. Eligibility for charity care, reduced fees, or Medical Assistance is determined within two (2)

business days of a client's request, and the probable eligibility determination is communicated promptly to the client or family.

ICS commits to providing charity care in an amount equal to or greater than the average level of charity care provided by home health agencies in the applicable jurisdiction, consistent with COMAR 10.24.16.08E. This commitment is supported by the agency's financial projections and operating budget, which include designated allocations for uncompensated and reduced-cost care.

Specific Plan for Achieving the Committed Charity Care Level

ICS will achieve its charity care commitment through the following structured process:

1. Proactive Identification of Eligible Patients:
   Charity care information will be provided at intake, assessment, and prior to service initiation. Staff will screen uninsured and underinsured patients for potential eligibility using standardized income-based criteria aligned with Federal Poverty Guidelines.
2. Sliding Fee Scale Implementation:
   For patients who do not qualify for full charity care but demonstrate financial hardship, ICS will apply a sliding fee discount and offer reasonable time payment arrangements consistent with agency policy.
3. Monthly Monitoring and Tracking:
   Charity care encounters, adjustments, and write-offs will be tracked through the agency's billing and accounting system. On a monthly basis, administrative leadership will review:

Performance will be compared against the committed benchmark to ensure the agency remains on track.

   a. Total charity care visits provided
   b. Dollar value of charity care rendered
   c. Percentage of charity care relative to total patient service revenue

4. Corrective Action if Needed:
   If monitoring indicates that ICS is not meeting its projected charity care commitment, outreach efforts, community education, and intake screening processes will be reinforced to ensure eligible individuals are identified and served.
5. Annual Reporting and Oversight:
   Charity care totals will be compiled annually and reviewed by executive leadership prior to submission in the required regulatory filings. Documentation will be maintained for Commission review. Leadership will evaluate charity care performance annually and update policies as necessary to maintain compliance and community access.

ICS's structured monitoring, financial allocation, and leadership oversight ensure the credibility and sustainability of its charity care commitment.

Financial Feasibility

6. What are the utilization projections for each county the agency seeks to provide home health services.

ICS Response:

ICS's projected utilization reflects a conservative and structured ramp-up strategy aligned with the statistical projections provided in Table 2B of the application.

ICS projects approximately 25 admissions per month per jurisdiction, resulting in 300 annual admissions in Anne Arundel County, 300 annual admissions in Montgomery County, and 300 annual admissions in Prince George's County, for a total projected annual volume of 900 admissions across the three-county service area.

During the first three to six months of operation, ICS will leverage existing credentialed payer relationships and referral coordination processes that currently serve Maryland residents through its Washington, DC operations. These include established contracts with AmeriHealth, Kaiser Permanente, UnitedHealthcare, CareFirst, Wellpoint, BlueCross BlueShield, and Humana, as well as referral management platforms such as WellSky CarePort QuickCase and WellSky Extended Care Premium Portal, and discharge planning relationships with regional hospital systems, physician practices, and clinics that routinely discharge Maryland residents.

Concurrently, ICS will implement structured outreach to Maryland-based hospitals, rehabilitation facilities, physician practices, and community care coordinators to establish and expand referral pathways within each jurisdiction.

The projected census does not assume accelerated market capture or speculative referral growth. Rather, the model reflects disciplined forecasting consistent with staffing availability, operational readiness, patient compliance, and financial feasibility as outlined in Table 4. Any expansion beyond projected levels would occur incrementally and only as clinical staffing and quality standards support additional capacity.

7. The revenue projections for gross patient service revenue on page 23 is not consistent with the data presented in table 4B on page 114. Please explain the differences.

ICS Response:

TABLE 4B

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2026	2027	2028	2029
1. Revenue				
Gross Patient Service Revenue	1,441,188.00	3,431,400.00	3,671,598.00	3,928,609.86
Allowance for Bad Debt	(86,471.28)	(205,884.00)	(220,295.88)	(235,716.59)
Contractual Allowance				
Charity Care	(100,883.16)	(240,198.00)	(257,011.86)	(275,002.69)
Net Patient Services Revenue	1,253,833.56	2,985,318.00	3,194,290.26	3,417,890.58
Other Operating Revenues (Specify)				
Net Operating Revenue	1,253,833.56	2,985,318.00	3,194,290.26	3,417,890.58
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	295,819.16	704,331.34	725,461.28	747,225.12
Contractual Services	500,976.00	1,192,800.00	1,252,440.00	1,315,062.00
Interest on Current Debt	-			
Interest on Project Debt	-			
Current Depreciation	13,000.00	26,000.00	27,300.00	28,665.00
Project Depreciation	-			
Current Amortization	-			

Project Amortization	-			
Supplies	30,000.00	60,000.00	63,000.00	66,150.00
Other Expenses (management salaries,Occupancy, office expenses, IT systems)	226,744.69	535,445.46	558,414.35	582,417.57
Total Operating Expenses	1,066,539.86	2,518,576.81	2,626,615.63	2,739,519.70
3. Income				
Income from Operation	187,293.70	466,741.19	567,674.63	678,370.88
Non-Operating Income				

The gross patient service revenue projections presented on page 23 reflect preliminary revenue estimates developed during early drafting of the narrative section of the application. During completion of the required CON financial schedules, projected census ramp-up, visit frequency, and revenue assumptions were refined to align precisely with the detailed staffing, expense, and payor mix projections incorporated into Table 4B.

As a result, projected gross patient service revenue for 2027–2029 in Table 4B is modestly lower than the preliminary figures presented on page 23. The 2026 projection remains consistent across both sections, as it reflects the initial partial-year ramp-up period.

Table 4B represents the finalized and internally reconciled financial model for the proposed Maryland Home Health Agency. All related calculations including bad debt allowance (6%), charity care (7%), net patient service revenue, total operating expenses, and income from operations are derived from and aligned with the Table 4B projections.

ICS confirms that Table 4B contains the controlling gross patient service revenue projections for purposes of this application.

8. The staffing projections in the chart on page 24 are not consistent with the projections in Exhibit 6, page 118, please provide justification or rectify the discrepancies.

ICS Response:

Our staffing chart on page 24 reflects projected full-time equivalents (FTEs) required for the proposed Maryland expansion only. The originally submitted Exhibit 6 (page 118) inadvertently

included enterprise-wide staffing levels associated with ICS's existing District of Columbia operations rather than staffing additions specific to the proposed Maryland project.

To rectify this discrepancy, exhibit 6 has been revised to reflect only the staffing changes required for the Maryland expansion, calculated on a 2,080 paid-hour FTE basis. The revised Exhibit 6 now aligns directly with the FTE projections presented on page 24 and with the corresponding salary and expense projections reflected in Table 4.

ICS confirms that the revised exhibit accurately represents project-specific staffing additions and does not include enterprise-wide personnel unrelated to the proposed Maryland service area expansion.

Revised Exhibit 6 (Table 5)
Staffing Changes Required by the Proposed Maryland Project

This revised Exhibit 6 reflects only the staffing additions required for the proposed Maryland expansion and aligns directly with the FTE projections presented on page 24 of our CON application. Enterprise-wide District of Columbia staffing levels have been removed to eliminate prior inconsistencies.

Position	2026 FTE	2027 FTE	2028 FTE	2029 FTE	Employee/Contract
Registered Nurse (RN)	6.0	7.0	8.0	9.0	Employee/Contract
Physical Therapist (PT)	4.0	5.0	6.0	7.0	Contract
Occupational Therapist (OT)	4.0	5.0	6.0	7.0	Contract
Home Health Aide (HHA)	2.0	3.0	4.0	5.0	Employee
Clinical Supervisor / QA / Admin	2.0	3.0	4.0	5.0	Employee

All FTE calculations are based on 2,080 paid hours per year. Staffing will scale in a phased manner consistent with projected census growth and visit volume reflected in Table 2B and financial projections in Table 4.

9. Provide staffing projections for each county in which the agency seeks to provide home health services.

ICS Response:

ICS projects staffing requirements by county based on planned service delivery volumes, phased implementation, and projected census growth in Anne Arundel County, Montgomery County, and Prince George's County.

Projected staffing reflects additional personnel required specifically for Maryland expansion and aligns with projected client volumes in Table 2B and corresponding financial projections in Table 4. All FTE calculations are based on 2,080 paid hours annually.

Year 1 (2026) County-Level Staffing Allocation

Projected Annual Admissions: 300 per county (900 total)

Anne Arundel County – 2026

- 2.0 FTE Registered Nurses
- 1.3 FTE Physical Therapists
- 0.7 FTE Occupational Therapists
- 2.5 FTE Home Health Aides
- 1.0 FTE Clinical Supervisor/QA/Admin (shared regional oversight)

Montgomery County – 2026

- 2.0 FTE Registered Nurses
- 1.3 FTE Physical Therapists
- 0.7 FTE Occupational Therapists
- 2.5 FTE Home Health Aides
- 1.0 FTE Clinical Supervisor/QA/Admin (shared regional oversight)

Prince George's County – 2026

- 2.0 FTE Registered Nurses
- 1.4 FTE Physical Therapists
- 0.6 FTE Occupational Therapists
- 3.0 FTE Home Health Aides
- 1.0 FTE Clinical Supervisor/QA/Admin (shared regional oversight)

Total Maryland Staffing – 2026

- 6.0 FTE Registered Nurses
- 4.0 FTE Physical Therapists
- 2.0 FTE Occupational Therapists
- 8.0 FTE Home Health Aides
- 4.0 FTE Clinical Supervisor / QA / Administrative Support

Growth Projections (2027–2029)

Staffing will scale proportionally with census growth as follows:

Position	2026	2027	2028	2029
RN	6.0	7.0	8.0	9.0
PT	4.0	5.0	6.0	7.0
OT	2.0	3.0	4.0	5.0
HHA	8.0	10.0	12.0	14.0
Clinical/QA/Admin	4.0	5.0	6.0	7.0

Allocation among counties will remain proportional to referral volume and active census distribution. As patient concentration increases within specific jurisdictions, dedicated supervisory and clinical staff will be assigned accordingly to maintain regulatory compliance and timely service delivery.

Staffing Model Rationale

Staffing projections are based on:

- RN caseload assumption of approximately 25–30 active patients
- Therapy utilization patterns consistent with PDGM case-mix
- HHA visit frequency assumptions aligned with Plan of Care requirements
- Supervisory ratio ensuring appropriate oversight under 42 CFR §484
- Geographic travel considerations within each county

This phased staffing model ensures:

- Timely Start of Care within 24–48 hours
- Adequate clinical supervision

- Continuity of care across all three counties
- Workforce sustainability and operational scalability

Impact

10. Please describe the impact ICS will have on existing agencies' caseloads, staffing, or payor mix, supported by evidence/data/citations?

ICS Response:

ICS does not seek to displace or diminish the role of existing home health providers within the proposed service areas. The organization recognizes that Maryland's current providers play a critical role in meeting community healthcare needs.

The intent of this proposal is to serve as a positive addition to the existing provider landscape, not as competition intended to replace or reduce current services. ICS aims to supplement the services already available by responsibly expanding access, improving service timelines, and offering patients additional options when selecting a home health provider.

Consistent with the conservative utilization projections reflected in Table 2B, ICS's proposed expansion represents incremental capacity rather than market replacement. The projected census constitutes a modest proportion of overall county-level home health utilization and is designed to support system capacity rather than disrupt it.

Market conditions are influenced by multiple variables, including workforce availability, payer mix, referral patterns, and patient choice. By introducing additional clinically supervised capacity, ICS intends to help alleviate service delays where they exist, support timely start-of-care, and enhance continuity of care.

Overall, this proposal is structured to responsibly expand access to high-quality home health services while maintaining market stability, preserving patient choice, and strengthening the broader healthcare delivery system within the proposed service areas.

11. Provide assumptions or sources used to conclude that there is an unmet demand for skilled home health services that are driven by staffing shortages and discharge delays.

ICS Response:

Demographic, Medicare Enrollment, Discharge and Workforce Analysis for: Montgomery County, Prince George's County, and Anne Arundel County:

1. Demographic Trends and Population at Risk

The demand for skilled home health services correlates strongly with the number of older adults in a region, as this population demonstrates higher prevalence of chronic illness, disability, and post-acute recovery needs. The Maryland State Health Plan for Home Health Services (COMAR 10.24.16) recognizes demographic trends, including age distribution, as a core factor in evaluating service needs and capacity.

1.1 Aging Population Growth

County	Total Population (2020 Census)	Population Age 65+	% Age 65+
Montgomery County	1,062,061[1]	177,505[1]	16.7%[1]
Prince George's County	967,201[1]	132,049[1]	13.7%[1]
Anne Arundel County	588,261[1]	95,254[1]	16.2%[1]

These figures demonstrate substantial and aging Medicare-eligible populations in each county. Statewide, older adults (65+) represent approximately 17.6% of Maryland's population (2024 estimate).[2] Growth in this demographic directly increases demand for intermittent skilled nursing, therapy, and post-acute services delivered in the home.

Assumption #1: The population aged 65+ in Montgomery, Prince George's, and Anne Arundel Counties is large and growing, increasing projected demand for skilled home health care services.

2. Medicare Enrollment and Hospital Discharge Utilization

Medicare enrollment closely tracks the 65+ population and disabled beneficiaries under age 65. CMS Geographic Variation Public Use Files and Medicare Enrollment Dashboards confirm that each of the subject counties maintains substantial Medicare beneficiary enrollment. [3]

Hospital discharge data reported through the Maryland Health Services Cost Review Commission (HSCRC) demonstrate significant annual inpatient discharge volumes within each county. [4] A measurable portion of these discharges require post-acute care services, including home health.

COMAR 10.24.16 requires evaluation of utilization trends and referral patterns in assessing home health need. MHCC's Home Health Agency Annual Survey collects admissions, referral source data (including hospital referrals), and visits by payer to evaluate system capacity. [5]

Assumption #2: A significant percentage of home health referrals are hospital discharge-related, linking inpatient discharge volume directly to home health demand.

3. Workforce Shortages Driving Capacity Constraints

Maryland is experiencing documented shortages in Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and direct-care personnel critical to skilled home health delivery. The Maryland Nursing Workforce Center projects substantial RN demand growth through 2035, with shortages anticipated if supply trends persist. [6]

Healthcare workforce vacancy reporting indicates elevated vacancy rates across Maryland healthcare roles, contributing to reduced functional capacity among home health agencies.[7]

Assumption #3: Workforce shortages reduce the functional capacity of existing home health agencies to accept referrals, initiate timely start-of-care visits, and manage clinically appropriate caseloads.

4. Discharge Delays and Unmet Demand

When skilled home health services are unavailable due to staffing or capacity limitations, hospitals may delay discharge or patients may be discharged without clinically indicated services. National inpatient data demonstrate that not all patients requiring post-acute support receive home health referrals at discharge.[8]

Assumption #4: Delays in securing home health services represent unmet demand at the community level.

5. Conclusion

The convergence of substantial and aging Medicare populations, significant inpatient discharge volumes, and documented nursing workforce shortages supports the conclusion that unmet demand for skilled home health services exists within Montgomery County, Prince George's County, and Anne Arundel County, consistent with the need evaluation principles of COMAR 10.24.16.

Footnotes / References

1. U.S. Census Bureau, 2020 Decennial Census, County-Level Population Data.

2. Maryland Department of Planning, Population Estimates and Projections (2024).

3. Centers for Medicare & Medicaid Services (CMS), Medicare Enrollment Dashboard and Geographic Variation Public Use Files (latest available year).

4. Maryland Health Services Cost Review Commission (HSCRC), Inpatient Discharge Data Reports (latest available year).

5. Maryland Health Care Commission (MHCC), Home Health Agency Annual Survey; COMAR 10.24.16 State Health Plan for Home Health Services.

6. Maryland Nursing Workforce Center, Maryland Nursing Workforce Report (latest edition).

7. Maryland Hospital Association, Healthcare Workforce Vacancy Reports.

8. Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP) National Inpatient Discharge Data.

Linkages with Other Service Providers

12. Please describe ICS's strategy for establishing partnerships with service providers in the Maryland market.

ICS Response:

ICS's referral and market entry strategy is structured, phased, and aligned with the conservative utilization projections reflected in Table 2B of the application.

During the initial phase of operations, ICS will leverage existing credentialed payer relationships and established regional discharge planning networks that currently serve Maryland residents through the organization's Washington, DC operations. These include existing contracts with Kaiser Permanente, UnitedHealthcare, CareFirst BlueCross BlueShield, Cigna, AmeriHealth and Humana, as well as referral coordination platforms such as One Call and WellSky-CarePort QuickCase and Extended Care premium portal. ICS also maintains established discharge planning relationships with regional hospital systems, including Howard University Hospital, MedStar Georgetown University Hospital, Holy Cross, GW University Hospital and other facilities within the greater Washington metropolitan area that routinely discharge Maryland residents.

In addition to these regional relationships, ICS intends to establish and formalize direct referral relationships with Maryland-based hospitals, including University of Maryland Capital Region Health and other facilities within the University of Maryland Medical System that serve Prince George's, Montgomery, and Anne Arundel Counties. These relationships will focus on supporting timely discharge transitions, reducing avoidable readmissions, and improving start-of-care timelines for Maryland residents requiring skilled home health services.

In addition to these regional relationships, ICS will formalize and expand direct referral relationships with Maryland-based hospitals, including University of Maryland Capital Region Health and other facilities within the University of Maryland Medical System serving Prince George's, Montgomery, and Anne Arundel Counties. These partnerships will focus on facilitating timely discharge transitions, reducing avoidable readmissions, and improving start-of-care timelines for Maryland residents requiring skilled home health services.

As part of its workforce and partnership development strategy, ICS maintains an existing collaborative relationship with the University of Maryland, Baltimore County (UMBC), including engagement with student clinicians and social work programs. Through this

established partnership, this ongoing collaboration enhances recruitment pipelines and reinforces ICS's commitment to building sustainable, locally engaged healthcare partnerships in Maryland

ICS will also expand payer alignment by pursuing credentialing with additional insurance carriers operating within Maryland that are not currently part of the organization's DC portfolio. This ensures compliance with Maryland-specific managed care requirements while strengthening access across multiple payor types.

Immediately following CON approval, ICS will implement a structured outreach plan within Montgomery County, Prince George's County, and Anne Arundel County. Outreach efforts will include engagement with:

- Maryland-based hospitals and rehabilitation facilities;
- Physician groups and case management departments;
- Managed care organizations and care coordination entities; and
- Community-based healthcare networks.

The objective of this outreach is to establish formal referral pathways, introduce ICS's clinical service model, and ensure integration with local discharge planning and care coordination processes.

ICS's projections do not rely on speculative referral assumptions or abrupt market shifts. Projected census growth reflects incremental expansion supported by existing credentialed relationships, documented referral patterns involving Maryland residents, structured hospital engagement, and demographic trends discussed elsewhere in the application.

The organization's objective is to establish a stable, quality-driven presence within each jurisdiction while maintaining disciplined growth consistent with staffing capacity, operational readiness, financial feasibility, and overall system stability

Discharge Planning

13. Identify and describe the circumstances, reasons and considerations for a patient's transfer to a health care facility/program.

ICS Response:

See the ICS "Discharge Planning" Policy, Exhibit 10 for detailed information.

Patients will be discharged or transferred based on one or more of the following reasons:

Valid Reasons for Discharge or Transfer

- Goals met or no further skilled services required
- Patient relocation outside service area
- Change in medical condition requiring higher/different level of care

- Safety concerns or threatening behaviors
- Repeated missed visits after documented attempts to coordinate care
- Non-compliance making care ineffective or unsafe
- Insurance or payer issues (e.g., lack of authorization)
- Patient request to discontinue services
- Admission to hospice, hospital, or facility

ICS will never discharge a patient without adequate effort to provide safe transition and appropriate referrals.

14. Please provide additional information regarding the discharge planning process, as the submission lacks sufficient detail on care coordination and communication, as well as environmental assessments to support patient success beyond the provision of care. Additionally, describe current relationships and referral partners and submit supporting documentation, such as letters or emails from care partners.

ICS Response:

ICS maintains a comprehensive, person-centered discharge planning program that extends beyond clinical needs to include environmental safety assessments, social determinant screening, and structured interdisciplinary coordination. ICS conducts daily interdisciplinary case conferences, performs home safety evaluations at SOC and throughout care, and uses standardized SDOH tools to identify risks that may impact a patient's ability to remain safely at home. ICS maintains established relationships with hospitals, skilled nursing facilities, primary care providers, specialists, DME suppliers, hospice programs, and community-based organizations to ensure seamless transitions of care. Prior to discharge, ICS performs a warm handoff to the receiving caregiver/family member, provider, hospice program, SAR, SNF or relevant community-based program and ensures that all relevant clinical information, referrals, and follow-up instructions are communicated. Supporting documentation, including our existing policy, letters of collaboration from referral partners and sample communication logs, are included. Please see Exhibit 11 for letters of collaboration.

The following is a list of our Referral Partners and Community-based Organizations that are utilized:

Current Relationships & Referral Partners

A. Hospitals:

- Howard University Hospital
- Kaiser Permanente
- George Washington University Hospital
- Georgetown University Hospital

- Holy Cross Hospital
- MedStar Washington Center
- Cedar Hill Hospital
- University of Maryland Medical Center
- University of Maryland Capitol Region Medical Center
- NYU Langone Health
- Inova Health
- Tisch Hospital
- Mayo Clinic
- One Call

B. Skilled Nursing & Rehabilitation Facilities:

- Encompass Health Rehab Hospital of Richmond
- FutureCare Capitol Region
- Unique Rehab & Health
- Capitol Region Health
- Stoddard Baptist Nursing Home
- Adventist HealthCare
- Crescent City Nursing & Rehab
- Knollwood
- Forestville Healthcare Center
- Abram Assisted Living Facility
- Serenity Rehab

C. Web-based Referral Portals:

- WellSky Care Port Quick Care
- WellSky Care Port Extended Care

D. Primary Care & Specialty Providers:

- Kaiser Permanente UM Department
- Daja Health
- MedStar Medical Group Family Medicine
- Internal Medicine Colleagues
- MedStar Home HealthCare
- Howard University Family Medicine
- Unity Health Care
- House Calls of DC
- Bread for the City
- PCPs in DC

E. Community-Based Organizations

- Meals on Wheels
- Bread for the City
- Renaissance Adult Day Health Care
- PSI Family Services, Inc.
- Iona Senior Services
- PACE- Program of All-inclusive Care for the Elderly
- Transportation assistance programs (e.g., Metro Access)
- DME suppliers (e.g., Adapt Health; New Hampshire Pharmacy)
- Hospice and palliative care programs (e.g., Capitol Caring Health & Vitas Healthcare)
- Behavioral health providers in DC

Data Collection and Submission

15. As an existing HHA in DC, provide documentation that ICS is in compliance with data collection and submission.

ICS Response:

ICS Data Collection and Submission – Compliance Statement

Integrated Community Services (ICS) is currently licensed and operating as a Home Health Agency in Washington, DC, and is fully compliant with all federal and District data collection and reporting requirements. ICS follows the same regulatory standards that Maryland requires under COMAR 10.24.16.08K, COMAR 10.07.10.12, 42 CFR §484 and the CMS Home Health Quality Reporting Program (HH QRP). As demonstrated in the attached ICS Data Collection and Submission Policy, the agency maintains a comprehensive, structured system for collecting, validating, and submitting all required home health data.

ICS demonstrates compliance through the following:

1) Active CMS Certification
   a. Medicare provider enrollment in good standing
   b. OASIS submission access through iQIES
2) OASIS Submission Compliance
   a. Timely submission of required OASIS assessments
   b. Validation error correction processes
   c. No active CMS sanctions related to reporting
3) HH QRP Participation
   a. Participation in required quality data submission
   b. Internal review of CMS quality measures
4) HHCAHPS Compliance
   a. Engagement with CMS-approved vendor (as applicable based on volume thresholds)

5) Internal QA Oversight
    a. Monthly OASIS audits
    b. SOC/ROC timeliness monitoring
    c. Quarterly QAPI review

"ICS affirms that it is in full compliance with CMS OASIS submission requirements, HH QRP participation requirements, and applicable reporting standards under 42 CFR §484."

16. Provide outcomes for CMS OASIS submissions, and HHCAHPS measures.

ICS Response:

Integrated Community Services (ICS) is a Medicare-certified home health agency in DC. ICS has been authorized to provide skilled home health services throughout this period, the agency did not meet the CMS minimum episode threshold required for calculation and public reporting of OASIS-based quality measures until the end of calendar year 2025.

During 2024, skilled service volume remained below the CMS minimum reporting threshold, and therefore CMS did not generate publicly reportable outcome measures for that period. Skilled service expansion throughout 2025 resulted in attainment of the required reporting criteria; however, CMS has not yet issued publicly reportable OASIS outcome measures through iQIES or Care Compare due to standard data aggregation, validation, and publication timelines.

Pursuant to COMAR 10.24.16.08K and COMAR 10.24.16.04B, ICS submits all required OASIS assessments in compliance with federal Conditions of Participation (42 CFR §484.55 and §484.65) and CMS reporting requirements.

ICS has:
• Submitted all required OASIS assessments in compliance with CMS timelines via iQIES.
• Maintained timely transmission compliance and internal validation review.
• Implemented structured OASIS accuracy audits and documentation review protocols.
• Incorporated outcome monitoring into its Quality Assessment and Performance Improvement (QAPI) Program consistent with 42 CFR §484.65 and COMAR 10.24.16.08K.

HHCAHPS Participation
ICS will initiate participation in the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey beginning April 2026, consistent with CMS participation requirements following attainment of minimum eligible patient volume.

In accordance with 42 CFR §484.250–§484.295 and COMAR 10.24.16.08K, ICS has implemented the necessary infrastructure to ensure full compliance with HHCAHPS data submission requirements.

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

17. Provide documentation to justify the statement that ICS has a proven track record of serving patients across a broad range of payor types.
    a. Explicitly identify and list all forms of payment accepted by the agency.
    b. Include data demonstrating the proportional distribution of patients by payor type over multiple reporting periods.
    c. Describe the agency's commitment to serving Medicaid beneficiaries, including:
    • The proportion of Medicaid patients served
    • Any applicable policies or targets related to Medicaid services

ICS Response:

Integrated Community Services (ICS) has a proven operational track record serving patients across straight Medicaid (State Plan and EPD Waiver), Medicaid Managed Care Organizations, Dual Special Needs Plans, Medicare Fee-for-Service, Medicare Advantage products, and Private Pay.

In Washington, DC, ICS routinely manages care for beneficiaries enrolled in UnitedHealthcare DSNP, AmeriHealth, Amerigroup, Cigna, Blue Cross, MedStar Family Choice, Kaiser Permanente, and Medicare, in addition to straight Medicaid populations and private pay clients.

This diversified payor mix reflects ICS's operational capacity to manage varied reimbursement structures, authorization requirements, and care coordination expectations.

This multi-payor experience requires and demonstrates:

- centralized eligibility verification
- prior authorization tracking
- payer-specific documentation compliance
- integrated nursing, therapy, home health and personal care aide delivery
- utilization monitoring
- coordination with multiple payer case managers and private pay clients

These systems are already operational within ICS and will be replicated directly in Maryland.

The proposed Maryland program will mirror this established payor mix, with Medicaid, dual-eligible, commercially insured, private pay and Medicare beneficiaries representing the majority of patients served, ensuring access for indigent and low-income populations while maintaining regulatory compliance and quality oversight. Provider participation agreements can be seen in Exhibit 11.

a. Explicitly identify and list all forms of payment accepted by the agency.

ICS Response:
ICS accepts reimbursement from multiple third-party payors and other payment sources. The agency currently accepts the following forms of payment:

- Kaiser Permanente
- Amerigroup
- Amerihealth
- UnitedHealthcare
- MedStar Health
- Blue Cross Blue Shield
- Humana
- Cigna
- Medicaid (fee-for-service and managed care plans)
- Medicare Advantage plans
- Private commercial insurance
- Self-pay
- Sliding Fee Scale (income-based discounts)
- Charity Care (in accordance with COMAR 10.24.16.08)

ICS maintains active participation agreements, where applicable, and bills these payors in accordance with contractual and regulatory requirements.

b. Include data demonstrating the proportional distribution of patients by payor type over multiple reporting periods

ICS Response:
ICS tracks patient utilization by payor category through its billing and patient accounting systems. For reporting clarity, Medicaid includes both fee-for-service (DHCF) and Medicaid Managed Care Organizations (MCOs), including UnitedHealthcare Community Plan, AmeriHealth Caritas, MedStar Family Choice, and Wellpoint.

Payor Category	2023 (# / %)	2024 (# / %)	2025 (# / %)
Medicaid (FFS + All MCOs including UHC)	482 (99.2%)	534 (98.5%)	588 (94.2%)
Medicare (CGS)	0 (0%)	8 (1.5%)	25 (4.0%)
Kaiser	0 (0%)	0 (0%)	8 (1.3%)

Payor Category	2023 (# / %)	2024 (# / %)	2025 (# / %)
Cigna	0 (0%)	0 (0%)	3 (0.5%)
CareFirst	4 (0.8%)	0 (0%)	0 (0%)
Total Patients	486 (100%)	542 (100%)	624 (100%)

Across multiple reporting periods, Medicaid beneficiaries have represented the overwhelming majority of ICS's patient population:

- 2023: 482 of 486 patients (99.2%) were covered under Medicaid fee-for-service or Medicaid managed care plans.
- 2024: 534 of 542 patients (98.5%) were Medicaid beneficiaries.
- 2025: 588 of 624 patients (94.2%) were Medicaid beneficiaries.

The remaining patients during these periods were covered by Medicare, limited commercial insurance participation, or other third-party payers.
These data demonstrate that ICS maintains a historically Medicaid-centered payer mix, with consistent and substantial participation in publicly funded insurance programs. While the organization has incrementally expanded participation in Medicare and selected commercial plans in recent years to support service continuity and financial diversification, Medicaid remains the foundational reimbursement source for the agency's services.
This multi-year distribution reflects operational capacity to manage Medicaid billing, authorization, compliance, and care coordination requirements across both fee-for-service and managed care structures.

c. Describe the agency's commitment to serving Medicaid beneficiaries, including:
• The proportion of Medicaid patients served
• Any applicable policies or targets related to Medicaid services

ICS Response:
Since initiating Personal Care Aide (PCA) services in 2014, Integrated Community Services, Inc. (ICS) has historically served a predominantly Medicaid population. Across recent reporting periods, Medicaid beneficiaries including both fee-for-service and Medicaid Managed Care Organizations represented:

- 99.2% of total patients in 2023
- 98.5% of total patients in 2024
- 94.2% of total patients in 2025

More than 98 percent of the organization's PCA services and overall billing have historically been reimbursed through Medicaid programs. This longstanding payer mix reflects ICS's mission-driven commitment to serving medically underserved and economically vulnerable populations.

Over the past 16 months, ICS has expanded participation in selected third-party insurance networks, including Medicare Advantage and limited commercial plans, to enhance patient access and support continuity of care. However, Medicaid beneficiaries remain the foundational component of the agency's service population, and ICS does not impose caps or restrictions on Medicaid admissions within operational capacity.

For the proposed Maryland skilled home health program, the projected payer mix reflects the reimbursement structure typical of Medicare-certified home health services. As outlined in Table 4 of the application, projected revenue includes Medicare Advantage, Medicaid, Medicaid managed care, and commercial insurance payers. This diversification reflects the reimbursement landscape applicable to skilled services and does not represent a departure from ICS's historical commitment to Medicaid populations. Rather, it ensures financial sustainability while preserving access for low-income, dual-eligible, and medically complex individuals.

Operationally, ICS supports timely access for Medicaid patients through centralized intake coordination, geographically structured staff deployment, 24-hour on-call clinical coverage, and electronic medical record tracking of referral-to-visit intervals. The organization maintains a balanced workforce of salaried and contract staff to ensure consistent coverage and monitors payer mix and service initiation timelines through its quality assurance and performance improvement processes to ensure equitable access across all payer categories.

ICS does not intend to shift away from its history of serving Medicaid populations. The Maryland expansion is structured to extend high-quality skilled home health services across payer categories while maintaining a strong, measurable, and sustained commitment to Medicaid beneficiaries.

Proven Track Record in Providing a Comprehensive Array of Services.

18. Provide documentation to support the statement that ICS's comprehensive array of home health services demonstrates operational capacity and clinical breadth for the proposed Maryland program.

a. Provide evidence of specialized clinical tracks, such as disease management protocols for high-need populations.

b. Include documentation showing integration of social and support services within the home health program.

c. Clarify how these programs and services will be implemented in the Maryland program

ICS Response:

Integrated Community Services (ICS) has developed a comprehensive home health model in Washington, DC that demonstrates operational capacity, clinical breadth, structured clinical programming, and integrated care service coordination. The Maryland program will replicate and scale these established systems, supported by documented policies, disease-specific protocols, and interdisciplinary workflows currently in use.

1. Evidence of Comprehensive Home Health Services & Operational Capacity

ICS currently operates under CMS Conditions of Participation, 42 CFR Part 484 – Home Health Services and maintains all required systems for clinical oversight, quality management, and regulatory compliance. ICS's DC program demonstrates:

- Qualified clinical leadership
- Structured care coordination processes
- A fully implemented QAPI program
- Clinical documentation and/order-management compliance
- Emergency preparedness program planning
- Infection prevention and control program

ICS's operational infrastructure includes:

- Structured Start of Care (SOC) and Resumption of Care (ROC) workflows
- Dedicated QA Nurses overseeing documentation compliance, timeliness, and clinical outcomes
- Centralized order management system
- Electronic Health Record (Axxess EHR) with real-time monitoring and reporting
- Quarterly KPI dashboards aligned with CMS quality metrics
- Monthly chart audits and OASIS accuracy reviews
- High-risk patient tracking and escalation protocols

These systems demonstrate ICS's operational readiness and regulatory compliance and are fully transferable to Maryland.

2. Specialized Clinical Tracks for High-Need Populations

ICS has established disease-specific clinical pathways that support high-risk Medicare and Medicaid beneficiaries. These include:

A. Congestive Heart Failure (CHF) Track

- Daily weight monitoring protocols

- Symptom escalation pathways
- Medication reconciliation oversight
- Red-flag reporting to PCP

B. Diabetes Management Track

- Blood glucose monitoring oversight
- Diet and medication compliance education
- Hypoglycemia/hyperglycemia escalation guidelines

C. Dialysis & Renal Support Track

- Coordination with dialysis centers
- Post-dialysis fatigue monitoring
- Fluid management surveillance

D. Oxygen-Dependent & Respiratory Patients

- Oxygen safety assessment
- DME coordination
- Respiratory distress escalation protocol

E. Fall Prevention & Post-Fall Management Program

Aligned with National Patient Safety Goals:

- Environmental risk assessment
- Fall risk scoring tools
- 24–48 hour nurse reassessment post-fall
- Plan of Care updates when indicated

These clinical tracks support CMS Home Health quality measures such as Potentially Preventable Hospitalizations (PPH) and 30-Day Readmissions (PPR). ICS will implement these same tracks in Maryland beginning at program launch.

3. Integration of Social and Support Services

ICS integrates clinical services with social support coordination through:

A. Beneficiary Care Coordinators (BCC) Model

- Insurance eligibility verification
- Prior authorization tracking

- Coordination with patient/family, managed care organizations and the interdisciplinary team.
- Community-based referrals

B. Discharge Planning & Care Transition Integration

- Communication with SAR/SNF and hospital discharge planners
- Coordination with PCPs and specialists
- Medication access support
- Durable Medical Equipment (DME) coordination
- Specialized Pharmacies (e.g., IV Antibiotics, etc.)

C. Social Determinants of Health (SDOH) Awareness

ICS screens and addresses:

- Caregiver availability
- Medication access barriers
- Housing safety risks
- Transportation limitations
- Financial hardships
- Food insecurity

D. Caregiver Engagement Model

- Family education
- Participation in Care planning
- Safety reinforcement training

This interdisciplinary structure reflects the care coordination standards under CMS Conditions of Participation (42 CFR §484.60) and will be fully implemented in Maryland.

4. Implementation Plan for Maryland Program

ICS will implement the Maryland program through a phased operational rollout:

A. Phase 1 – Infrastructure Replication (Pre-Launch)

- Adoption of existing EHR templates and disease-track protocols
- Expand existing referral relationships and develop new relationships in Maryland
- Establishment of Maryland QAPI oversight committee
- Implementation of ICS Order Management & SOC/ROC workflow

B. Phase 2 – Clinical Track Deployment (First 6 Months)

- SOC/ROC and recertification timeliness dashboard monitoring
- Training ICS Maryland nurses and other clinical team members
- Infection control and disease management protocol
- Risk reduction of hospital readmissions protocol
- Standardized fall-prevention assessment tools
- COPD, CHF, Dialysis and other high-risk discharge coordination pathways

C. Phase 3 – Care Coordination Integration

- Managed care communication pathways
- Dedicated Maryland Care Coordinator model
- Escalation protocol for high-risk patients

D. Phase 4 – Quality Monitoring & Performance Reporting- On going

ICS is committed to delivering high-quality, patient-centered, and value-based home care services. To ensure optimal outcomes, reduce avoidable hospital utilization, and promote safety in the home, ICS will continue its current structured performance monitoring system. This system tracks:

1. Start of Care (SOC) Timeliness.

This timeliness measures the percentage of patients whose initial skilled visit occurs within the ordered timeframe and within 48 hours of referral/ or discharge from an inpatient setting. Weekly performance reports review timeliness with an expected compliance goal of 95%. Delays are reviewed and categorized, and root causes are completed to determine trends exceeding greater than 5%. In the provision of value-based care, timely Starts of Care reduces Emergency Room visits, medication discrepancies, and avoids early rehospitalizations.

2. Resumption of Care (ROC) Timeliness.

Resumptions of care are monitored to ensure completion within the specified 48-hour timeframe. Care coordination with case managers/ hospital social workers track hospitalized patients through to the time of discharge. Weekly performance reports look at ROC compliance with a target compliance rate of 95%. Delayed ROCs are reviewed for any correlation with early readmissions, < than 7 days, falls post discharge or medication related errors.

3. 30-Day Hospital Readmissions.

Hospital readmissions look at those patients who are readmitted within 30 days of discharge from an inpatient facility. Weekly reports from the Incident Manager/ Quality Assurance team will track re-admissions based on disease processes such as CHF; COPD; Diabetes; Falls; Infection and medication compliance. ICS will review the causes of readmission, including gaps in education, lack of in-home support, and social determinants of health. Quality improvements include increased visit frequency for high-risk patients, medication reconciliation within 24 hours of the Start of Care, and Resumption of Care.

4. Fall Incident Rate.

Falls are monitored by the Incident Manager and the Quality team. Reporting falls within the 24–hour specified timeframe, and completion of the incident report is monitored. Patients identified as high risk for falls are assessed using a standardized assessment tool. The fall assessment is done on admission, on an annual basis, and after a change in condition or post fall. Prevention measures look at environmental safety, fall prevention education for the patient and caregiver, increased supervision for the personal care aides, medication review and referral for skilled services – physical/ occupational therapy services.

5. Utilization of Approved Personal Care Hours.

Utilization of approved PCA hours looks at the percentage of hours utilized by the client as opposed to the number of hours approved by the payer. Reasons for underutilization of hours are reviewed by the QA team to determine if it is due to staffing gaps, patient refusal, or scheduling issues. Ensuring full utilization of approved hours supports safety, assistance with ADL care and reduces falls and hospitalizations.

These indicators are reviewed through ICS's QAPI Program and aligned with value-based care expectations under CMS and Managed Care payer requirements (MCOs).

Need Review Criterion

19. Please provide additional detail and specific examples demonstrating your organization's experience serving culturally and linguistically diverse populations, including the types of services delivered, languages supported, and outcomes achieved in medically underserved communities.

ICS Response:

Integrated Community Services (ICS) has extensive experience delivering home health services to culturally, linguistically, and socioeconomically diverse populations in Washington, DC, including medically underserved communities. This experience directly informs the design of ICS's proposed Maryland program.

ICS operates in compliance with the Conditions of Participation established by the Centers for Medicare & Medicaid Services and within DC Medicaid managed care requirements overseen by the District of Columbia Department of Health Care Finance.

1. Populations Served and Community Context

ICS's DC patient population reflects many of the same demographics found in Prince George's and Montgomery Counties, including:

- Black and African American seniors
- Immigrant and refugee households
- Low-income Medicaid beneficiaries
- Patients with limited English proficiency
- High-acuity populations (CHF, diabetes, ESRD, oxygen dependence & mobility impairment)

Many beneficiaries experience overlapping challenges such as:

- limited transportation access
- food insecurity
- housing instability
- low health literacy
- limited caregiver support

ICS has established the operational infrastructure, staffing model, and compliance systems necessary to sustainably deliver services in underserved communities. This intentional approach ensures both access and continuity of care and is reflected in Section 3, Types of Services Delivered in Underserved Communities, which details the agency's service capacity, community reach, and payer accessibility

2. Languages Supported and Communication Access

ICS routinely provides services to patients and families speaking multiple languages, including:

- English
- French
- Spanish
- Arabic

- Amharic/Oromo

Language access is supported through:

- multilingual field staff (nurses, aides, care coordinators)
- use of interpreter services, including LanguageLine Solutions, when needed
- translated care instructions and verbal education
- culturally appropriate patient engagement approaches
- Language relay systems (e.g., Video Remote Interpreting (VRI) & Video Relay Services (VRS))
- Language Access Service, in accordance with Section 1557 of Affordable Care Act (ACA)

For Medicaid Managed Care and Fee-for-Service beneficiaries, ICS follows all applicable District and plan-specific requirements to request and document interpreter services. Requests are initiated promptly through the appropriate managed care organization or contracted language service vendor in accordance with regulatory guidance and DHCF transmittals

Care plans are reviewed verbally with patients and caregivers in their preferred language whenever possible to ensure understanding of medications, safety precautions, and treatment goals.

3. Types of Services Delivered in Underserved Communities

ICS provides comprehensive home health and personal care services, including:

Clinical Services

- Skilled nursing (e.g., wound care, disease process teaching, IV medication/administration)
- Chronic disease monitoring (CHF, diabetes, ESRD, COPD)
- Fall risk assessments and post-fall nursing visits
- Medication management, reconciliation and education
- Oxygen safety monitoring
- Therapy services (e.g., Physical and Occupational Therapy)

Personal Care Services

- Provided by:

  Personal Care Aides (PCAs)

Home Health Aides (HHAs)

- Services provided:

  Activities of Daily Living (ADLs)

  Instrumental Activities of Daily Living (IADLs)

Care Coordination & Social Support

- Care coordination with PCPs, clinical staff, PCAs/HHAs, specialists, dialysis centers, SARs/SNFs, Adult Day Care Centers, hospitals, Case Managers, Social Workers, specialty pharmacies, and community-based services/programs
- Insurance eligibility assistance
- Recertification and Prior authorization tracking
- DME coordination
- Linkage to transportation and community resources
- Caregiver education and engagement

These services are delivered through an interdisciplinary model that integrates nurses, therapists, aides, PCPs, patient/care givers, Beneficiary Care Coordinators, and QA oversight.

These services are delivered through an interdisciplinary model that integrates nurses, therapists, aides, Beneficiary Care Coordinators, and QA oversight.

20. Provide data comparing the state population to the agency's projected volume in each jurisdiction, including projected utilization rates and the relevant population considered in the analysis.

ICS Response:

ICS analyzed projected service volume relative to both total county population and the population aged 65 and older (U.S. Census Bureau, most recent available estimates[1]) to ensure a responsible, data-informed, and incremental market entry strategy.

ICS projects approximately 300 annual admissions per jurisdiction during initial operations. When compared to total county population, projected utilization represents a minimal percentage of residents, reflecting a conservative expansion model designed to supplement the existing home health landscape.

Jurisdiction	Estimated Total Population	Projected Annual Admissions	Utilization Rate (Total Population)
Anne Arundel County	~1,082,273	300	0.028%
Montgomery County	~966,629	300	0.031%
Prince George's County	~602,350	300	0.050%

These projections demonstrate that ICS's anticipated service volume represents a very small fraction of each county's overall population.

Because home health services primarily serve older adults and medically complex individuals, ICS also evaluated projected admissions relative to residents aged 65 and older.

Jurisdiction	Estimated 65+ Population	Projected Annual Admissions	Utilization Rate (65+ Population)
Anne Arundel County	~101,200	300	~0.30%
Montgomery County	~194,800	300	~0.15%
Prince George's County	~153,600	300	~0.20%

Even when measured against the senior population, the demographic most likely to require home health services projected utilization remains modest. This reflects a phased growth strategy aligned with workforce capacity, referral development, and quality oversight.

ICS's growth strategy is intentionally structured to align staffing capacity, referral patterns, and care coordination infrastructure to ensure regulatory compliance, quality monitoring, and continuity of care. ICS will prioritize medically underserved areas within each jurisdiction, focusing on Medicaid beneficiaries, dual-eligible individuals, and high-acuity populations requiring home-based clinical services.

Footnote

[1] U.S. Census Bureau, QuickFacts: Anne Arundel County, Montgomery County, and Prince George's County, Maryland; most recent population and age distribution estimates available at time of analysis.

21. Elaborate on how your experience and expertise uniquely position you to address the specific needs identified in the 2025 Home Health Review, particularly in Montgomery, Prince George's, and Anne Arundel Counties, where Commission staff noted a shortage of quality providers?

ICS Response:

Integrated Community Services (ICS) respectfully submits that its leadership experience, operational infrastructure, and quality-driven clinical oversight uniquely position the agency to address the needs identified in the 2025 Home Health Review, particularly within Montgomery County, Prince George's County, and Anne Arundel County, where Commission staff noted shortages of quality providers.

I. Alignment with 2025 Home Health Review Findings

The 2025 Home Health Review identified variability in quality outcomes, workforce shortages affecting timeliness of care, access barriers in underserved and high-LEP communities, and ongoing preventable utilization patterns. ICS's operational model was intentionally developed to address these issues.

II. Quality Infrastructure

ICS operates under a structured Quality Assurance and Performance Improvement (QAPI) framework consistent with 42 CFR §484.65 and COMAR 10.24.16. The agency utilizes centralized intake with risk stratification, 24-hour post-discharge follow-up for high-risk patients, nurse-led clinical escalation protocols, structured fall response pathways, and monthly KPI benchmarking reviewed by leadership.

III. High-Risk Patient Management

ICS specializes in managing complex patients with CHF, COPD, diabetes, CKD/ESRD, oxygen dependency, recurrent falls, and recent hospitalizations. These structured clinical pathways directly address the need for improved post-acute stabilization and reduced preventable utilization.

IV. Workforce Continuity Model

ICS implements staffing contingency protocols, continuity-of-care assignments for high-risk patients, QA monitoring of missed visits, and supervisory oversight to reduce care disruptions in high-need communities.

V. Linguistic and Cultural Competence

In counties with elevated Limited English Proficiency (LEP), ICS integrates interpreter access, preferred language identification at intake, teach-back protocols, and caregiver engagement strategies to improve comprehension and adherence.

VI. County-Specific Focus

ICS targets HRSA-designated underserved areas in Montgomery (Aspen Hill, Takoma/Langley), Prince George's (District Heights/Capitol Heights), and Anne Arundel (North Anne Arundel, Medicaid Central Annapolis), where chronic disease burden and access limitations have been documented.

Conclusion

ICS's leadership experience, structured QAPI framework, high-risk clinical pathways, workforce safeguards, and data-driven oversight uniquely position the agency to address the quality and access gaps identified in the 2025 Home Health Review and expand capacity in counties where shortages of quality providers have been noted.

Alternatives to the Project Review Criterion

22. Provide sources that support ICS's efforts in the following areas:
    a. Preventing avoidable hospital readmissions.
    b. Supporting timely Start of Care (SOC) and Resumption of Care (ROC).
    c. Ensuring appropriate utilization of authorized hours and services.
    d. Maintaining strong care coordination with clinical and payer partners.
    e. Provide evidence that these issues are relevant in the proposed service counties, including any data, reports, or analyses demonstrating local need.

ICS Response:

A. Preventing avoidable hospital readmissions

Centers for Medicare & Medicaid Services (CMS) formally tracks home health performance using outcome measures including:

- Potentially Preventable 30-Day Post-Discharge Readmissions (PPR)
- Potentially Preventable Hospitalizations During Home Health (PPH)

These measures establish readmission reduction as a core quality expectation for all Medicare-certified home health agencies.

ICS's DC operations already address these measures through:

- post-hospital follow-up protocols
- high-risk patient monitoring (CHF, diabetes, dialysis, oxygen)
- medication reconciliation support
- rapid escalation pathways after falls, ER visits, or clinical decline

These interventions directly align with CMS quality benchmarks and form the foundation of ICS's Maryland care model.

B. Supporting Timely Start of Care (SOC) and Resumption of Care (ROC) for Skilled and Non-Skilled Services

Integrated Community Services (ICS) has established a structured, measurable, and clinically integrated framework to ensure the timely initiation and resumption of home health services for both skilled and non-skilled patients. Timely Start of Care (SOC) and Resumption of Care (ROC) are central to ICS's commitment to improving access, reducing avoidable hospitalizations, and strengthening continuity of care across Montgomery County, Prince George's County, and Anne Arundel County.

The 2025 Maryland Home Health Services Review identified gaps in access and variability in provider quality within these jurisdictions, noting that shortages of high-performing providers have contributed to delays in care initiation and inconsistent follow-up after hospitalization. ICS's service model directly addresses these findings through defined SOC and ROC performance benchmarks, dedicated intake coordination, and structured oversight within its Quality Assurance and Performance Improvement (QAPI) program.

Upon receipt of a referral for skilled services, ICS initiates intake processing immediately. Referrals are clinically reviewed on the same business day to verify physician orders, authorization, and medical necessity. Patients are triaged by acuity, with priority given to high-risk discharges, wound care, medication changes, and individuals with multiple chronic conditions. ICS targets completion of 95 percent of skilled SOC visits within 48 hours of referral or on the physician-ordered start date, whichever is earlier. Same-day SOC is arranged when clinically indicated to prevent deterioration or avoidable readmission.

During the SOC visit, a comprehensive clinical assessment is completed, including medication reconciliation, fall-risk screening, chronic disease management planning, social determinants of health, insurance eligibility verification and/or patient's ability to pay, for approved services. After the SOC assessment has been completed, a Patient-Centered Plan of Care (POC) is developed. The POC is developed collaboratively with the patient, and the interdisciplinary care team to reflect individualized goals and preferences. Any clarifications or modifications are promptly communicated to the ordering provider through addendum orders to avoid care delays after the POC has been developed. Real-time scheduling and electronic visit verification ensure accountability and continuity.

Resumption of Care (ROC) protocols are activated immediately upon notification of hospitalization or service interruption. ICS obtains discharge documentation promptly and conducts an ROC assessment within 48 hours of the patient's return home, unless otherwise ordered by the physician. The ROC assessment includes reassessment of clinical status,

medication reconciliation, evaluation of new diagnoses or risk factors, and revision of the Plan of Care as necessary. Updated physician orders are secured without delay. Non-skilled services resume immediately upon confirmation of RN assessment following discharge to prevent functional decline.

ICS's operational infrastructure supports these timelines through centralized intake coordination, on-call clinical coverage for urgent cases, and electronic medical record tracking of referral-to-visit intervals. These systems are specifically designed to ensure that service expansion into Maryland maintains responsiveness and operational feasibility.

Importantly, ICS's commitment to timeliness is reinforced by its strong regulatory compliance history and survey performance. The agency has demonstrated consistent compliance with oversight requirements from state and federal regulatory bodies, including successful survey outcomes in which deficiencies were minimal and, in many instances, did not require formal Plans of Correction. ICS's quality management systems, documentation standards, and internal audit processes reflect a culture of compliance and accountability. This established track record distinguishes ICS as a high-performing provider prepared to meet the quality expectations outlined in the 2025 Maryland Home Health Services Review.

Timeliness metrics are continuously monitored through ICS's QAPI program. Monthly dashboards track SOC completion rates, ROC timeliness, referral processing intervals, and causes of delay. Variances from the established 95 percent benchmark trigger structured review and corrective action. These reports are reviewed at the leadership level to ensure continuous quality improvement.

Intake screening incorporates assessment of social determinants of health and language needs; interpreter services are coordinated at scheduling, and high-risk patients are flagged for priority scheduling. By embedding equity-focused triage within its SOC and ROC model, ICS directly addresses disparities in access and outcomes.

Through defined performance benchmarks, structured oversight, demonstrated regulatory compliance, and a proven culture of quality, ICS is operationally prepared to provide timely, uninterrupted skilled and non-skilled home health services in Montgomery, Prince George's, and Anne Arundel Counties. The agency's SOC and ROC framework directly responds to the Commission's findings regarding provider shortages and variability in quality and aligns with the access, quality, and feasibility standards set forth under COMAR 10.24.01.08G(3)(g).

C. Ensuring appropriate utilization of authorized hours and services

For skilled services, CMS requires Home Health Agencies to operate under the Patient Driven Groupings Model (PDGM), which is a 30-day period of care based on patient clinical characteristics rather than therapy volume requiring agencies to deliver medically necessary, ordered, and coordinated services while avoiding over- or under-utilization.

ICS's utilization controls include:

- Plan of Care (POC) driven visit scheduling
- Monitoring authorized vs delivered hours
- QA review of documentation supporting medical necessity
- Corrective action when service patterns deviate from clinical need

This framework supports fiscal stewardship while ensuring beneficiaries receive appropriate care.

D. Maintaining strong care coordination with clinical and payer partners

Integrated Community Services (ICS) maintains a robust, structured, and regulation-aligned care coordination framework designed to ensure seamless transitions of care, interdisciplinary collaboration, and payer integration across the continuum of home-based services.

The Federal Conditions of Participation for Home Health Agencies require active coordination of care among physicians and allowed practitioners, hospitals and discharge planners, managed care organizations, and interdisciplinary clinical teams. ICS operationalizes these requirements through a proactive, system-based approach that integrates clinical oversight, communication protocols, and electronic workflow management.

At the core of ICS's coordination model is a structured physician engagement. All Plans of Care (POCs), addendum orders, and clinical updates are communicated to the Primary Care Provider (PCP) or authorized practitioner in a timely manner. Notifications, for example: include changes in condition, post-hospitalization assessments, medication reconciliation findings, fall incidents, and service adjustments. Orders are tracked electronically to ensure signature compliance and regulatory timeliness, reducing care gaps, and maintaining clinical accountability.

ICS also conducts daily interdisciplinary case reviews involving nursing staff, Beneficiary Care Coordinators (BCC), therapists (when applicable), and administrative leadership. These structured reviews allow the team to assess patient progress, address barriers to care, discuss and address patient and/or case manager complaints/concerns, evaluate risk factors for hospitalization, and update individualized care plans. High-risk patients, including those with multiple chronic conditions or recent hospitalizations, receive enhanced monitoring and priority review.

Care coordination extends to payer collaboration, hospitals, SAR/SNF, providers, case managers, and clinical staff. ICS maintains active communication with Managed Care Organizations (MCOs), Dual-Special Needs Plans (DSNPs), Medicaid Fee-for-Service programs, and other

insurance partners. Authorization status, service adjustments, utilization management, and discharge planning are coordinated to ensure services align with payer requirements while prioritizing patient safety and continuity of care.

Hospital discharge coordination is another critical component of ICS's model. The agency works directly with hospital discharge planners and case managers to ensure safe transitions from acute care to home. Care conferences are convened for complex cases to align hospital recommendations, physician directives, caregiver input, and payer requirements.

After discharge, ICS initiates rapid reassessment visits, reconciles medications, evaluates environmental safety risks, and updates the Plan of Care as needed.

Technology supports every level of coordination. ICS utilizes Chesapeake Regional Information System for our Patients (CRISP), a Health Information Exchange for hospitalization and ER visit tracking and an integrated Electronic Medical Record system (Axxess) for real-time documentation, order tracking, scheduling, referral management, and interdisciplinary communication. The EMR allows for centralized visibility of patient status, pending physician orders, hospitalization alerts, and compliance timelines. This structured digital oversight enhances operational efficiency and regulatory compliance.

Collectively, these processes mirror CMS regulatory expectations and demonstrate ICS's ability to operationalize care coordination in a measurable, sustainable manner. The agency has successfully implemented these systems in its District of Columbia operations, achieving strong compliance outcomes and positioning ICS to deliver the same high standard of coordinated, patient-centered care within Maryland.

e. Provide evidence that these issues are relevant in the proposed service counties, including any data, reports, or analyses demonstrating local need.

Demonstrated Statistical Need – Montgomery, Prince George's, and Anne Arundel Counties

This section provides quantitative statistical evidence demonstrating local need for home health services in Montgomery County, Prince George's County, and Anne Arundel County, Maryland. The data below supports ICS's multi-payer initial Certificate of Need (CON) request.

Statewide Context

Maryland's All-Payer Model and the Maryland Health Services Cost Review Commission (HSCRC) Readmissions Reduction Incentive Program (RRIP) hold hospitals financially accountable for avoidable readmissions. This statewide framework increases reliance on effective post-acute providers, including home health agencies, to reduce preventable hospital returns.

Preventable Hospital Stays (Per 100,000 Medicare Enrollees)

Maryland State Average: Approximately 2,655 preventable hospital stays per 100,000 Medicare enrollees.[1]

Prince George's County: Approximately 2,997 preventable hospital stays per 100,000 Medicare enrollees, exceeding the Maryland benchmark and demonstrating elevated need for care coordination and post-discharge management services.[1]

Anne Arundel County: Approximately 2,520 preventable hospital stays per 100,000 Medicare enrollees, reflecting ongoing opportunity for strengthened outpatient and home-based care support.[2]

Montgomery County: County Health Rankings data indicates fewer preventable hospital stays relative to many Maryland jurisdictions; however, persistent chronic disease burden and health disparities continue to require strong transitional and home-based care services.[1]

Medicare Population & Utilization Context

Maryland has approximately 1.1 million Medicare beneficiaries statewide, representing nearly 17% of the total population.[3] The proposed service counties contain substantial Medicare populations and demonstrate sustained utilization of post-acute and home health services according to CMS Geographic Variation data.[4]

Conclusion

The statistical indicators above demonstrate measurable local need in the proposed service counties. Elevated preventable hospital stay rates, substantial Medicare enrollment, and Maryland's readmission accountability framework collectively support the necessity of additional high-quality home health capacity. ICS's proposed services are aligned with these quantified regional health system needs.

Footnotes

1. County Health Rankings & Roadmaps, Maryland Preventable Hospital Stays data (2022-2024 reports).
2. Anne Arundel County Community Health Needs Assessment (Luminis Health), 2024-2025 report.
3. Maryland Medicare enrollment data, 2024 estimates.
4. Centers for Medicare & Medicaid Services (CMS), Medicare Geographic Variation Public Use File.

23. Provide the source(s) and supporting documentation used to determine the need for Personal Care Aide services at an average rate of 14–16 hours per day, seven (7) days per week. Include any assessments, evaluations, records, or other evidence relied upon in reaching this determination.

ICS Response:

The average service level of 14 to 16 hours per day, seven (7) days per week referenced in the narrative reflects Integrated Community Services, Inc.'s (ICS) current utilization patterns within its Personal Care Aide (PCA) program in the District of Columbia. Based on ICS's active census of more than 400 PCA patients, the average number of authorized and utilized PCA service hours is approximately 14 hours per day, seven days per week.

These service levels are not internally determined by ICS but are established through the District of Columbia Medicaid medical necessity and authorization process. Annually, within sixty (60) days prior to each patient's level-of-care renewal date, ICS clinical staff collaborate with each PCA patient, the patient's guardian (if applicable), and/or the assigned case manager to obtain a physician order requesting renewal of PCA services. The completed District of Columbia physician order form is submitted to Telligen. Telligen serves as an Independent Assessment Vendor under contract with the DC Department of Health Care Finance (DHCF) to support Medicaid long-term care services (LTSS) and needs-based eligibility determinations.

Telligen then schedules and conducts an in-person annual recertification assessment for each patient. Based on that independent clinical evaluation and medical necessity determination, Telligen authorizes PCA service hours ranging from 1 to 24 hours per day, depending on the individual's medical condition, functional limitations, and documented care needs.

Accordingly, the referenced 14-hour average represents the aggregate outcome of independent Medicaid medical necessity determinations across ICS's current PCA census. These authorizations are supported by physician orders, utilization review determinations, and care plans maintained in ICS's electronic medical record system and DC Care Connect. DC Care Connect is the District of Columbia Department of Health Care Finance's (DHCF) centralized electronic case management and data system used to coordinate, document, and manage Medicaid long-term services and supports (LTSS). The system serves as the primary platform through which eligibility determinations, level-of-care assessments, service authorizations, and care coordination activities are recorded and monitored.

The reference to PCA service intensity was included solely to demonstrate ICS's experience managing high-intensity, community-based services for medically complex and high-support individuals. It was not intended to represent a projected average utilization rate for the proposed Maryland skilled home health program.

The Maryland projections are based exclusively on the unduplicated patient counts and anticipated skilled visit utilization reflected in Table 2B of the application. The financial projections contained in Table 4 do not incorporate or rely upon the historical PCA service averages associated with ICS's DC operations.

Accordingly, the Maryland utilization model reflects a conservative, phased ramp-up structure independent of the PCA service intensity levels currently observed in the District of Columbia.

The PCA utilization reference was provided to illustrate operational capacity and experience—not to establish projected service demand in Maryland.

24. The staffing structure described in the response to Section B.2. is inconsistent with Exhibit 6 on page 118. Please provide justification for, or revise, the identified discrepancies.

ICS Response:

Our staffing chart on page 24 reflects projected full-time equivalents (FTEs) required for the proposed Maryland expansion only. The originally submitted Exhibit 6 (page 118) inadvertently included enterprise-wide staffing levels associated with ICS's existing District of Columbia operations rather than staffing additions specific to the proposed Maryland project.

To rectify this discrepancy, exhibit 6 has been revised to reflect only the staffing changes required for the Maryland expansion, calculated on a 2,080 paid-hour FTE basis. The revised Exhibit 6 now aligns directly with the FTE projections presented on page 24 of CON application and with the corresponding salary and expense projections reflected in Table 4.

ICS confirms that the revised exhibit accurately represents project-specific staffing additions and does not include enterprise-wide personnel unrelated to the proposed Maryland service area expansion.

Explanation of Revision:

The staffing chart on page 24 reflects projected FTEs required for the Maryland project only. The previously submitted Exhibit 6 included enterprise-wide staffing levels for ICS's existing operations, which created inconsistency. Exhibit 6 has been revised to reflect only the staffing additions required for the proposed Maryland expansion and now aligns directly with page 24 of CON application.

Project Financial Feasibility and Facility or Program Viability Review Criterion

25. Please provide the full details of the methodologies and assumptions used to develop the projections, including historic data from comparable home health agencies operating within the jurisdictions referenced in the application. The Link to the MHCC public use data is https://mhcc.maryland.gov/public_use_files/homehealthdownload.html

ICS Response:

ICS developed the utilization, revenue, and expense projections for the proposed Maryland Home Health Agency using a structured, bottom-up methodology based on projected service

volume, reimbursement rates, staffing requirements, and historic benchmarking data from comparable Maryland home health agencies.

I. Utilization Methodology

A. 2026 Partial-Year Ramp-Up

- 2026 projections reflect a six-month operational period.
- Visit volume assumptions were developed based on anticipated referral development and ramp-up capacity.
- Only incremental project activity is shown in the projections.

B. Base-Year Visit Assumptions (Full-Year Equivalent)

Projected annual service volumes at stabilization were developed by discipline:

Discipline	Visits/Hours
RN Skilled Nursing	5,600 visits
Physical Therapy	5,600 visits
Occupational Therapy	3,360 visits
Home Health Aide	11,200 hours

These volumes were derived from:

- Expected referral patterns in the proposed service area
- Comparable Maryland HHA utilization patterns (MHCC Home Health Agency Annual Survey data)
- Staffing productivity assumptions by discipline

II. Revenue Methodology

A. Reimbursement Rate Assumptions

Revenue was calculated using discipline-specific reimbursement rates:

Discipline	Rate	Volume	Base-Year Revenue
RN	$165.39 per visit	5,600	$926,184

Discipline	Rate	Volume	Base-Year Revenue
PT	$178.85 per visit	5,600	$1,001,560
OT	$180.05 per visit	3,360	$604,968
HHA	$80.24 per hour	11,200	$898,688
Total Gross Revenue (Full-Year Equivalent)			$3,431,400

These rates reflect projected payer reimbursement levels based on expected payer mix and market benchmarks.

B. Revenue Growth Assumptions

- 2028 and 2029 revenue growth: 7% annually from prior year
- Growth reflects gradual census stabilization and volume increases.
- 2027 reflects addition of FTEs added in 2026.
- 2029 reflects cumulative FTE additions from 2026–2028.

C. Revenue Reductions

Revenue reductions were applied as a percentage of gross patient service revenue:

- Bad Debt: 6%
- Charity Care: 7%
- Total Reduction: 13% of Gross Patient Service Revenue

These percentages were applied consistently across projection years.

III. Expense Methodology

A. Staffing and FTE Assumptions

- Current FTEs are limited to the HHA portion of the business.
- FTE increases occur in Years 1 and 3 only.
- 2027 staffing includes additions made in 2026.

- 2029 staffing reflects cumulative additions through 2028.
- No G&A allocation from other lines of business is included.

B. Provider Pay Assumptions

Discipline	Pay Rate	Volume	Total Cost
RN	$100 per visit	5,600	$560,000
PT	$105 per visit	5,600	$588,000
OT	$105 per visit	3,360	$352,800
HHA	$21.11 per hour	11,200	$236,432
Total Direct Clinical Compensation			$1,737,232

These rates reflect market-competitive compensation levels in the Maryland service area.

C. Contractual Services

Contractual services include:

- Contract Nurses
- Contract Physical Therapists
- Contract Occupational Therapists

These costs reflect supplemental staffing during ramp-up and coverage variability.

D. Depreciation

- 10% of current overall depreciation allocated to the HHA project.
- Allocation reflects shared administrative infrastructure.

E. Expense Scope

- Only incremental revenues and incremental expenses attributable to the proposed HHA are reflected.
- Existing corporate overhead is not allocated to the project.

IV. Use of Comparable Maryland Agency Data

ICS reviewed historic utilization and financial data from comparable home health agencies operating within the jurisdictions identified in the application using MHCC Home Health Public Use Files.

These data were used to:

- Validate visit intensity assumptions
- Confirm reasonableness of payer reimbursement assumptions
- Benchmark expense structure and operating margins
- Assess growth trajectories for similarly sized agencies

26. ICS states that it "will operate the proposed Maryland Home Health Agency from an existing administrative office location." Please provide an itemized list of all startup and infrastructure costs associated with the proposed home health agency office in Beltsville, including but not limited to: • Office furniture and fixtures • IT systems (EHR, billing, scheduling, cybersecurity, hardware) • Telecommunications • Clinical equipment and supplies • Vehicles or mileage infrastructure • Leasehold improvements or build-out • Licensing, accreditation, and certification costs • Recruitment and training expenses Indicate whether each cost is treated as capital or operating and provide the estimated amounts.

ICS Response:

ICS will operate the proposed Maryland Home Health Agency from its existing administrative office location in Beltsville, Maryland. The following itemized startup costs reflect the infrastructure required to operationalize the agency. Each expense is classified as either capital or operating in accordance with standard accounting treatment.

Category	Capital Costs	Operating Costs
Office Furniture and Fixtures	$80,685.00	—
IT Systems (EHR, billing, scheduling, cybersecurity, hardware)	$69,402.00	—
Telecommunications	—	$77,603.36
Clinical Equipment and Supplies	—	$11,105.90
Vehicles / Mileage Infrastructure	$114,000.00	$115,664.78

Category	Capital Costs	Operating Costs
Leasehold Improvements / Build-Out	—	—
Licensing, Accreditation, and Certification	—	—
Recruitment and Training Expenses	—	$35,000.00
Total	$264,087.00	$239,374.04

Cost Classification Explanation

Capital Costs ($264,087.00)
Capital expenditures include durable assets with a useful life exceeding one year. These include:

- Office furniture and fixtures
- IT hardware and infrastructure systems
- Vehicles used to support field-based clinical operations

These assets will be capitalized and depreciated in accordance with standard accounting practices.

Operating Costs ($239,374.04)
Operating startup costs reflect non-capital expenditures required to initiate services, including:

- Telecommunications setup and service costs
- Initial clinical equipment and disposable supplies
- Mileage reimbursement infrastructure and operational vehicle expenses
- Recruitment, onboarding, and initial staff training

These costs will be expensed in the period incurred.

Leasehold Improvements

Because ICS will operate from an existing administrative office location, no leasehold improvements or structural build-out costs are anticipated.

Licensing and Accreditation

Licensing and accreditation costs are not reflected as startup capital expenditures and will be addressed within standard operating expenses upon application and certification.

Project Impact Review Criterion

27. Please explain how the projected number of skilled nursing admissions was determined and how it aligns with estimated patient demand in the service area.

ICS Response:

ICS evaluated projected admissions relative to documented demographic demand indicators within each jurisdiction. The agency projects 300 annual skilled admissions per county, which represents a modest level of service penetration relative to overall population and senior population size.

When compared to total population:

- Anne Arundel County: 0.028% of total population
- Montgomery County: 0.031% of total population
- Prince George's County: 0.050% of total population

Because home health services primarily serve older adults, ICS also evaluated projected admissions relative to residents aged 65 and older:

- Anne Arundel County: approximately 0.30% of the 65+ population
- Montgomery County: approximately 0.15% of the 65+ population
- Prince George's County: approximately 0.20% of the 65+ population

Even when measured against the senior population the demographic most likely to require skilled home health services projected admissions represent a small fraction of potential demand. These figures demonstrate that ICS's projections reflect a conservative market entry strategy rather than aggressive market capture.

The projected admission levels are designed to supplement existing home health capacity, expand patient choice, and improve access for medically complex and Medicaid-eligible individuals, while maintaining alignment with staffing availability and operational readiness.

28. What experience does ICS have in serving patients with high acuity? Provide proportion of high acuity patients relative to general patient population.

ICS Response:

ICS is experienced with providing care for patients with high acuity levels. These patients typically present with complex medical conditions, multiple comorbidities, polypharmacy, recent

hospitalizations, advanced disease processes, or significant functional limitations that place them at increased risk for emergency department utilization or rehospitalization.

High acuity patients are identified from the time of intake, with a review of hospital discharge summaries, Physician orders and diagnosis, clinical assessment prior to referral, medication profile, prior hospitalization usage, functional and cognitive assessment. All patients are classified as high, moderate, or low risk based on their acuity level.

Timely Start of Care (SOC) is prioritized within 24-48 hours of referral or hospital discharge to reduce gaps in care. The admitting RN or therapist completes the comprehensive assessment addressing the medical, psychosocial, environmental, and availability of a caregiver. This timely transition is critical to ensuring clinical stabilization of the patient and reducing the risk of rehospitalization.

For unskilled admissions, a follow-up visit, 72 hours after admission is completed by the RN to perform a detailed head to toe assessment, complete a medication reconciliation, evaluate functional status, respiratory and cardiac function, infection risk and integumentary status. A Plan of Care (POC) review is completed with the caregiver and home safety evaluated. For skilled admissions, the follow-up visits consist of a complete review of systems assessment.

Visit frequency and skilled oversight is determined based on the skilled interventions needed, such as wound care, IV therapy, diabetic management, cardiac monitoring, and respiratory care.

ICS utilizes an interdisciplinary Care Coordination approach which involves Registered Nurses, Therapists – PT, OT, Home Health Aides (HHA), Personal Care Aides (PCAs), Care Coordinators, Physicians, Case Managers (external) Social Workers and insurance payers. Care coordination meetings are conducted to review progress, identify areas for intervention, physician notification for changes in condition, medication adjustment, and involvement of external case management, as appropriate.

Hospitalization prevention strategies are utilized to prevent avoidable hospitalization and Emergency Room visits. Early identification of red-flag symptoms (CHF weight gain, COPD exacerbation signs, hyper/hypoglycemia, infection indicators). Patients and caregiver are provided with education on disease management, signs and symptoms to look for and when to contact the Registered Nurse. Ongoing home safety and fall prevention measures are discussed.

The Quality Team tracks the timeliness of Start of Care (SOC), fall incident rates, rehospitalization and emergency room utilization rates, medication issues and patient satisfaction scores. These data are reviewed through our QAPI program and identify trends, supports our value-based care performance metrics, and implements performance improvement projects.

All clinical data are documented in the patient's EMR to ensure regulatory compliance, clinical continuity, and communication with providers. Clinical documentation supports medical necessity and reflects progress towards patient-centered goals.

Patient-centered and culturally competent care looks at cultural preferences, health literacy, socioeconomic barriers and caregiver availability and ability to assist with patient care. Community resources are utilized to assist patients when needed to address food insecurity, transportation challenges, or other social determinants that can impact health outcomes.

Through structured risk stratification, clinical oversight, interdisciplinary coordination, and proactive hospitalization prevention strategies, ICS safely manages patients with high acuity levels in the home care setting. This approach improves outcomes, attempts to reduce avoidable hospital utilization, and supports value-based care objectives while maintaining the highest standards of patient safety and quality.

29. Provide evidence that existing providers cannot adequately serve patients with higher acuity needs.

ICS Response:

Evidence of High-Acuity Demand and Capacity Constraints

Integrated Community Services (ICS) submits the following evidence demonstrating that existing providers face constraints in adequately serving patients with higher acuity needs in Montgomery County, Prince George's County, and Anne Arundel County. This evidence supports the need for enhanced skilled home health capacity consistent with COMAR 10.24.16 regulatory criteria.

1. Demographic and Health System Pressures

Montgomery County, Prince George's County, and Anne Arundel County collectively represent some of the largest and fastest-growing jurisdictions in Maryland. Each county has a substantial population of Medicare beneficiaries, older adults, and individuals living with chronic and complex medical conditions. The continued aging of the population, combined with increasing prevalence of conditions such as diabetes, cardiovascular disease, renal disease, cancer, and neurological disorders, has resulted in a higher concentration of patients requiring skilled home health services with greater clinical complexity.

2. Hospital Discharge Patterns and Acuity Levels

Hospitals serving these counties continue to experience high discharge volumes for patients requiring post-acute care. Increased emphasis on reduced hospital length of stay and value-based purchasing programs has shifted more medically complex patients into the home setting earlier in their recovery.

These patients frequently require:

• Complex wound care (including negative pressure therapy)
• IV therapy and infusion services
• Post-surgical monitoring
• Nephrostomy and catheter management
• Tracheostomy and respiratory support
• Comprehensive medication management
• Skilled nursing oversight of unstable chronic conditions

3. Persistent High Acute Care Utilization and Readmission Patterns

Hospital care remains a significant resource for medically complex patients in these counties, reflecting ongoing post-acute care demand that skilled home health services are intended to address.

Maryland hospitals recorded significant numbers of monitorable acute care hospital discharges in 2025, reflecting high utilization for patients who frequently require skilled follow-up care, particularly those with complex medical needs. For example:

Montgomery County reported 1,372 total monitorable hospital discharges in FY2025 (62.8% monitorable as defined by MHCC acute care discharge data).[1]

Prince George's County hospitals collectively had a high volume of monitorable discharges, with individual hospitals showing a substantial share of discharges requiring close follow-up.[1]

Anne Arundel County hospitals similarly showed high monitorable discharge counts, including large general hospitals where nearly all discharges were clinically complex.[1]

Monitorable discharges reflect patients whose conditions often require ongoing skilled nursing, therapy, or other post-acute services after discharge.

4. Hospital Readmission and Preventable Utilization Patterns

Preventable hospital utilization and readmissions correlate strongly with unmet post-acute care needs, particularly for patients with multiple comorbidities or high-acuity conditions.

Historical Maryland data show that Medicare 30-day hospital readmission rates remain an important quality and utilization metric, with statewide Medicare readmission rates around 15% in recent years, indicating ongoing challenges in care transitions and post-acute management.[2]

High readmission rates often result from insufficient follow-up care, particularly for high-acuity patients who require intensive skilled interventions that many existing agencies struggle to provide consistently due to workforce and capacity constraints.

5. Clinical Complexity and Chronic Condition Burden

Older adults and patients with chronic diseases have higher hospitalization and emergency department utilization rates, further demonstrating demand for skilled home health services.

Published public health assessments document preventable hospital stays among Medicare beneficiaries in Montgomery County, reflecting conditions such as congestive heart failure and diabetes that are associated with frequent hospital utilization and high post-acute care requirements.[2]

Patients with complex chronic disease profiles are overrepresented in high readmission and extended hospital stay cohorts, underscoring the need for more robust skilled home care capacity.

6. Workforce Strain Impacts Existing Agency Capacity

Maryland's nursing workforce reports and vacancy data identify ongoing deficits in Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and aides critical to delivering complex skilled home care.[3]

Elevated vacancy rates constrain functional capacity, particularly for staff-intensive, high-acuity services that require experienced nursing oversight and coordination.

These workforce constraints are a structural barrier limiting the ability of many existing agencies to consistently serve patients with complicated care needs.

Not all currently licensed providers have the infrastructure or staffing mix to safely manage complex cases.

7. Demonstrated Service Gap

ICS has observed through stakeholder engagement that:

• Hospitals and discharge planners report difficulty placing complex patients.
• Some existing agencies limit admissions based on clinical intensity.
• Families experience delays securing skilled services for medically fragile individuals.
• Higher-acuity cases frequently require multiple agency outreach attempts before placement.

8. Conclusion

Based on demographic growth, hospital discharge trends, chronic disease prevalence, and documented workforce constraints, ICS submits that existing providers are not adequately positioned to fully meet the growing demand for high-acuity home health services in Montgomery, Prince George's, and Anne Arundel Counties.

The combination of significant hospital discharge volumes from monitorable acute care stays, persistent readmission rates that signal unmet post-acute care needs, documented chronic disease burden, and ongoing home health workforce limitations indicates that existing providers face challenges in adequately serving higher-acuity patients in the community.

ICS proposes to address these gaps through enhanced skilled nursing capacity, specialized clinical resources, and increased availability of post-acute home health services targeted to higher-acuity populations, consistent with COMAR 10.24.16 need criteria.

ICS proposes to enhance capacity by:

• Accepting complex, high-acuity referrals
• Maintaining skilled RN-led care coordination
• Implementing rigorous QAPI monitoring
• Maintaining infection control oversight

• Supporting hospital discharge efficiency

Accordingly, ICS respectfully asserts that approval of this CON application is necessary to ensure access, quality, and continuity of care for higher-acuity patients within the proposed service areas.

References

1. Maryland Health Services Cost Review Commission (HSCRC), Acute Care Discharge Data, FY2025 – Monitorable Discharge Volumes.

2. Montgomery County Community Health Needs Assessment – Preventable Hospital Utilization and Readmission Indicators.

3. Maryland Nursing Workforce Center – Nursing Workforce Reports and Vacancy Data.

30. Please clarify what is meant by 'skilled nursing admissions' in the projected volumes. If patients are admitted to nursing facilities, they would not typically require home health services. Are these projections intended to reflect skilled nursing visits or nursing home discharges to home health, and how does this definition support the statement regarding limited impact on overall home health utilization and market share?

ICS Response:

Clarification of "Skilled Nursing Admissions" Terminology

Integrated Community Services (ICS) respectfully submits the following clarification regarding the term "skilled nursing admissions" as used in the projected volume tables within the CON application. This clarification is provided in accordance with 42 CFR §409 (Coverage of Home Health Services), 42 CFR §484 (Home Health Conditions of Participation), and COMAR 10.24.16 (State Health Plan for Home Health Services).

The term "skilled nursing admissions" was not intended to reference admissions to Skilled Nursing Facilities (SNFs) or institutional nursing home settings. Rather, the term was used to describe the initiation of a Medicare-certified home health episode of care involving the provision of skilled services in the patient's place of residence under a physician's order, consistent with 42 CFR §409 and §484.

For clarity:

• "Skilled nursing admissions" refers to patients admitted to ICS as a licensed Home Health Agency for skilled home health services.

• These services are delivered in the home and may include skilled nursing, physical therapy, occupational therapy, speech therapy, and medical social work, consistent with 42 CFR §484 (CMS Conditions of Participation).

• The term was intended to distinguish skilled home health episodes from non-skilled personal care services.

ICS acknowledges that the phrase "skilled nursing admissions" may be interpreted as referring to Skilled Nursing Facility placement. That was not the intent.

The projections provided in the CON application reflect:

• Home health episodes of care initiated under a physician's order;
• Skilled services delivered in a community/home setting;
• Medicare-certified home health utilization;
• Not institutional admissions.

Accordingly, the projected volumes represent anticipated home health admissions (episodes), not nursing facility placements.

Market Impact Clarification

Because the projections refer solely to home health episodes:

• They do not represent shifts from institutional long-term care;
• They do not reflect diversion from nursing homes;
• They represent incremental skilled home health capacity within the existing home health market.

ICS's projected volumes remain modest relative to total Medicare beneficiaries, overall annual home health utilization in Montgomery County, Prince George's County, and Anne Arundel County, and the total licensed provider capacity within those jurisdictions.

Therefore, the clarified definition supports the statement that ICS's projected volumes will have limited impact on overall home health utilization and market share. The projections reflect a small percentage of total county home health volume and are consistent with gradual market entry for a provider expanding skilled home health services.

ICS appreciates the opportunity to clarify this terminology and confirms that all projected volumes are based on home health episodes involving skilled services delivered in the patient's residence.

Market Share and Utilization Impact Analysis (COMAR 10.24.16)

COMAR 10.24.16 requires evaluation of utilization trends and the impact of proposed services on existing providers. ICS's projected home health admissions represent a modest percentage of overall county home health utilization.

County	Estimated Annual Home Health Episodes*	ICS Projected Admissions (Year 2)	Projected Market Share %
Montgomery County	18,000	150	0.83%
Prince George's County	16,000	140	0.88%
Anne Arundel County	11,000	120	1.09%

*Estimated total episodes reflect aggregate Medicare home health utilization levels based on recent public CMS and MHCC utilization summaries.

As illustrated above, ICS's projected volumes represent less than approximately 1% of total estimated home health utilization within each county. This level of market entry is incremental and is not expected to materially affect existing provider viability or overall market share distribution.

Rather, ICS's proposed capacity expansion is intended to supplement existing services, particularly for higher-acuity patients who require enhanced skilled interventions and timely Start-of-Care visits. This incremental impact is consistent with COMAR 10.24.16 criteria evaluating need, access, and system-wide utilization.

ICS respectfully affirms that its projections reflect home health episodes delivered in the community setting pursuant to 42 CFR §409 and §484, and that the limited projected market share supports the conclusion that approval will enhance access without disrupting existing provider operations.

31. Please provide data or other measurable indicators (e.g., staffing vacancy rates, referral rejection rates, or hiring challenges) demonstrating that workforce constraints limit existing home health agencies' ability to accept all referrals.

ICS Response:

Across the region, existing home health agencies are experiencing significant workforce constraints that directly limit their ability to accept all referrals. ICS has observed these challenges firsthand through referral patterns, communication with hospital discharge planners,

and operational experience in Washington, DC. These constraints are consistent with statewide and national shortages in nursing, therapy, and home-based care staff.

Staffing Vacancy Rates

Home health agencies continue to report persistent vacancies in key clinical roles, including Skilled Nursing (RN), Physical Therapy (PT), Occupational Therapy (OT), and Home Health Aides (HHA). Referral partners frequently report that agencies decline patients due to lack of available RNs for Start of Care (SOC), insufficient PT/OT staffing for post-acute rehabilitation needs, inability to staff high-acuity or high-frequency cases, and limited weekend or after-hours coverage. These shortages result in delayed discharges, extended hospital stays, and increased caregiver burden.

Referral Rejection Rates

ICS tracks referral outcomes as part of its quality and operational monitoring. Based on referral data from the past 12 months, approximately 22–28% of referrals received by ICS were previously rejected by another home health agency due to staffing limitations. Hospital discharge planners frequently report that 2–3 agencies decline a patient before ICS is contacted, particularly for high-acuity patients, those requiring same-day or next-day SOC, patients living in underserved neighborhoods, and patients needing PT/OT within 24–48 hours post-discharge.

Hiring Challenges

ICS's experience mirrors broader workforce shortages affecting the home health sector. Recruitment timelines for RNs and PTs often require 6–12 weeks to fill a single position. Competition with hospitals and outpatient facilities—who offer higher wages and sign-on bonuses—further reduces the available home health workforce. Many clinicians prefer remote or hybrid roles, reducing the pool willing to perform in-home visits. Seasonal fluctuations also exacerbate shortages and increase referral denials.

Impact on Patient Access and Equity

Workforce shortages disproportionately affect Medicare Advantage beneficiaries, patients in underserved ZIP codes, and high-need populations with chronic disease or limited caregiver support. ICS frequently receives referrals for patients who were declined elsewhere due to staffing constraints, demonstrating a clear gap in regional capacity.

Health Equity

32. Please provide data demonstrating how ICS patient demographics compares to the Washington, DC service area population in terms of cultural diversity, medical underserved status, and linguistic diversity.

ICS Response:

ICS provides community-based services exclusively to residents of Washington, D.C., with 100% of patients residing within the District of Columbia service area. The organization serves a predominantly minority population, with approximately 94% of patients identifying as African American/Black, reflecting the demographic composition of medically vulnerable communities within the region.

Category	Number of Patients	Percentage
African American / Black	387	94.3%
White	2	0.5%
Hispanic / Latino	17	4.1%
Amharic-speaking / Other Cultural Group	4	1.0%
Other / Unknown	1	0.2%
Total	411	100%

The geographic distribution of patients demonstrates meaningful service penetration in historically underserved neighborhoods, including Ward 7 and Ward 8, which are widely recognized as areas experiencing higher levels of socioeconomic disadvantage, chronic disease burden, and barriers to healthcare access. By delivering services within these communities, ICS supports state and regional objectives to reduce healthcare disparities and promote equitable access to care.

Geographic Residence	Patients Served	Percentage
Washington, D.C. Residents	411	100%
Ward 7 & Ward 8 Combined	216	52.55%
Other DC Wards	195	47.45%

ICS operates within a culturally responsive care framework that supports racial, ethnic, and linguistic diversity. The organization serves patients across multiple minority groups, including Hispanic/Latino and other culturally distinct populations. Although specific language utilization statistics are not publicly reported, service protocols are designed to

accommodate individuals with limited English proficiency and culturally specific communication needs.

Language Preference	Percentage
English	94%
Spanish	3.9%
Other languages served	2.1%
Total	100%

A significant portion of ICS patients may be considered medically underserved due to disability-related service needs, chronic health conditions, and/or socioeconomic barriers to traditional healthcare delivery. Community-based service models are particularly important in the District of Columbia, where certain neighborhoods are designated as medically underserved or face healthcare workforce access limitations.

ICS contributes to addressing these access gaps by providing home and community-based services that reduce transportation barriers, improve continuity of care, and support independent living within community settings.

The utilization and demographic data demonstrate that ICS operates in alignment with community health needs within the District of Columbia. The organization's service population reflects the cultural, geographic, and socioeconomic characteristics of vulnerable communities, including high-minority and historically underserved areas such as Ward 7 and Ward 8.

33. What percentage of staff are multilingual?

ICS Response:

Integrated Community Services (ICS) maintains a diverse and multilingual workforce that reflects the patients, families, and communities we serve. Based on current HR data, approximately 90% of our staff report proficiency in one or more languages in addition to English. This language diversity strengthens our ability to provide culturally responsive care and enhances communication with patients and their families from varied linguistic backgrounds. Our multilingual staff helps reduce communication barriers, improve care coordination, and promote better health outcomes across the populations we support. As a community-based organization, ICS prioritizes workforce diversity as part of our commitment to equitable, accessible, and family-centered care delivery

Language	% of Staff	Number of Staff
English	100%	687
Pidgin	34%	233
French	33%	230
Other	11%	73
Amharic	7%	46

Yoruba	5%	35
Spanish	3%	24
Igbo	2%	14
Arabic	2%	12
Hausa	1%	7
Luganda	1%	6
Swahili	1%	5
Ewe	<0.15%	1
Portuguese	<0.15%	1

34. Please describe the operational systems and care coordination mechanisms established to address access barriers, improve continuity of care, and manage highrisk patients in the home setting, including the rationale for their development, target populations, and expected outcomes. Identify the specific underserved geographic areas within Anne Arundel County, Montgomery County, and Prince George's County. For each identified area, provide:
    a. The criteria and data sources used to designate the area as underserved;
    b. Demographic and linguistic characteristics, including primary languages spoken and rates of limited English proficiency; and
    c. The prevalence and distribution of major chronic conditions relevant to home health service demand

ICS Response:

Operational Systems, Care Coordination Mechanisms, Underserved Areas, and Measurable Outcomes

Integrated Community Services (ICS) has established structured operational systems to address care coordination mechanisms, identification of underserved geographic areas, access barriers, improve continuity of care, and manage high-risk patients in the home setting. These systems are developed consistent with 42 CFR §484 (Home Health Conditions of Participation), including §484.65 (QAPI), and align with COMAR 10.24.16.04B(1)-(3) (need criteria: population characteristics, utilization patterns, and availability of existing providers) and COMAR 10.24.16.08K (data collection and reporting requirements).

I. Operational Systems and Care Coordination Framework

In accordance with COMAR 10.24.16.04B(1), ICS designed its systems to address the demographic, clinical, and socioeconomic characteristics of underserved populations. In alignment with COMAR 10.24.16.04B(2), the model emphasizes timely start-of-care and transition management to mitigate preventable utilization. Pursuant to COMAR 10.24.16.04B(3), the systems expand capacity in areas where provider accessibility and continuity are limited.

ICS developed its operational systems to address barriers to home-based care in underserved communities, including delayed start/resumption of care following hospitalization, fragmented communication, transportation limitations, Limited English Proficiency (LEP), workforce reliability challenges, and high chronic disease burden.

Core systems include:

• Centralized intake with standardized high-risk screening protocols and rapid start-of-care workflows.

• Integrated home health EHR (Axxess) supporting interdisciplinary documentation and care coordination.

• Structured nurse and care coordinator roles for high-risk oversight.

• High-risk management pathways (post-ER, falls, CHF/COPD, diabetes, dialysis, oxygen dependence).

• Language access safeguards including interpreter use and teach-back protocols.

• Workforce continuity safeguards to minimize missed visits for high-risk patients.

• Utilization of CRISP to track ER visits and/or hospitalizations.

Target populations include older adults with functional limitations; individuals with CHF, COPD, diabetes, CKD/ESRD, stroke history; patients recently hospitalized or with repeated ED utilization; and households with LEP.

II. Identification of Underserved Geographic Areas

ICS identifies underserved areas using HRSA Medically Underserved Area/Population (MUA/P) designations[1], as objective federal indicators. This methodology aligns with COMAR 10.24.16.04B(1), which requires evaluation of population need and service access barriers. Demographic and linguistic characteristics are derived from U.S. Census Bureau American Community Survey (ACS) 5-Year Estimates[2], (census tract-level demographic and language data) and chronic disease prevalence indicators from CDC PLACES tract-level data[3].

Designated areas include:

Anne Arundel County: North Anne Arundel (MUA 6204); Meade Heights (MUA 7359); Medicaid Central Annapolis (MUP 1499); Low Income – Owensville (MUP 7565).

Montgomery County: Aspen Hill (MUA 7906); Low Income – Takoma/Langley (MUP 7369).

Prince George's County: District Heights/Capitol Heights (MUA 7968); Medicaid Eligible – College Park (MUP 7969); Accokeek (MUA 7849); Collington (MUA 7848); Low Income – Brandywine (MUP 1481); Low Income – Takoma/Langley (MUP 7369).

III. Demographic and Linguistic Characteristics

ACS 5-Year Estimates indicate elevated rates of households speaking languages other than English within designated census tracts. Spanish is the predominant non-English language, with additional Indo-European and Asian language representation. Limited English Proficiency (LEP), defined as speaking English less than 'very well,' is elevated in multiple tracts, particularly in Takoma/Langley and Aspen Hill[2].

IV. Chronic Condition Prevalence and Distribution

CDC PLACES small-area estimates demonstrate higher prevalence of diabetes, COPD/asthma, coronary heart disease, stroke risk, hypertension, obesity, and functional disability across several HRSA-designated tracts[3]. These conditions directly correlate with increased demand for skilled nursing oversight, medication management, fall prevention, chronic disease monitoring, and post-acute stabilization.

V. Expected Outcomes and Measurable Performance Indicators

In compliance with 42 CFR §484.65 (QAPI) and COMAR 10.24.16.08K, ICS will monitor the following KPIs:

• Referral-to-start-of-care within 48 hours (≤24 hours for high-risk discharges).
• 30-day hospital readmission rate below county baseline benchmarks for comparable populations.
• ≥90% post-hospital follow-up within 24 hours for high-risk patients.
• ≤3% missed visit rate among high-risk patients.
• ≥95% fall reassessment within 24 hours of reported event.
• Medication reconciliation accuracy ≥98% at SOC/ROC.
• ≥95% LEP patients receiving interpreter-supported education.
• Quarterly QA audits completed for 100% of high-risk pathways.

These measurable benchmarks support COMAR 10.24.16 objectives by enhancing access, improving continuity of care, strengthening provider accountability, and expanding service capacity in underserved communities.

Conclusion

Through HRSA-based underserved area identification, ACS language analysis, CDC PLACES chronic disease assessment, and structured QAPI-aligned operational safeguards, ICS has developed a comprehensive care coordination model consistent with 42 CFR §484 and COMAR 10.24.16.04B and 10.24.16.08K. These systems are expected to reduce preventable ER & hospital utilization, improve continuity of care, and expand access to high-risk populations in Anne Arundel County, Montgomery County, and Prince George’s County.

References

1. Health Resources and Services Administration (HRSA), Medically Underserved Areas/Populations (MUA/P) Dashboard Dataset.

2. U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates (Census Tract Level Data).

3. Centers for Disease Control and Prevention (CDC), PLACES: Local Data for Better Health (Census Tract Estimates).

4. 42 CFR §484 – Home Health Conditions of Participation; 42 CFR §484.65 – QAPI.

5. COMAR 10.24.16 – Maryland State Health Plan for Home Health Services.

35. How do your timely start-of-care processes specifically address disparities in access to care or outcomes among different patient populations?

ICS Response:

ICS's timely Start-of-Care (SOC) processes are intentionally designed to reduce disparities in access to home-based healthcare services and to improve outcomes among vulnerable and historically underserved populations throughout the District of Columbia.

1. Rapid Response to Prevent Delays in Care

Our structured intake and triage system prioritizes:

- Patients discharged from hospitals with high readmission risk.
- Patients with limited caregiver support
- Individuals with chronic conditions associated with higher morbidity (CHF, COPD, diabetes, and ESRD)
- Dual-eligible Medicare/ Medicaid beneficiaries

All referrals are reviewed within 2 hours of receipt, and SOC visits are scheduled within 24-48 hours or sooner when clinically indicated. This rapid response reduces gaps between hospital discharge and home-based intervention, for all population types.

Delays in post-acute follow-up are associated with increased readmissions and emergency department utilization. By ensuring prompt SOC, we directly address these preventable adverse outcomes.

2. Geographic Access and Transportation Equity

Certain DC jurisdictions experience clinician shortages due to parking related issues, however ICS:

- Ensures clinical coverage across all DC service areas through flexible staffing and deployment models.

- Maintains adequate clinician capacity to meet patient needs in every service area, including those that are more difficult to access.

This structure reduces service inequities that often impact patients in areas where parking is difficult.

3. Language Access and Cultural Responsiveness

To eliminate language related barriers that delay care initiation, we provide:

- Multilingual office and field staff
- On-demand certified medical interpretation services
- Translated patient education materials
- Cultural competency training for clinicians

Limited English Proficiency (LEP) is associated with reduced understanding of discharge instructions and poorer outcomes. Immediate language support during intake improves patient comprehension, medication adherence, and care plan engagement.

4. Social Determinants of Health (SDOH) Screening at Intake

At intake, the coordinator completes screening for:

Key SDOH Affecting Home Health Patients

- Economic Stability: Limited income, inability to afford medications, and financial strain to pay for necessary home care or utilities.
- Neighborhood & Built Environment: Unsafe housing, lack of transportation for medical appointments, lack of clean water.
- Social & Community Context: High rates of social isolation, lack of family/informal caregivers, and, in some cases, discrimination.
- Health Care Access & Quality: Lack of access to healthcare, limited health literacy, and poor access to nutritious food.
- Education: Limited education levels which affect the ability to manage personal health, understand care instructions, or navigate the healthcare system. National Institutes of Health (.gov) +8

Identified needs would trigger referrals to community-based organizations and care coordination partners. Addressing SDOH at the initiation of care prevents avoidable deterioration that disproportionately impacts low-income populations.

5. Integration with Value-Based Care and Hospital Readmission Reduction

Timely SOC is a key driver in reducing hospital readmissions. Under models promoted by the Centers for Medicare & Medicaid Services (CMS), delayed follow-up is a known risk factor for avoidable readmissions.

By ensuring rapid initiation of skilled services, particularly for high-risk patients.

ICS will:

- Improve medication reconciliation accuracy
- Identify early signs of deterioration
- Reinforce discharge instructions
- Reduce preventable rehospitalizations

These interventions benefit those populations at higher risk for poor outcomes.

6. Alignment with Maryland Health Equity Priorities

ICS's timely SOC framework supports Maryland's focus on:

- Reducing avoidable hospital utilization
- Improving care access in underserved communities
- Advancing health equity across racial and socioeconomic groups

By embedding equity checkpoints into every phase of intake and care initiation, ICS ensures that timely access is not dependent on payer type, geography, language or socioeconomic status.

Measurable Commitments

ICS commits to:

- ≥ 95% of SOC visits completed within 48 hours of referral (or physician-ordered timeframe)
- Zero statistically significant disparities in SOC timeliness across racial or payer groups
- Ongoing quarterly equity reporting to leadership and the governing body
- Continuous improvement intervention when disparities are identified

Conclusion

Timely SOC is not simply an operational metric- it is an equity strategy. By prioritizing rapid access, removing structural barriers and monitoring outcomes across demographic groups, ICS directly addresses disparities in both access to care and clinical outcomes.

This approach ensures that all Maryland residents, regardless of background or socioeconomic status, will receive prompt, high-quality home-based services.

36. Provide a more detailed explanation of your structured intake process that identifies Social Determinants of Health barriers, and explain how it triggers referrals and support linkages?

ICS Response:

I. Description of Structured Intake Process

ICS has implemented a standardized, protocol-driven intake and admission process designed to systematically identify, document, and address Social Determinants of Health (SDOH) barriers that may impede access to skilled home health services, adherence to treatment plans, and optimal clinical outcomes.

This structured intake model supports:

- Timely access to care
- Reduction in avoidable hospital readmissions
- Improved care coordination
- Reduction in health disparities
- Alignment with Maryland's Total Cost of Care Model
- The intake process is embedded into the ICS's operational workflow and electronic medical record (EMR) system (Axxess) and applies uniformly to all new patient referrals. This model will also be applied within Montgomery County, Prince George's County, and Anne Arundel County.

II. INTAKE WORKFLOW AND TIMELINES

II.A. Referral Receipt and Initial Review

Upon receipt of a referral, the referrals are reviewed within 2 hours of receipt. The preliminary intake review includes:

1. Verification of payer eligibility and service coverage
2. Confirmation of geographic service area

3. Clinical appropriateness review
4. Standardized SDOH screening
5. No patient is scheduled for SOC without completion of the initial SDOH screening

II.B.1. Housing Stability

- Risk of eviction or homelessness
- Unsafe or unstable housing conditions
- Utility interruption risk
- Environmental barriers affecting safe delivery of skilled services

II.B.2. Food Security

- Inconsistent access to nutritious meals
- Inability to follow prescribed therapeutic diets

II.B.3. Transportation Access

- Inability to attend medical appointments
- Barriers to pharmacy access
- Dialysis or specialty visit transportation limitations

II.B.4. Financial Strain

- Medication affordability
- Insurance coverage gaps
- Inability to obtain durable medical equipment or supplies

II.B.5. Health Literacy and Language Access

- Preferred language
- Need for interpreter services
- Cognitive or educational barriers affecting care adherence

II.B.6. Social Support and Caregiver Capacity

- Absence of caregiver support
- Caregiver burnout
- Risk of unsafe care environment

II.B.7. Home Safety Risks

- Fall hazards

- Structural safety concerns
- Environmental safety barriers

III. RISK STRATIFICATION AND ESCALATION PROTOCOL

All identified SDOH barriers are categorized into a three-tiered risk framework:

III.A. Level I – Immediate Risk

Barriers posing an imminent threat to patient safety or continuity of care.
Action: Same-day escalation to the Clinical Manager and immediate intervention planning.

III.B. Level II – Moderate Risk

Barriers likely to impact treatment adherence or outcomes.
Action: Referral initiated within 24 hours and documented follow-up.

III.C. Level III – Preventive Risk

Potential risks requiring monitoring and reassessment during SOC.

For the skilled SOC, the SDOH findings alert the clinician to develop interventions and goals to address any barriers. For the unskilled SOC, the SDOH findings are documented within a designated EMR field.

The Electronic Visit Verification (EVV) System generates automated alerts to:

- Clinical Director
- Assigned Registered Nurse
- Care Coordination Team

IV. REFERRAL TRIGGERS AND COMMUNITY SUPPORT LINKAGES

IV. Referral Activation

When specific SDOH responses are recognized, an appropriate intervention is initiated.

Examples of triggered referrals include:

- Food insecurity → Referral to regional food distribution networks and county social services

- Housing instability → Referral to case management services; housing and social services departments
- Transportation barriers → Referral to transportation assistance programs and office on aging services
- Medication affordability concerns → Medicaid- insured patients are referred to Medicaid case management services and Medicare, commercially insured and private pay patients are referred to pharmaceutical assistance programs

V. INTEGRATION WITH START OF CARE (SOC)

During the in-person SOC visit, the assigned Registered Nurse or Therapist:

- Assesses for and validates SDOH barriers
- Conducts a comprehensive home safety evaluation
- Updates risk level classification
- Incorporates social barriers into the individualized Plan of Care (POC)

Examples of integrated interventions include:

- Utility protection coordination for oxygen-dependent patients
- Fall mitigation strategies in unsafe home environments
- Medication reconciliation with financial assistance referrals
- Case Management and Chore Aide for cluttered environments and referral to Adult Protective Services for unsafe environments

All identified SDOH barriers are incorporated into the POC when clinically relevant.

VI. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

VI.A. SDOH Performance Indicators

For example:

1. Readmission rate among patients with two or more SDOH barriers
2. Emergency department and hospitalization utilization associated with lack of family support and unresolved social needs

VI.B. QAPI Oversight

For example:

- Staff education initiatives
- Enhanced community partnership development

VII. IMPACT ON ACCESS, EQUITY, AND COMMUNITY NEED

The DC communities' serviced by ICS include diverse socioeconomic and demographic populations, including:

- Linguistically diverse communities
- High chronic disease burden populations
- Patients experiencing transportation and housing instability
- Vulnerable elderly and disabled populations

By embedding SDOH screening into the intake process,

ICS:

- Reduces barriers to accessing skilled services
- Improves medication adherence and care compliance
- Decreases preventable ER and hospital utilization
- Enhances continuity of care
- Advances health equity objectives

This structured process ensures that social risk factors are identified early and addressed proactively, thereby supporting improved outcomes.

VIII. CONCLUSION

This approach demonstrates: 1) responsiveness to community needs, 2) strengthens access to skilled home health services, and 3) will also support MHCC’s review criteria related to access, quality, and reduction of health disparities within Montgomery County, Prince George’s County, and Anne Arundel County.

37. Clarify the term “field-based reinforcement” in your training process, and provide specific examples of the activities or interventions that supervisory registered nurses use during monthly PCA/HHA visits to monitor quality, performance, and patient experience?

ICS Response:

I. OVERVIEW

ICS utilizes experienced Supervisory Registered Nurses (RNs) in the District of Columbia, to conduct structured monthly supervisory visits for Personal Care Aides (PCAs).

These visits are designed to:

- Monitor quality of care delivery
- Evaluate aide competency and performance
- Ensure compliance with the individualized Plan of Care (POC)
- Assess patient safety and home environment risks
- Assess patient satisfaction with services and to address any questions or concerns
- Perform medication reconciliation
- Capture and respond to patient experience feedback
- Provide teaching and education to the patient/family and aides
- Identify early warning signs of clinical deterioration

The monthly supervisory visit is standardized, documented in the electronic medical record (EMR), and incorporated into the agency’s QAPI program.

II. STRUCTURED MONTHLY SUPERVISORY VISIT COMPONENTS

During each monthly PCA supervisory visit, the Supervisory RN performs the following structured activities:

III. QUALITY MONITORING ACTIVITIES

III.A. Direct Observation of Care Delivery

The Supervisory RN conducts direct observation of the PCA performing assigned tasks, including:

- Safe transfer techniques (bed-to-chair, toileting, ambulation)
- Proper infection control practices (hand hygiene, PPE use)
- Bathing and personal hygiene assistance
- Proper positioning to prevent pressure injuries
- Safe meal preparation consistent with therapeutic diet orders

The RN evaluates adherence to:

- The individualized Plan of Care (POC)
- Agency clinical protocols
- Universal precautions and Safety standards
- Scope-of-practice limitations

Any deviations trigger immediate corrective instruction and documentation.

III.B. Plan of Care Compliance Audit

The RN reviews:

- Aide documentation accuracy and completeness
- Task completion consistency
- Variance from ordered services
- Missed or incomplete visits
- Timeliness of documentation submission

Documentation discrepancies are addressed in real time and may result in performance counseling or retraining.

IV. PERFORMANCE EVALUATION INTERVENTIONS

IV.A. Competency Reinforcement and Skills Validation

Supervisory RNs conduct:

- Skills re-demonstration (e.g., gait belt usage, transfer technique, catheter care observation, if applicable)

- Re-education on infection prevention
- Fall prevention training reinforcement
- Proper body mechanics review

If competency gaps are identified, the RN:

1. Provides immediate corrective instruction
2. Documents performance concerns
3. Develops a corrective action plan
4. Schedules follow-up supervisory reassessment

Repeated deficiencies trigger formal disciplinary processes per agency policy.

IV.B. Professional Conduct Assessment

The RN evaluates aide:

- Communication skills
- Professional boundaries
- Cultural sensitivity
- Respect for patient dignity
- Adherence to HIPAA and confidentiality standards

Any concerns are escalated to the Clinical Director and incorporated into personnel performance files.

V. PATIENT SAFETY AND CLINICAL MONITORING

Although PCA services are non-skilled, the Supervisory RN uses the visit to assess patient condition and safety risks, including:

V.A. Environmental Safety Assessment

- Clutter or fall hazards
- Lighting adequacy
- Bathroom safety supports

- Functionality of medical equipment
- Oxygen safety compliance (if applicable)

Identified hazards result in:

- Immediate corrective instruction
- Referral to community resources, if needed
- Care plan modification

V.B. Early Clinical Risk Identification

The RN evaluates for:

- Changes in mobility
- Signs of skin breakdown
- Weight changes
- Medication non-adherence
- Increased shortness of breath
- Cognitive decline
- Changes in physical condition

If deterioration is suspected, the RN:

- Notifies the physician
- Initiates skilled service reassessment
- Coordinates urgent care or emergency intervention, if necessary

This proactive intervention supports the reduction of avoidable ER visits or hospitalizations.

VI. PATIENT EXPERIENCE MONITORING

VI.A. Structured Patient Satisfaction Interview

During each supervisory visit, the RN conducts a structured patient (or caregiver) interview addressing:

- Satisfaction with aide punctuality and reliability
- Quality of care provided

- Respect and professionalism
- Communication effectiveness
- Cultural and language appropriateness
- Perceived unmet needs

Responses are documented in the EMR.

VI.B. Grievance Identification and Resolution

The RN specifically asks whether the patient has:

- Any complaints
- Any safety concerns
- Any unmet care needs

If concerns are identified:

1. Immediate investigation is initiated
2. Clinical Director is notified
3. Findings are documented
4. Corrective action plan is implemented
5. Follow-up contact occurs within 72 hours

All complaints are incorporated into the QAPI tracking system.

VII. PERFORMANCE DATA INTEGRATION INTO QAPI

Supervisory visit findings are aggregated quarterly to monitor:

- Aide competency trends
- Re-training frequency
- Patient satisfaction patterns
- Safety concern trends
- Incident frequency by staff member

Data are reviewed by leadership and may result in:

- Performance Improvement Projects (PIPs)
- Targeted staff education initiatives
- Policy revision

VIII. ALIGNMENT WITH MHCC REVIEW CRITERIA

The monthly supervisory RN process supports MHCC CON standards by:

- Ensuring continuous quality monitoring
- Strengthening patient protections
- Reducing risk of neglect or substandard care
- Enhancing patient satisfaction
- Preventing avoidable ER or hospital utilization
- Maintaining regulatory compliance

The structured and documented nature of the supervisory process demonstrates ICS's commitment to measurable oversight, accountability, and quality assurance within the proposed service area.

IX. CONCLUSION

ICS's Supervisory Registered Nurse model incorporates:

- Education and direct observation of aide performance
- Competency validation
- Documentation audits
- Environmental safety assessments
- Early clinical risk detection
- Structured patient experience evaluation
- Closed-loop grievance resolution
- Integration into QAPI oversight

This comprehensive supervisory framework ensures high-quality personal care delivery, protects vulnerable populations, and aligns with CMS and Maryland's emphasis on quality, accountability, and health equity in the provision of home-based services.

38. What is the current staffing model used in ICS's Washington, DC service, including specific roles, staff-to-patient ratios, and workflows, and how do you plan to adapt it for Maryland requirements?

ICS Response:

ICS operates a team-based home health model integrating clinical care, care coordination, quality oversight, and administrative support.

Core Roles Include:

- Administrator
- Clinical Manager / Director of Nursing, oversight of all HHA activities
- Assistant Clinical Manager/Assistant Director of Nursing, oversight of intake for PCA referrals
- Skilled Services Manager, oversight of the skilled services program and skilled referrals
- Quality Assurance Manager, oversight of the QA Team and QAPI Program
- Administrative Manager, responsible for Prior Authorizations
- Records Room Manager, oversight of Records Room staff
- Incident Manager, responsible for all incidents and complaints
- Care Coordinator, responsible for coordinating activities with the Interdisciplinary Team
- Beneficiary Care Coordinator (BCC) Supervisor, oversight of the BCCs
- Registered Nurses (SOC, ROC, recertifications, post-hospital follow-up, PCA, HHA and LPN supervision)
- Therapists (PT/OT) (SOC and PT/OT Assessments/Reassessments)
- Home Health Aides (HHA) / Personal Care Aides (PCA)

Staff-to-Patient Ratios (Operational Targets):

- Registered Nurse:
- PCA Supervisory RN: approximately 25–30 active patients per RN, adjusted for acuity
- Skilled Nurse: caseloads adjusted based on ordered visit frequency
- Therapy caseloads adjusted based on ordered visit frequency

Key Workflows

Centralized intake with same-day referral review

- Insurance verification & eligibility
- Prior Authorization request
- Scheduling of all field visits (RNs, therapists, PCAs, & HHAs), including SOC
- Supervisory and QA review of clinical documentation to ensure compliance, visit frequency and receipt of timely documentation
- Records room creation of all patient charts (Electronic & hard copy), faxing of completed POC/orders
- Care coordinator: responsible for care coordination with the interdisciplinary team
- Incident Management: review all incidents to include ER visits, hospitalizations, incidents in the patient's home, etc.
- Routine QA audits and QAPI review
- Clinical Manager/Skilled Services Managers responsible for training and education

ICS will replicate its DC staffing model in Maryland while aligning with 42 CFR §484 and COMAR 10.24.16 requirements.

Adaptations include:

- County-based staffing allocation for Anne Arundel, Montgomery, and Prince George's Counties
- Staffing scaled to projected admissions
- Prioritization of underserved areas and Medicaid populations
- Continued SDOH screening, language access, and quality monitoring safeguards

This approach ensures timely care delivery, regulatory compliance, and continuity of services across the Maryland service area.

39. Confirm that Rose Oma is the sole owner of the organization. Additionally, who is responsible for implementation of the program or service, and provide their credentials/experience?

ICS Response:

The proposed Maryland program will be implemented under the direct oversight of the organization's executive and clinical leadership team, including the Chief Executive Officer, Administrator, Clinical Manager, and Skilled Services Manager.

Executive Leadership

Rose Oma is the sole owner of Integrated Community Services, Inc. and serves as Chief Executive Officer. Since the organization's inception, she has provided executive leadership throughout its operational growth and regulatory development. Under her direction, ICS has expanded its service lines, strengthened compliance systems, and maintained oversight across administrative and clinical functions.

Administrative Leadership

Mr. Joe Morris currently serves as Administrator of ICS. In this role, he oversees the administrative and operational teams responsible for program implementation, regulatory compliance, staffing infrastructure, and quality oversight.

Mr. Morris began his tenure with ICS as Director of Operations in 2014 and was promoted to Administrator in 2017. He has held this leadership position continuously since that time.

As Administrator, Mr. Morris has overseen operational expansion, regulatory compliance initiatives, workforce development, and quality assurance systems within the organization's home health operations. He was actively involved in the preparation and approval process of the organization's prior Certificate of Need (CON) for home health services and has led the agency through sustained growth while maintaining compliance with Department of Health and Medicaid oversight requirements.

His operational experience and direct involvement in prior CON processes position him to oversee the proposed Maryland expansion in a structured and compliant manner.

Clinical Leadership

The Clinical Manager will oversee all clinical operations associated with the Maryland program, including compliance with 42 CFR §484 Conditions of Participation, supervision of nursing staff, review of plans of care, and quality assurance oversight.

The Skilled Services Manager will be responsible for implementation and oversight of the skilled nursing and therapy components of the program, including referral intake, coordination of SOC

assessments, supervision of therapists and skilled clinicians, and monitoring of visit utilization consistent with physician orders and regulatory requirements.

Implementation Structure

The Administrator, Clinical Manager, and Skilled Services Manager will collectively be responsible for:

Program implementation and operational rollout

Staffing recruitment and onboarding

Clinical supervision and compliance monitoring

Alignment with COMAR 10.24.16 requirements

Ongoing quality assurance and QAPI oversight

This leadership structure ensures that the proposed Maryland expansion is implemented with executive oversight, clinical accountability, and regulatory discipline consistent with ICS's established operating model.

Home Health Agency Application: Charts and Tables Supplement

40. Please complete Table 2A (Statistical Projections) to reflect the current status of the home health agency's operations in Washington, DC

ICS Response:

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).

	Two Most Current Actual Years		Projected years – ending with first year at full utilization			
CY or FY (circle)	2024	2025	20	20	20	20
Client Visits	155747	164045				
Billable	153577	161750				
Non-Billable	2170	2295				
TOTAL	155747	164045				
# of Clients and Visits by Discipline						
Total Clients (Unduplicated Count)	501	557				
Skilled Nursing Visits	5178	5824				
Home Health Aide Visits	148458	156631				
Physical Therapy Visits	94	839				

Occupational Therapy Visits	101	949				
Speech Therapy Visits						
Medical Social Services Visits						
Other Visits (Please Specify)						

Table 2A reflects the two most current actual reporting periods for ICS's Washington, DC home health operations. The data demonstrate growth in unduplicated clients (from 501 to 557), increased total visit volume, and expansion of skilled nursing and therapy services. The consistent increase in service utilization supports ICS's demonstrated operational capacity and readiness to implement the proposed Maryland skilled home health program.

EXHIBIT 9- Time Payment Plan Policy& Charity Care and Sliding Fee Scale Policy

	SOP Title: Time Payment Plan Policy
Effective Date:1/9/2025	Version No.:001
Approved By:	Revision Date:

1. Purpose

The purpose of this Time Payment Plan Policy is to ensure that patients who are unable to pay the full cost of home health services at the time services are rendered are provided with reasonable, structured payment options. This policy supports access to medically necessary services regardless of ability to pay and is consistent with COMAR 10.24.16.08D–E.

2. Policy Statement

Integrated Community Services, Inc. (ICS) maintains written policies governing fee disclosure, charity care, sliding fee reductions, and time payment arrangements. Individuals unable to make full payment may request a structured, interest-free payment plan based on financial capacity.

3. Eligibility and Determination Process

a. At intake and prior to the initiation of services, ICS verifies insurance coverage and provides written notice of financial assistance options, including charity care, sliding fee reductions, and time payment plans.

b. Upon a patient's request for financial assistance, ICS will determine probable eligibility for medical assistance, charity care, reduced fees, and/or time payment options within two (2) business days. The determination will be communicated to the patient in writing.

c. Patients who do not qualify for full charity care but are unable to pay the full balance may enroll in a structured time payment plan.

4. Payment Plan Structure

Time payment arrangements include the following provisions:

• Equal monthly installment payments based on financial capacity.

• Interest-free repayment terms.

• Flexible repayment periods, with extended terms subject to Administrator approval.

• Written payment agreement signed by the patient or responsible party.

5. Continuity of Care Protections

Services will not be denied, delayed, or discontinued solely due to inability to make immediate payment, provided the patient is actively participating in an approved time payment plan or has a pending financial assistance determination.

6. Documentation and Recordkeeping

All payment arrangements will be documented in writing and maintained in the patient's financial record. A copy of the signed agreement will be provided to the patient.
Financial assistance records will be maintained in accordance with applicable regulatory requirements.

7. Oversight and Review

ICS leadership will review participation in time payment plans periodically to ensure compliance with this policy and regulatory standards. This policy will be reviewed annually and updated as necessary to maintain compliance with MHCC and COMAR requirements.

Facility Team: ICS Administration	SOP Title: Charity Care and Sliding Fee Scale Policy
Effective Date:1/9/2026	Version No.:001
Approved By:	Revision Date:

1. Purpose

The purpose of this Charity Care and Sliding Fee Scale Policy is to ensure access to medically necessary home health services regardless of an individual's ability to pay. This policy establishes clear eligibility standards, financial screening procedures, discounted fee structures, and oversight requirements consistent with COMAR 10.24.16.08E.

2. Policy Statement

Integrated Community Services, Inc. (ICS) shall provide home health services on a charitable basis to qualified indigent and low-income individuals. ICS maintains written policies governing full charity care, reduced fees under a sliding fee scale, and time payment options for individuals who do not qualify for full charity care but are unable to pay the full cost of services.

3. Eligibility Determination Process

a. At intake and prior to initiation of services, ICS verifies insurance coverage and provides written notice of financial assistance options.

b. Upon a client's request for financial assistance or application for Medicaid, ICS shall determine probable eligibility for medical assistance, charity care, reduced fees, and/or time payment options within two (2) business days. The determination will be communicated to the client in writing.

c. Documentation may include proof of income, household size, and other relevant financial information. All documentation will be handled confidentially in accordance with HIPAA requirements.

4. Sliding Fee Scale Structure

ICS maintains a sliding fee scale based on Federal Poverty Level (FPL) guidelines. Discount eligibility is structured as follows:

• 100% discount for households at or below 100% of the Federal Poverty Level.

• Reduced fees for households between 101% and 300% of the Federal Poverty Level.

Discount levels are determined based on income verification and applied consistently across eligible patients.

5. Coordination with Time Payment Plan

Patients who do not qualify for full charity care but remain unable to pay the full discounted balance may enroll in an interest-free time payment plan consistent with ICS's Time Payment Plan Policy.

6. Notice and Public Information

ICS provides notice of its Charity Care and Sliding Fee Scale Policy in the following ways:

• Written notice provided at intake.

• Posted notice in the business office.

• Available upon request to patients and families.

• Publication of a public notice annually in a local newspaper within each jurisdiction served, informing the community of the availability of charity care, sliding fee discounts, and time payment options.

ICS addresses client and family concerns regarding payment prior to the provision of services.

7. Continuity of Care Protections

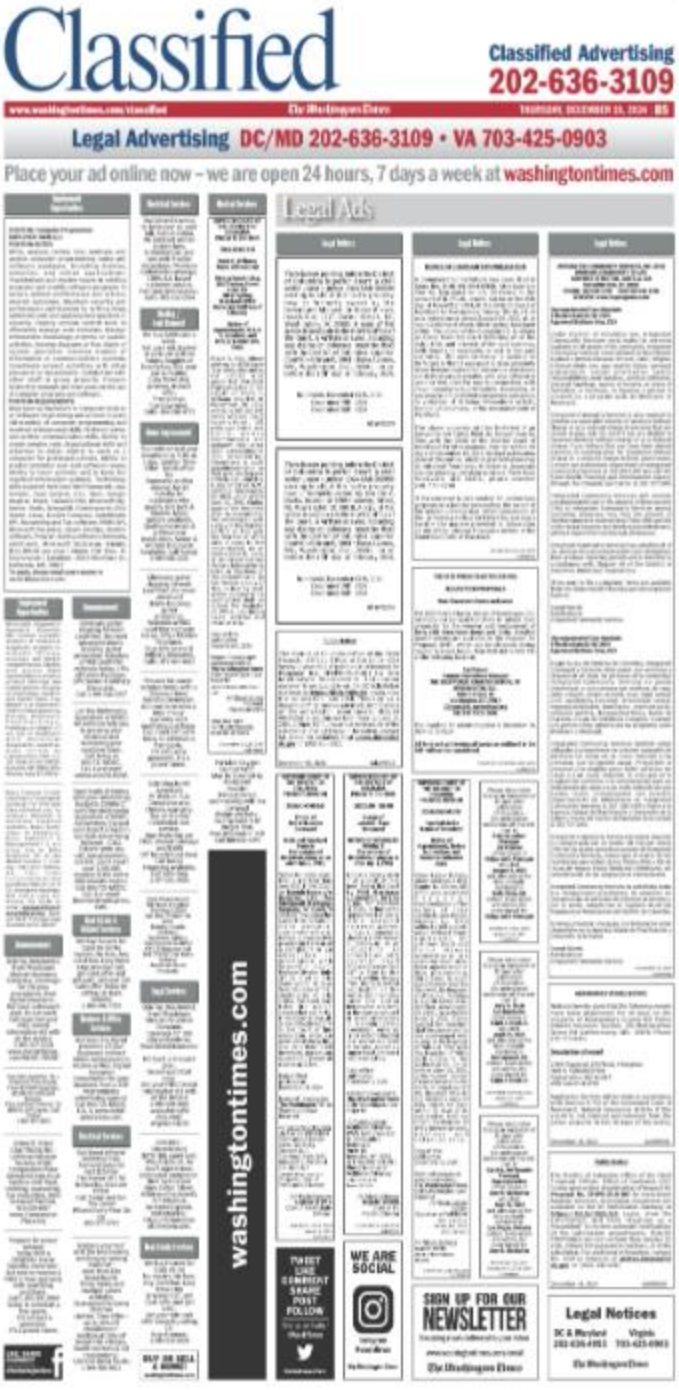
Services will not be denied, delayed, or discontinued during the financial assistance screening process or solely due to inability to pay, provided the client is actively participating in the financial assistance process or an approved payment arrangement.

8. Charity Care Commitment

ICS commits to providing an amount of charity care at least equivalent to the average amount provided by home health agencies in the jurisdictions served, based on the most recent available MHCC data. ICS leadership will monitor charity care utilization annually to ensure compliance with this commitment.

9. Oversight and Annual Review

ICS leadership will review charity care determinations, sliding fee participation, and related financial assistance data on a periodic basis. This policy will be reviewed annually and updated as needed to ensure continued compliance with MHCC and COMAR requirements.



INTEGRATED COMMUNITY SERVICES, INC. (ICS)
BRINGING COMMUNITY TO LIFE
820 FIRST STREET NE, SUITE LL-110
WASHINGTON, DC 20002
PHONE: 202-506-1209 FAX: 202-506-1396
WEBSITE: www.icsprograms.com

Uncompensated Care Mandate
Effective Date:01/01/2023
Approved By:Rose Oma, CEO

Under District of Columbia law, Integrated Community Services must make its services available to all people of the community. Integrated Community Services is not allowed to discriminate against a person because of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, family responsibilities, matriculation, political affiliation, physical handicap, source of income, or place of residence or business, or because a person is covered by a program such as Medicare or Medicaid.

Integrated Community Services is also required to provide a reasonable volume of services without charge or at a reduced charge to persons that are unable to pay. Ask the staff if you are eligible to received services without charge or at a reduced charge if you believe that you have been denied services or consideration for treatment without charge or a reduced charge without good reason, contact our Admissions Department at Integrated Community Services at 202-506-1209 and call the State Health Planning and Development Agency through the Citywide call Center at 202-727-1000.

Integrated Community Services will provide uncompensated care in the amount of three percent (3%) of Integrated Community Services annual operating expenses, less than the amount of reimbursements it received from Titles XVIII and XIX of the Social Security Act (Medicaid and Medicare), without regard from contractual allowances.

Integrated Community Services has satisfied all of its outstanding uncompensated care obligations from previous reporting periods and is therefore in compliance with Chapter 44 of the District of Columbia Municipal Regulations.

If you want to file a complaint, forms are available from the State Health Planning and Development Agency.

Joseph Morris
Administrator
Integrated Community Services

Uncompensated Care Mandate
Effective Date:01/01/2023
Approved By:Rose Oma, CEO

Según la ley del Distrito de Columbia, Integrated Community Services debe poner sus servicios a disposición de todas las personas de la comunidad. Integrated Community Services no puede discriminar a una persona por motivos de raza, color, religión, origen nacional, sexo, edad, estado civil, apariencia personal, orientación sexual, responsabilidades familiares, matriculación, afiliación política, discapacidad física, fuente de ingresos, o lugar de residencia o negocio, o porque una persona está cubierta por un programa como Medicare o Medicaid.

Integrated Community Services también están obligados a proporcionar un volumen razonable de servicios sin cargo oa un costo reducido a las personas que no pueden pagar. Pregúntele al personal si es elegible para recibir servicios sin cargo o a un costo reducido. Si cree que se le negaron los servicios o la consideración para un tratamiento sin cargo o a un costo reducido sin una buena razón, comuníquese con nuestro Departamento de Admisiones en Integrated Community Services al 202 -506-1209 y llame a la Agencia Estatal de Planificación y Desarrollo de la Salud a través del Centro de llamadas de la ciudad al 202-727-1000.

Integrated Community Services brindará atención no compensada por un monto del tres por ciento (3%) de los gastos operativos anuales de Integrated Community Services, menos que el monto de los reembolsos que recibió de los Títulos XVIII y XIX de la Ley del Seguro Social (Medicaid y Medicare), sin consideración de las asignaciones contractuales.

Integrated Community Services ha satisfecho todas sus obligaciones pendientes de atención no compensadas de períodos de informes anteriores y, por lo tanto, cumple con el Capítulo 44 de las Regulaciones Municipales del Distrito de Columbia.

Si desea presentar una queja, los formularios están disponibles en la Agencia Estatal de Planificación y Desarrollo de la Salud.

Josoph Morris
Administrator
Integrated Community Services

EXHIBIT 10- Discharge Planning & Data Collection

Facility Team: ICS Administration	SOP Title: Discharge Planning - Regulatory Authority: COMAR 10.24.16.08J
Effective Date:1/9/2025	Version No.:001
Approved By:	Revision Date:2/17/2026

Applies To: All ICS clinical and administrative personnel involved in patient care coordination, including RNs, LPNs, therapists, social workers, clinical supervisors, Quality Review Nurses, QA Manager, Skilled Services Manager, and the Clinical Director.

Purpose

To establish a structured, comprehensive, person-centered discharge planning process that ensures continuity of care, supports patient safety, and complies with Maryland's Certificate of Need (CON) standards for home health agencies. This policy outlines ICS's procedures for interdisciplinary coordination, communication with providers, environmental assessments, and referral pathways to support patient success beyond the provision of home health services.

Policy Statement

ICS maintains a formal, person-centered discharge planning process designed to ensure that all patients receive coordinated, safe, and appropriate transitions of care. ICS will provide timely referrals, conduct environmental and social determinant assessments, and facilitate communication with all relevant providers to maintain continuity of care. All discharges and transfers will occur only for valid, clearly defined reasons, and ICS will ensure safe transition planning for every patient.

Scope

This policy applies to all ICS clinical and administrative personnel involved in patient care coordination, including RNs, LPNs, therapists, social workers, clinical supervisors, Quality Review Nurses, QA Manager, Skilled Services Manager, and the Clinical Director.

Discharge Planning Process

1. Initiation of Discharge Planning

- Begins at admission and is updated throughout the episode of care.
- Conducted by the RN Case Manager or admitting therapist with support from the interdisciplinary team (IDT).
- High-risk patients (e.g., CHF, COPD, wound care, unsafe home environment, lack of caregiver support) are flagged for enhanced monitoring.

2. Patient and Caregiver Involvement

- Patients and caregivers participate in planning, goal setting, and education.
- Preferences, needs, risks, and barriers are incorporated into the discharge plan.
- ICS provides written and verbal education to support self-management after discharge.

3. Coordination and Communication

- ICS maintains structured communication pathways to ensure continuity of care between the Interdisciplinary Team.

A. Interdisciplinary Team (IDT) Coordination (WE SHOULD BE DOING THIS)

- Weekly IDT case conferences include nursing, therapy, QA, and clinical leadership.
- IDT reviews progress toward goals, barriers, safety concerns, caregiver limitations, and discharge readiness.
- All IDT discussions are documented in the EMR.

B. Provider Communication Protocols

- ICS communicates with PCPs, specialists, and other providers regarding:
- Changes in condition
- Medication discrepancies
- Missed visits
- Safety concerns
- Discharge summaries
- Follow-up needs
- All communication is documented in the EMR within 24 to 48 hours.

C. Warm Handoff Procedures

- Prior to discharge, ICS ensures a warm handoff to the next level of care, (e.g., caregiver/family member, provider, hospice program, SAR, SNF or relevant community-based program) by:
- Providing/sending the discharge summary and medication list
- Communicating goals met/unmet
- Providing follow-up instructions

- Confirming receipt with the receiving provider

4. Environmental & Social Determinant Assessments (In the OASIS Assessement)

A. Home Environment Safety Assessment

- Performed at SOC and updated as needed:
- Fall hazards
- Clutter or hoarding concerns
- Adequacy of lighting
- Bathroom/bedroom accessibility
- DME needs (walker, commode, hospital bed, grab bars)
- Medication storage and safety
- Food security and nutrition concerns

B. Social Determinants of Health (SDOH) Screening

- ICS screens for:
- Caregiver availability
- Transportation barriers
- Financial hardship
- Health literacy
- Access to food, utilities, and safe housing
- Risk of social isolation

C. Unsafe Environment Escalation Protocol

- If a patient is unsafe at home:
- RN notifies PCP immediately
- ICS contacts hospital discharge planner or case manager
- ICS initiates referral to SAR/SNF or social services
- Documentation includes narrative, risk assessment, and photos (if permitted)
- ICS follows the patient until safely transitioned

5. Referrals and Continuity of Care

- ICS makes referrals to appropriate community resources, including:
- Primary and specialty care
- Hospice and palliative care
- Community-based programs
- DME providers
- Social services
- Outpatient therapy
- Skilled rehabilitation or nursing facilities
- All referrals are documented in the EMR.

6. Patient Education Prior to Discharge
    - Disease-specific education
    - Medication reconciliation and instructions
    - Follow-up appointment scheduling
    - Emergency contact information
    - Written discharge summary
7. Documentation Requirements
    - PT/OT Discharge Summaries completed when therapy services end
    - OASIS Discharge completed within 5 calendar days of last discipline visit
    - All communications, referrals, goals met/unmet, and rationale for discharge documented
    - Discharge Summary sent to PCP following discharge
8. Valid Reasons for Discharge or Transfer
    - Goals met or no further skilled services required
    - Patient relocation outside service area
    - Change in medical condition requiring higher/different level of care
    - Safety concerns or threatening behaviors
    - Repeated missed visits after documented attempts to coordinate care
    - Non-compliance making care ineffective or unsafe

- Insurance or payer issues (e.g., lack of authorization)
- Patient request to discontinue services
- Admission to hospice, hospital, or facility
- ICS will never discharge a patient without adequate effort to provide safe transition and appropriate referrals.

Facility Team: ICS Administration	SOP Title: Data Collection and Submission - Regulatory Authority: COMAR 10.24.16.08K; COMAR 10.07.10.12; 42 CFR §484
Effective Date: 1/9/2025	Version No.:001
Approved By:	Revision Date:2/17/2026

Purpose

To ensure that Integrated Community Services (ICS) collects, maintains, and reports all required State and federal home health data in compliance with COMAR, CMS Conditions of Participation, and Maryland Health Care Commission (MHCC) requirements.

Policy Statement

ICS is committed to accurate, timely, and complete data reporting in adherence with all applicable Maryland and federal regulations, including:

• CMS Home Health Quality Reporting Program (HH QRP).

• Outcome and Assessment Information Set (OASIS).

• Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS).

• Maryland Home Health Agency Annual Survey (COMAR 10.07.10.12).

Scope

This policy applies to all clinical and administrative personnel responsible for documentation, data quality, reporting, and regulatory compliance.

I. Federal (CMS) Data Collection Requirements

1. OASIS Data (42 CFR §484.55; §484.65)

OASIS assessments are:

• Completed by trained clinicians.

• Conducted at required time points: Start of Care (SOC), Recertification, Resumption of Care (ROC), Transfer, Discharge.

• Reviewed for accuracy prior to transmission.

• Submitted electronically through CMS-approved systems (iQIES).

• Corrected and resubmitted when validation errors occur.

ICS maintains internal audit procedures to ensure timely submission and data integrity consistent with the CMS Home Health Quality Reporting Program.

2. HHCAHPS (42 CFR §484.250–295)

• ICS has contracted with a CMS-approved HHCAHPS survey vendor.

• Patient information will be securely transmitted to the HHCAHPS vendor in strict compliance with HIPAA, applicable State law (e.g., Health-General Article, §4-302-5), and MHCC guidance.

• ICS will review HHCAHPS reports quarterly within its QAPI program.

• ICS will implement corrective action plans when trends are identified.

II. Maryland Reporting Requirements (COMAR 10.07.10.12)

ICS will:

• Complete and submit the Maryland Home Health (MHCC) Agency Annual Survey.

• Submit data to MHCC by established deadlines.

• Report required data elements to include: agency-level data including patient/service volume, financial data, staffing, utilization patterns, quality indicators, and demographics.

• Ensure Skilled Services Manager verification of data accuracy prior to submission.

III. Internal Data Quality Assurance

ICS utilizes an electronic health record (Axxess) with built-in validation tools to support real-time documentation, reporting accuracy, and compliance tracking.

Quality safeguards include:

• Monthly chart audits to ensure accuracy and completeness.

• OASIS accuracy review.

• SOC/ROC timeliness monitoring.

• Quarterly QAPI review.

• Annual staff training on documentation standards and updates to reporting requirements.

• Corrective action plans will be implemented if audit findings identify deficiencies or trends of non-compliance.

IV. Record Retention

All records supporting regulatory data submissions are retained for a minimum of five (5) years or longer if required by law.

V. Compliance Oversight

• The Skilled Services Manager oversees compliance with State and federal reporting requirements.

• ICS leadership reviews reporting compliance quarterly.

• Any reporting errors, delays or discrepancies are addressed immediately.

EXHIBIT 11- Letters of Collaboration

ANCILLARY SERVICES AGREEMENT

THIS ANCILLARY SERVICES AGREEMENT ("Agreement") is made and entered into this July 1, 2025 ("Effective Date") by and between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser") and Integrated Community Services, an S corporation organized under the laws of Washington D.C. ("Provider").

WHEREAS, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Health Plan") is a Maryland, Virginia and District of Columbia licensed health maintenance organization that provides or arranges for certain ancillary services to its enrollees by ancillary services providers, such as Provider, either directly or through its agreements with Kaiser Foundation Hospitals or the Mid-Atlantic Permanente Medical Group, P.C. ("MAPMG"); and

WHEREAS, Provider provides Ancillary Services (as defined herein) through its employees or contractors; and

WHEREAS, Kaiser and Provider mutually desire to enter into an agreement whereby Provider shall provide certain ancillary services to Members (as that term is defined herein).

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained and other good and valuable consideration, the parties hereto agree as follows:

1. **Definitions**

1.1. "**Ancillary Services**" means those health care services described on Appendix D that are (a) Covered Services and Medically Necessary (as those terms are defined herein), (b) customarily provided by Provider within the scope of Provider's licensure and/or certification, and expertise and (c) provided pursuant to a referral from a Referring Physician (as that term is defined herein) in compliance with the policies and procedures of Health Plan and/or MAPMG unless such Ancillary Services do not need a referral.

1.2. "**Covered Services**" means all medical and hospital services that are specifically included as covered benefits under the terms of the applicable Membership Agreement (as that term is defined herein).

1.3. "**Emergency**" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

1.4. "**Experimental or Investigational Services**" means those services which, at the time such service(s) is provided to a Member, (a) cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; (b) the service is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; (c) the service is subject to the approval or review of an Institutional Review Board of the treating facility that approves or reviews research concerning the safety, toxicity or efficacy of services; or, (d) the service is the subject of a written protocol used by the treating facility for research, clinical trials or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

1.5. "**Kaiser Permanente**" means Health Plan, KFH and MAPMG, and all of their officers, directors, and employees, and may refer to each entity severally or collectively.

24.3. **Compensation to Provider.** Provider shall be compensated for care provided pursuant to this Section 24 according to the terms of this Agreement, or as otherwise required by law.

25. **Products**

Kaiser will notify Provider of the addition of new products offered and administered by Kaiser Permanente or the elimination of existing products.

26. **Notices**

Unless expressly provided otherwise, all notices herein required to be given or which may be given, by any party to the other, shall be in writing and shall be deemed to have been fully given when personally delivered, with acknowledged receipt; sent by prepaid certified or registered mail, return receipt requested; by courier with signature confirming delivery; or by a nationally recognized overnight delivery service using delivery confirmation, and addressed as follows:

To Kaiser: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Health Plan Provider Contracting
4000 Garden City Drive
Hyattsville, MD 20785

To Provider: Integrated Community Services
Attention: Administrator
820 First Street, NE Suite #425
Washington, DC 20002

Any prior written notice required by this Agreement shall be deemed as given on the date of receipt.

27. **Nondiscrimination**

Provider will provide services to Members without discrimination as set forth in Section 2.7 (Non-Discrimination of this Agreement, or veteran's status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 ("ADA"). Provider recognizes that, as a governmental contractor, Kaiser may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to its subcontractors, including Provider. Provider, therefore, agrees that any and all applicable equal opportunity and affirmative action clauses shall be incorporated herein as required by federal laws, executive orders, and regulations including but not limited to the following:

The nondiscrimination and affirmative action clauses contained in: Executive Order 11246, as amended, and the implementing rules and regulations prescribed by the Secretary of Labor in Title 51, part 60 of the Code of Federal Regulations (CFR), relative to equal opportunity for all persons without regard to race, color, religion, sex or national origin (Federal Acquisition Regulation (FAR) at 48 CFR 52.222-26); the Rehabilitation Act of 1973, as amended, relative to the employment of qualified disabled individuals without discrimination based upon their physical or mental disabilities (FAR at 48 CFR 52.219-36); the Vietnam ERA Veterans' Readjustment Assistance Act of 1974, as amended relative to the employment of disabled veterans and veterans of the Vietnam Era (FAR at 48 CFR 52.222-35); and

The utilization of small, small disadvantaged, and women-owned small businesses clauses contained in the Small Business Act, as amended, relative to the utilization of small business concerns,

IN WITNESS WHEREOF, the parties have caused this Addendum to be executed by their authorized representatives.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

By: _____

Printed Name: _____

Title: _____

Date: _____

Integrated Community Services

By: _____

Printed Name: Joseph Marcus

Title: Administrator

Date: 05-20-2025

Tax ID: 05-0573124

By: Signed by: Emily Holliman _____

Printed Name: **Emily Holliman**

Title: Interim, President and COO

Date: 6/17/2025 | 8:28 AM PDT

Ancillary Provider Participation Agreement

This Agreement is entered into by and between UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of the Mid-Atlantic, Inc. and the other entities that are United's Affiliates (collectively referred to as "United") and INTEGRATED COMMUNITY SERVICES ("Facility").

This Agreement is effective on 1/1/2022 (the "Effective Date").

In the event this Agreement has not been executed timely in relationship to the Effective Date, no interest or penalty otherwise required under applicable law will be due on any claim which was initially processed timely and accurately, but which requires reprocessing as a result of the untimely execution.

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

United wishes to arrange to make Facility's services available to Customers. Facility wishes to provide those services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper or electronic format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Payment Policies** are the guidelines adopted by United for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in the Payment Appendix or Payment Appendices to this Agreement. The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Facility's services under this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

INTEGRATED COMMUNITY SERVICES as signed by its authorized representative:	**Address to be used for giving notice to Facility under this Agreement:**
Signature:	Street: 6323 GEORGIA AVE NW STE 305
Print Name: Joseph Morris	City: WASHINGTON
Title: Administrator	State: DC Zip Code: 20011
Date: 09/15/2021 Jan 28, 2022	Email: jmorris@icsprograms.com

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of the Mid-Atlantic, Inc. and its other affiliates, as signed by its authorized representative:

Signature:
Print Name: Karen Cain
Title: VP Network Management
Date: 09/15/2021

Address to be used for giving notice to United under this Agreement: Street: 9700 Health Care Lane MN017-E010 ATTN: National Ancillary VP City: Minnetonka State: MN Zip Code: 55343
For office use only: Contract number: 1858670 Month, day and year in which Agreement is first effective: 1/1/2022

Amerigroup

District of Columbia

Amerigroup DC
609 H St NE
Washington, DC 20002

8018

District of Columbia | Medicaid

June 2, 2025

8018
Integrated Community Svcs
820 1st St Ne Ste 425
Washington, DC 20002-9115

Subject: Amendment to Participating Provider Agreement for Amerigroup District of Columbia, Inc.

Dear Provider:

We are growing our Medicare Advantage network and would like you to join as a participating care provider. With your collaboration, we will expand our high-quality healthcare services into a Medicare Advantage program in 2026, followed by a Dual Eligible Special Needs Plan (D-SNP) in 2027. We welcome the opportunity for you to join us in continued excellence.

Reasons to join us:

- Our capacity to meet the unique needs of Medicare enrollees.
- No referrals needed for Medicare Advantage enrollees to visit participating specialists.
- Our convenient electronic claims submission and payment processing.
- Dedicated team of experienced professionals supporting our contracted care providers.
- Powerful web tools to simplify reporting and preapproval requests.

We're here to help:

- Grow your practice.
- Support your quality performance efforts.
- Keep your enrollees informed with educational materials and programs.
- Coordinate health and long-term care services with our care managers.

Partner with us today

This letter includes a contract amendment that will add the Medicare product to your Amerigroup DC portfolio. Your participation in the Medicare network will take effect as of the date defined in the attached Amendment. **If you agree with the terms of this Amendment, you are not required to sign or return any portion of the enclosed Amendment.**

If you object to the terms of this Amendment, please submit written notice to us within 30 days of this letter to AmerigroupContracts2020@amerigroup.com.

Except as expressly set forth herein, nothing contained herein shall be construed to modify the Agreement. To the extent this Amendment conflicts with any provision of the Agreement, this Amendment shall control.

Amerigroup warrants that it has full power and authority to enter into this Amendment and the person signing this Amendment on behalf of Amerigroup warrants that he/she has been duly authorized and empowered to enter into this Amendment.

THE EFFECTIVE DATE OF THIS AMENDMENT IS: January 1, 2026

Amerigroup District of Columbia, Inc.

By: _____ 6-2-2025

Signature, Authorized Representative of Amerigroup — Date

Printed: Salma Khaleq — Name

Vice President — Title

Address 2505 N. Hwy 360 — Street

Grand Prairie — City | TX — State | 75050 — Zip

MedStar Family Choice Ancillary Provider Participation Agreement

This MedStar Family Choice Ancillary Provider Participation Agreement (the "Agreement") is made and entered into as of **April 15, 2021** by and between **MedStar Family Choice, Inc.,** ("MedStar Family Choice"), and **Integrated Community Services, Inc.** ("Ancillary Provider").

WHEREAS, MedStar Family Choice arranges for the provision of Covered Services to its Members and provides or arranges for administrative services required to administer such health benefit plans; and

WHEREAS, MedStar Family Choice desires to contract with hospitals, physicians and other healthcare providers for the provision and delivery of Covered Services to Members; and

WHEREAS, Ancillary Provider agrees to provide or arrange for the provision of certain Covered Services to the Members of MedStar Family Choice upon the terms and conditions set forth below; and

NOW THEREFORE, in consideration for the mutual promises made in this Agreement, and for other good and valuable consideration, the parties agree as follows:

1.0 DEFINITIONS

For purposes of this Agreement, the following terms shall have the meanings set forth below:

1.1 **Ancillary Provider** when used generally, means a health care facility licensed under the laws of the State of Maryland, the District of Columbia or other state in which Ancillary Provider is located that provides Covered Services to Members. Ancillary Provider also refers to the Ancillary Provider indicated on the signature page as a party hereto.

1.2 **Approved Providers** means those health care providers and health care facilities which have been engaged by MedStar Family Choice to provide Covered Services to Members of MedStar Family Choice and whose names and addresses are contained on a list of Approved Providers which shall be updated and available to Physicians from time to time during the term of this Agreement.

1.3 **Clean Claim** means a claim for payment submitted to MedStar Family Choice with the data elements required under the applicable federal or State law or regulation and any attachments reasonably requested by MedStar Family Choice consistent with those applicable federal or State law or regulation. This term includes a claim for payment on a discounted or other fee-for-service basis for Covered Services which is filed with MedStar Family Choice or Payor, authorized under the terms of this Agreement, and prepared, delivered and supported in accordance with applicable state or federal regulations, and in accordance with protocols and procedures included herein and in MedStar Family Choice's policies and procedures, as amended from time to time. This term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

CONTRACT EXECUTION PAGE

In witness of the foregoing, the parties have executed this Agreement under their respective hands and seals as of the Effective Date:

DATE:

4/29/21

MEDSTAR FAMILY CHOICE, INC.

Lesley Wallace Digitally signed by Lesley Wallace Date: 2021.04.29 17:00:36 -04'00'

Lesley Wallace
VP Gov't Contract Management & Oversight

DATE:

4-20-2021

INTEGRATED COMMUNITY SERVICES, INC.

Signature

Sigal Morris, Administrator

Please Print Name & Title

Address:
6323 Georgia Avenue, NW, Suite 305

Washington, DC 20011

Federal Tax Identification Number:
05-0573124

Billing Address (if different from above):

NPI Number:
1407244304

W-9 Attached ☑

Ancillary Provider participates with the following products:
√ MEDSTAR FAMILY CHOICE DISTRICT OF COLUMBIA- District of Columbia Healthy Families and District of Columbia Healthcare Alliance

ANCILLARY PROVIDER PARTICIPATION AGREEMENT

BETWEEN

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC., CAREFIRST OF MARYLAND, INC. AND CAREFIRST BLUECHOICE, INC.

AND

Integrated Community Services

ANCILLARY PROVIDER PARTICIPATION AGREEMENT

Between

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC., CAREFIRST OF MARYLAND, INC. AND CAREFIRST BLUECHOICE, INC.

And

Integrated Community Services

THIS ANCILLARY PROVIDER PARTICIPATION AGREEMENT ("Agreement") is entered into by and between Group Hospitalization and Medical Services, Inc. ("GHMSI"), CareFirst of Maryland, Inc. ("CFMI") (both of which share the trade name CareFirst BlueCross BlueShield) and CareFirst BlueChoice, Inc. (collectively hereinafter referred to as "Corporation") and Integrated Community Services, (hereinafter referred to as "Provider"), for the provision of the services described herein. CFMI shall not be a party to an Agreement with a Virginia Provider. CareFirst BlueChoice, Inc. shall not be a party to an Agreement with any Provider not participating in CareFirst BlueChoice Provider Networks. Neither GHMSI nor CFMI shall be a party to an Agreement with any Provider participating only in CareFirst BlueChoice Provider Networks.

Corporation provides, insures, arranges for, or administers health benefits and related services to, individuals, employers, associations, health plan sponsors, health benefit payors and others, and contracts with Participating Providers (as defined below) in order to facilitate such services. Provider is duly licensed or otherwise authorized to provide or arrange for health care items and services to patients. The Parties desire for Provider to provide or arrange for Covered Services to Members, as those terms are defined below.

This Agreement and the applicable terms and conditions for participation in the Corporation's Networks in which Provider agrees to participate, as set out in Appendix A, attached hereto, as well as any other Attachments and/or Appendices, are collectively referred to herein as the "Agreement". Participation in each Provider Network is enforceable under the terms and conditions contained in the relevant Appendix A and, in the event of a conflict between the language of this Agreement and any section of Appendix A, the language of the relevant section of Appendix A will prevail.

PROVIDER HEREBY EXPRESSLY ACKNOWLEDGES Provider's understanding that this Agreement constitutes a contract between Provider and Corporation. Corporation is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, which permits Corporation to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, Maryland and portions of Virginia. Provider understands that Corporation is not contracting as an agent of the Association, and Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Corporation and that no person, entity or organization other than Corporation will be held accountable or liable to Provider for any of Corporation's obligations to Provider created under this Agreement. This paragraph will not create any additional obligations whatsoever on the part of Corporation other than those obligations created under other provisions of this Agreement.

IN CONSIDERATION of mutual covenants and promises stated herein and other good and valuable consideration, the undersigned have agreed to be bound by this Agreement as of October 1, 2025, the date set by Corporation as the effective date of the Agreement (hereinafter referred to as the "Effective Date").

I. DEFINITIONS

1.1 **COST SHARE, COINSURANCE, COPAYMENT AND DEDUCTIBLES** - If, pursuant to the terms of a Member's Health Benefit Plan, there is a shared liability and Corporation or a Third Party Payer does not pay one hundred percent (100%) of the allowance, it is the Member's responsibility to pay the remaining portion of the allowance ("Cost Share"). Although the terms of Health Benefit Plans vary, some call for shared proportional liability, (e.g., 80% of the allowance paid by Corporation and 20% owed by the

IN WITNESS WHEREOF, the Parties, through their duly authorized representatives, have signed this Agreement below in acknowledgment thereof.

PROVIDER		**CORPORATION**	
By:		By:	Brian R. Wheeler
Printed Name:	Joseph Morris	Printed Name:	Brian R. Wheeler
Address:	820 First Street NE #425 , Washington, DC 20002, USA	Title:	EVP, Health Services
Date:	08-06-2025	Date:	8/8/2025

Third AMENDMENT

TO THE

ANCILLARY SERVICES PROVIDER AGREEMENT

BETWEEN

INTERGRATED COMMUNITY SERVICES

AND AMERIHEALTH CARITAS DISTRICT OF COLUMBIA, INC.

This **Third** Amendment to Participating Ancillary Provider Agreement (this "Amendment") is entered into by and between **INTERGRATED COMMUNITY SERVICES**

and AmeriHealth Caritas District of Columbia, Inc. ("A.C.D.C.") and shall be effective **April 1, 2023**

WHEREAS, A.C.D.C. and Provider are parties to a Participating Ancillary Services Provider Agreement, which was effective as of **March 21, 2016** and as may have been amended from time to time (collectively, the "Agreement"); and ***First Amendment October 1, 2020 and Second Amendment January 1, 2022 and***

WHEREAS, A.C.D.C. and PROVIDER wish to amend the Agreement to reflect certain agreed-upon revisions.

NOW, THEREFORE, intending to be legally bound, and in consideration of the mutual promises contained in this Amendment, the parties agree as follows:

ARTICLE I. AMENDMENTS

1.1 Commencing on the Effective Date, AmeriHealth Caritas D.C. will compensate Provider for Covered Services under procedure **T1019-NP, T1004, T1000-TE, T1000-TD, G0299, G0300, G0153, G0152 and G0151** rendered by Provider to Medicaid enrollees in accordance with the terms of this Agreement at a rate of **100% of the published D.C. Medicaid Fee Schedule(s)** in effect on the date that the Covered Services were rendered, less applicable co-insurance and deductibles. In no event will AmeriHealth Caritas D.C.'s payment exceed Provider's charges.

ARTICILE II. MISCELLANEOUS PROVISIONS

2.1 Provider understands and agrees that the modifications to the Agreement made by this Amendment are the result of good-faith negotiations between A.C.D.C and Provider. Provider further agrees (i) to keep confidential this Amendment, which constitutes confidential and proprietary information, and (ii) not to disclose such confidential information to any person without the prior written consent of A.C.D.C.

2.2 Except as modified by this Amendment, the Agreement remains in full force and effect. Capitalized terms used in this Amendment, and not defined herein, have the meaning ascribed to them in the Agreement.

2.3 A signed copy of this Amendment transmitted by facsimile, email, or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original executed copy of this Amendment for all purposes. Each party agrees that this Amendment and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures appearing on this Amendment, or such other documents are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

[REMAINDER OF PAGE INTENTIONALLY BLANK; SIGNATURE PAGE FOLLOWS.]

IN WITNESS WHEREOF, intending to be legally bound, the parties hereto have caused this Agreement to be executed by their duly authorized representatives, which shall become effective April 1, 2023.

INTERGRATED COMMUNITY SERVICES	**AmeriHealth Caritas District of Columbia, Inc.**
Signature:	Signature:
Title: Administrator	Title:
Date: 6/12/2023	Date:

APPENDIX A-MA/ANCIL/PPO
MEDICARE ADVANTAGE PPO NETWORK

Provider shall provide Medically Necessary Covered Services to Members enrolled in MA Plans (as defined below) in accordance with the terms of the Agreement, this Appendix, the CMS Contract, the applicable Health Benefit Plan, the applicable Participating Provider Manual and the requirements of the Medicare Advantage program.

This Appendix is effective as of November 15, 2025.

1. **NETWORK OVERVIEW**

By virtue of Provider's participation in the Medicare Advantage PPO Network ("Network"), Provider agrees to accept certain allowances as payment in full for Covered Services furnished to Members. Provider agrees to provide services in accordance with the terms and conditions stated below, as well as those in the Agreement, and those applicable to each Member's Health Benefit Plan.

In the event of a conflict between the language of the Agreement and this Appendix with respect to Provider's participation in the Network, the language in this Appendix will prevail.

2. **ADDITIONAL DEFINITIONS**. For purposes of this Appendix, the following terms will have the below specified definitions. Otherwise, capitalized terms will have the meaning defined in the Agreement.

2.1. "CMS" means the Centers for Medicare and Medicaid Services - the agency within the Department of Health and Human Services that administers the Medicare program.

2.2. "CMS Contract" means the agreement between CMS and the Corporation pursuant to which the Corporation establishes one or more MA Plans for Members.

2.3. "MA Plan" means a Medicare Advantage Health Benefit Plan established or administered by Corporation.

2.4. "Medically Necessary," for purposes of determining medical necessity of services provided to Members in any MA Plan, means medical services that are determined by Corporation to be:

2.4.1. Rendered for the treatment or diagnosis of an injury or illness;

2.4.2. Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and

2.4.3. Not furnished primarily for the convenience of the Member, the attending physician or other provider of service.

Whether there is "sufficient scientific evidence" shall be determined by the Corporation based on the following: peer reviewed medical literature; publications; reports; evaluations and regulations issued by State and federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by the Corporation.

2.5. "Medicare" means the Medicare program established by Title XVIII of the federal Social Security Act, 42 U.S.C. § 1395 et seq. and any regulations promulgated thereunder.

2.6. "Medicare Advantage" is a health insurance plan established or administered by Corporation or a Corporation affiliate that provides coverage for Medicare enrollees within Part C of the Medicare program pursuant to a contract between CMS and the Corporation or affiliate.

2.7. "Member" means, for purposes of this Appendix, any Member as defined in the Agreement who is enrolled in an MA Plan.

2.8. "Preclusion List" means the list of individuals and entities compiled by CMS, as defined in 42 C.F.R. § 422.2 and as further described in 42 C.F.R. § 422.222.

3. **AGREEMENT SUBJECT TO REVIEW AND/OR APPROVAL.** The Agreement and this Appendix are subject to the review and/or approval of CMS, and if implemented prior to such review, the parties agree to incorporate into this Appendix any and all modifications required by CMS for approval or, alternatively, to terminate Provider's participation under this Appendix if so directed by CMS.

4. **MEDICARE PARTICIPATION.** Provider must participate in the Medicare program. Provider shall notify Corporation of any change in the Medicare program participation status of Provider in accordance with the notification terms of the Agreement.

5. **EXCLUDED INDIVIDUALS.** Provider shall not employ or contract with any individual excluded from participation in the Medicare program. Provider hereby represents and warrants that no such excluded person currently is employed by or under contract with Provider for the fulfillment of obligations hereunder. Provider must have a process in place to conduct review of its employees and any subcontractors against any and all applicable lists of excluded persons, including but not limited to the federal Excluded Parties List System, HHS Office of Inspector General List of Excluded Individuals/Entities and CMS's suspended providers list. Any person confirmed to be an excluded party must be terminated immediately upon confirmation and reported to the Corporation within one business day of termination.

6. **COMPLIANCE WITH LAW.** Provider acknowledges that payments for Covered Services rendered to Members are, in whole or in part, derived from federal funds and receipt of such payment is subject to all laws and regulations applicable to recipients of such funds. Therefore, Provider shall comply with all laws and regulations applicable to individuals and entities receiving federal funds and all other applicable federal and State laws and regulations, including, but not limited to, those laws and regulations governing participating in the Medicare Advantage and Special Needs Plan programs, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973, as well as their implementing regulations, all other laws and regulations governing the Medicare program, and all applicable CMS instructions.

7. **COOPERATION**

7.1. Provider shall cooperate with Corporation in furnishing an initial assessment of new Members' health care needs within ninety (90) days of enrollment in an MA Plan.

7.2. Provider shall cooperate with Corporation's procedures for identifying, assessing and establishing treatment plans for Members with complex or serious medical conditions. Such procedures are set forth in the applicable Participating Provider Manual.

7.3. Provider shall cooperate with all quality review and quality improvement activities required by CMS and/or Corporation.

7.4. Provider shall cooperate and comply with all Corporation and Medicare requirements regarding appeals of Members, including the obligation to provide information (including medical records and other patient information) to Corporation within the timeframe reasonably requested for such purpose.

7.5. Provider shall comply and cooperate with all Corporation and Medicare reporting requirements, including, but not limited to, statutory and regulatory reporting requirements such as reporting of encounter data.

8. **COLLECTION OF DATA.** When requested by Corporation or CMS, Provider shall participate in the collection and submission of data to CMS which shall include, but not be limited to: (a) inpatient hospital discharge data; (b) physician, outpatient hospital, skilled nursing facility and home health agency data; and (c) all other data deemed necessary by CMS. Where applicable, Provider shall certify the accuracy of the data collected and submitted under this section.

9. **CONTINUATION OF CARE.** Provider shall continue to provide or arrange for the provision of Covered Services to Members who are hospitalized on the date on which the CMS Contract or this Appendix terminates,

or in the event of the Corporation's insolvency, through the date of discharge of such Members. For all other Members, Provider shall continue to provide Covered Services to Members through the period for which CMS payments have been made for said Members. Such continuation of care shall be in accordance with the terms and conditions of the Agreement and this Appendix, including, but not limited to the rates set forth herein. This section shall survive the termination of the Agreement or this Appendix.

10. **MEDICAL RECORDS.** For any medical records or other health and enrollment information maintained by Provider with respect to Members enrolled in any MA Plan, Provider shall:

10.1. Safeguard the privacy of any information that identifies a particular Member and abide by all federal and State laws and regulations regarding confidentiality and disclosure of mental health records, medical records and all other protected health information. Information from or copies of records may be released only in accordance with federal and State laws and regulations governing such records and the information contained therein. Original medical and pharmaceutical records may be released only in accordance with federal or State laws, regulations, court orders or subpoenas;

10.2. Maintain Member records and information in an accurate and timely manner; and

10.3. Ensure timely access by Members to their own records and information in accordance with federal and State laws and regulations.

11. **RECORDS RETENTION AND INSPECTIONS.**

11.1. Provider recognizes and agrees that the United States Department of Health and Human Services (DHHS), the Comptroller General, or their designees may audit, evaluate or inspect any books, contracts, medical records, patient care documentation, and other records of Provider, its related entities, contractors, subcontractors or transferees, that pertain to any aspect of services performed, reconciliation of benefit liabilities, or determination of amounts payable under this Agreement for purposes of a MA Plan, or as the Secretary of DHHS may deem necessary. Provider shall make available their premises, physical facilities and equipment, records related to the provision of Covered Services, and any additional relevant information that DHHS may require.

11.2. CMS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit Corporation, Provider, and its contracted entities, for a period of ten (10) years after the final date of the contract period or the completion of an audit, whichever is later, unless: (a) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies Corporation or the Provider at least thirty (30) days before the normal disposition date; (b) there has been a termination, dispute, or fraud or similar fault by Corporation, Provider, or its contracted entities, in which case retention may be extended to ten (10) years from the date of any final resolution of the termination, dispute, or fraud or similar fault; or (c) CMS determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit Corporation, Provider, or its contracted entities, at any time. Provider shall therefore retain all contracts, books, documents, papers, and other records related to the provision of services to Members and/or as related to Provider's obligations under the Agreement and this Appendix for no less than such periods.

12. **COMPENSATION**

12.1. Compensation Rates. Payments to Provider, including any amounts owed by Members, will be based on one hundred percent (100%) of the applicable Medicare fee schedule in effect on the date of service. Corporation may revise the level of compensation by advising Provider in advance, in accordance with the Agreement.

12.2. General Terms. For purposes of any MA Plan, Provider shall not be entitled to accept or retain the above compensation during any period in which Provider is excluded or suspended from participation in the Medicare program or other government program. Notwithstanding any terms to the contrary, payment to Provider for Covered Services shall not exceed an amount equal to the lesser of Provider's billed charges or the applicable allowed amount for such Covered Services. As specified in Section 12.4 of this Appendix, Provider shall not balance bill Members.

12.3. Prompt Payment. Corporation shall pay Clean Claims submitted for the provision of Covered Services to Members within thirty (30) days of receipt of such Clean Claim. For interest paid under a Medicare Benefit Plan, the rate of interest shall be that set forth by the United States Secretary of the Treasury, as published in the Federal Register. For purposes of this Appendix, "Clean Claim" shall be defined as set forth in 42 C.F.R. § 422.500.

12.4. Member Non-Liability. Provider shall not, at any time, including insolvency of or non-payment by Corporation, hold any Member liable for payment of any fees that are the legal obligation of Corporation, and shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than Corporation for Covered Services provided by Provider for which payment is the legal obligation of Corporation. This provision shall not prohibit collection from Member for any non-covered service and/or Copayment, Coinsurance or Deductible in accordance with the terms of the applicable MA Plan. Provider agrees that: (i) this provision shall survive the expiration or termination of the Agreement and/or this Appendix regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of Provider.

12.5. Dual Eligible Members. Provider agrees that Members who are eligible for participation in both the Medicare and Medicaid programs will not be held liable for Medicare cost sharing (for example, Copayments) when the Medicaid program is responsible for paying such amounts. Provider may not impose cost-sharing on any Member that exceeds the cost-sharing that Provider would be permitted to impose with respect to that Member if that Member was not enrolled in the Medicaid program. Further, with respect to such Members, Provider agrees to: (i) accept the payment amount from Corporation as payment in full, or (ii) bill the appropriate State source.

12.6. Incentive Plans. Provider shall include in all contracts with other providers a description of all payment and incentive arrangements between such parties. Provider shall accurately disclose such payment and incentive arrangements to Corporation and CMS upon request and in the format requested. If any such arrangement results in Provider's being at substantial financial risk as defined by CMS, Provider must obtain either aggregate or per patient stop-loss insurance protection and comply with such other requirements governing physician incentive plans, as required by applicable law.

12.7 Specific Compensation Terms. Provider will be reimbursed according to the terms in 12.1 above accounting for any mandatory across-the-board adjustments required by the Budget Control Act of 2011 also known as sequestration.

12.8 Preclusion:

12.8.1 Provider agrees to immediately inform Corporation in the event that Provider becomes included on the Preclusion List.

12.8.2 In the event that Provider is included on the Preclusion List, Provider will not be eligible for payment from Corporation and will be prohibited from pursuing payment from any Member, following the 60-day period described in 42 C.F.R. § 422.222.

12.8.3 In the event that Provider is included on the Preclusion List, Provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after the 60-day period described in 42 C.F.R. § 422.222.

12.8.4 In the event that Provider is included on the Preclusion List, Corporation may immediately terminate this Appendix and Group's participation in the Network, upon notice to Provider.

13. **DELEGATION.** In the event that Corporation, pursuant to a separate agreement, delegates to Provider certain of Corporation's obligations under its CMS Contract, Provider shall perform such obligations as set forth in that other agreement and in accordance with all applicable laws, regulations and government policies and pronouncements. In the event that Corporation or CMS determines that Provider has not performed such delegated functions satisfactorily, or if has not met requisite reporting and disclosure requirements in a timely

manner, Corporation shall have the right, upon written notice to Provider, to revoke, in whole or in part, the delegated obligations as Corporation deems necessary.

In the event that Corporation delegates to the Provider the responsibility for selection and/or credentialing of providers, Corporation retains the right to approve, suspend or terminate any individual provider selected to be credentialed by the Provider. Provider's credentialing process shall be subject to review and approval by Corporation and Corporation shall have the right to audit such process from time to time as Corporation deems necessary and appropriate.

14. **AMENDMENT AND SEVERABILITY OF CONTRACTS.** In addition to the amendment procedures described in the Agreement, this Appendix may be amended upon request or mandate by CMS to comply with all relevant federal and State laws and regulations and government pronouncements. Additionally, this Appendix shall be amended to exclude any Medicare Benefit Plan or State-licensed entity specified by CMS.

15. **NOTICE OF CIVIL JUDGMENTS.** Provider shall report in writing to the Corporation within thirty (30) calendar days of the Provider's knowledge of any and all civil judgments and "other adjudicated actions or decisions" against Provider related to the delivery of any health care item or service (regardless of whether the civil judgment or other adjudicated action or decision is the subject of a pending appeal).

"Other adjudicated actions or decisions" means formal or official final actions taken against a health care provider by a federal or State government agency, which include the availability of a due process mechanism, and are based on some acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service. An action taken following adequate notice that meets the standards of due process set out in section 412(b) of the Health Care Quality Improvement Act (42 U.S.C. § 11112(b)) also would qualify as a reportable action under this definition. The fact that Provider elects not to use the due process mechanism provided by the authority bringing the action is immaterial, as long as such a process is available to the subject before the adjudicated action or decision is made final.

Provider shall comply with Corporation's policy regarding the reporting of all data required to be reported to the Health Care Integrity and Protection Data Bank, the National Practitioner Data Bank, or such other data repositories or organizations as Corporation may from time to time designate.

16. **PROGRAM INTEGRITY.** In accordance with 42 C.F.R. § 1001.952(m)(1)(i), Provider shall not claim payment in any form from CMS, another federal government agency or a State agency for items or services furnished in accordance with this Appendix except as approved by CMS, nor shall Provider otherwise shift the burden of such an agreement to the extent that Provider's claim increases payments from Medicare or a State health care program.

PROVIDER	CAREFIRST ADVANTAGE PPO, INC.
Print Name: Joseph Morris	By: Brian R. Wheeler
Signature:	Title: SVP, Health Services
Tax I.D. No.: 05-0573124	Signature:
Date: 10. 25- 2025	Date:

Cigna Healthcare
1640 Dallas Pkwy
Plano, TX 75093

Telephone: 800.244.6224
www.cignahealthcare.com

SINGLE CASE AGREEMENT

04 25 2025

Attn: Joe Morris
Integrated Community Services
820 First Street NE #425
Washington, DC 20002
Tax ID: **050573124**
NPI: **1407244304**

RE:
MEMBER ID#
AUTHORIZATION #
DATES OF SERVICE: 04/25/2025 - 10/25/2025

Dear **Integrated Community Services,**

Per your discussion with **Gayla Martin**, you have agreed to accept the following rate of payment for certain health care services to be provided to . As result, you are a Cigna participating provider with respect to such health care services provided to and the agreed upon reimbursement rate for such health care services shall be considered for reimbursement at the in-network benefit level under member's Open Access Plus benefit plan.

Service(s) Agreed upon rate:

Proc code / Modifiers	Unit Type: Visit	Billed Charge (per visit)	Total Billed Charge(s)	Allowed Amount (per visit)	Total Allowed Amount
G0299	10	$155.00	$1,550.00	$148.00	$1,480.00
G0151	20	$165.00	$3,300.00	$152.00	$3,040.00
G0152	20	$165.00	$3,300.00	$152.00	$3,040.00
Totals:			**$8,150.00**		**$7,560.00**

PLEASE FAX or E-MAIL TO: 855-890-0864 / ATTN: Gayla Martin, OR Gayla.Martin@CignaHealthcare.com

This Single Case Agreement (SCA) does not apply to any service other than those listed above. Any services other than those described herein must be authorized and a rate agreed upon in advance by Cigna in order to be considered at the in-network benefits level under the participant's benefit plan.

You shall accept as full and final payment for Services specified above, the lesser of billed charges or the reimbursement specified herein. This rate will be reduced by any applicable deductibles, copayments and/or coinsurance that You should collect from the participant and is subject to any applicable benefit plan limitations.

This SCA is based on the individual circumstances of the services for the claim underlying this SCA, and the parties agree that the rates agreed to in this SCA do not represent Cigna's view of fair market value, reasonable value, or the usual, customary, and reasonable rate for this claim or the types of services underlying the claim resolved through this SCA.

Payment pursuant to this SCA by Cigna (or other Payor, as applicable) will be subject to verification of the member's eligibility and coverage of the services according to the terms of the member's benefit plan at the time services are rendered. You may call member services number indicated on the member's identification card for more information. You will provide medical records as requested by Cigna pertaining to this service. Any deviation from the coding up to and including the procedure code, modifier, charge amount, and/or units negotiated will result in a delay in timely processing in accordance with this SCA.

You will abide by applicable federal and state laws and regulations including but not limited to the strict confidentiality of a Cigna member's identifiable information contained in any and all records regardless of medium utilized. You acknowledge that

medical and other relevant information may be considered strictly confidential. You will not release, disclose, distribute and/or otherwise disseminate or publish such member identifiable information received by you and report, if any, generated by you in a manner inconsistent with federal and state laws and regulations and only in accordance and related to the performance of your duties under this SCA.

You have agreed to accept this rate as payment in full for the service(s) described above and you will not seek payment from the participant or persons acting on the member's behalf for the services described in this Single Case Agreement or any additional services covered and authorized under the member's benefit plan. This provision shall not prohibit collection of applicable Copayments, Coinsurance or Deductibles in accordance with the terms of the member's benefit plan. You agree that this provision shall survive the termination of this SCA for described services and shall be construed in favor of the member. You agree that this provision supersedes any oral or written agreement now existing or hereafter entered into between you and Cigna with regard to this specific subject matter. You agree that you will never, under any circumstances, including Cigna's non-payment, insolvency, breach or termination of this SCA seek compensation from, have any recourse against or impose any additional charge on any eligible Cigna member for covered authorized services.

The relationship by and between Cigna and you established by this SCA is that of independent contractors and nothing contained in this SCA shall be construed to: a) constitute the parties as partners, joint ventures, co-owners or otherwise as participants in a joint or common undertaking; or b) allow either party to create or assume any obligation on behalf of the other party for any purpose whatsoever. All financial obligations associated with each party's business are the sole responsibility of that party. Employees and independent contractors of you will not be deemed to be employees of Cigna.

All claims arising under this SCA must be submitted within 90 days of the date of service or you will forego your right to collect for these services from any party, including the member.

You agree to cooperate with Cigna's medical management, discharge planning and quality assurance programs; with any Cigna dispute resolution and appeals process; and with any subrogation activities applicable to the member(s).

You agree to obtain and maintain during the effective period hereof, a policy or policies of professional malpractice insurance insuring you and your employees against any and all liabilities or claims for damages arising from or relating to personal injury or death occasioned directly or indirectly in connection with the performance of the services rendered by you and under this SCA. You shall maintain adequate professional liability insurance coverage. You shall notify Cigna immediately of any and all changes in or cancellation of insurance coverage during the term of this SCA.

Neither party shall transfer or assign directly or indirectly by operation of law or otherwise, this SCA or its rights and obligations hereunder without the prior written consent of the other party. Subject to the foregoing, this SCA shall be binding upon and inure to the benefit of the parties and their successors and assigns.

If all or part of any term or provision hereof is illegal or invalid for any reason whatsoever, the validity of the remaining provisions will not be affected, provided that the expected economic benefits of such remaining provisions shall not be denied to either party.

This SCA is effective on the date it is signed by both parties and may be modified or terminated only by written agreement signed by both parties.

Thank you for this opportunity to be of service to Cigna's member(s).

Cigna Healthcare
1640 Dallas Pkwy
Plano, TX 75093

Christina Hayward
AVP, National Contracting &
Nonpar Network Management
Cigna Healthcare

Date

Integrated Community Services
820 First Street NE #425
Washington, DC 20002

SIGNATURE

PRINT NAME Joseph Adams

PRINT TITLE Administrator

4-25-25

Date

Integrated Community Services (ICS), Inc.

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

Signature: _____
Name: Joseph Morris
Title: Administrator
Date:3/3/2026