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January 31, 2026

VIA EMAIL & FEDERAL EXPRESS MAIL

Ms. Deanna Dunn

Health Facilities Coordination Officer

Maryland Health Care Commission

4160 Patterson Avenue

Baltimore, Maryland 21215-2299

Re: Quality One Care Home Health, Inc., Responses to Completeness Questions dated 12-16-2025 to Establish a Home Health Agency in Baltimore City, Baltimore County, and Howard County (The Region)
Matter # 25-R2-2476, Baltimore City
Matter # 25-R2-2477, Baltimore County
Matter # 25-R2-2478, Howard County

Dear Ms. Dunn:

On behalf of Quality One Care Home Health, Inc., (QOC), we are submitting an electronic version, and four (4) hard copies of its Responses to Completeness Questions dated December 16, 2025, and related exhibits. We will be providing a WORD version of the responses and an updated EXCEL file of the MHCC tables under separate email.

We hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency as noted below.

If you have questions about the information provided above, please contact us at your convenience.

Sincerely,

Amon Chafukira

Program Coordinator

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Certificate of Need to Establish a Home Health Agency in Baltimore City, Baltimore County, and Howard County

Responses to Completeness Review Questions Dated December 16, 2025

Part I: Project Identification and General Information

- 1. Please clarify the project description in response to item #11 focusing on explaining the HHA services that are planned to be offered. It seems you are describing that your current RSA Level Three license (Quality One Care Home Health, Inc.) will expand to also be providing HHA services?**

Applicant Response – Completeness Question #1

Quality One Care Home Health, Inc. (QOC) clarifies that while it currently operates as a Maryland-licensed Residential Service Agency (RSA License No. R3057), this project seeks Certificate of Need approval to **establish a new, separately licensed, Medicare-certified Home Health Agency (HHA)** pursuant to COMAR 10.24.16.06(B)(3). This project **does not represent an expansion, conversion, or modification** of the existing RSA license.

Although the proposed HHA will be operated by the same parent corporation, it will function as a **distinct licensed and regulated entity**, subject to separate state licensure and Medicare certification requirements. The existing RSA will continue to operate independently under its current license and approved scope of services.

The proposed HHA will provide the full array of Medicare-covered core home health services, including:

- Skilled Nursing Services (e.g., wound care, medication management, disease management)
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Medical Social Services
- Home Health Aide Services

These services will address the intermittent skilled care needs of patients who require interdisciplinary home health services delivered under physician orders and coordinated through a plan of care, in accordance with the Medicare Conditions of Participation at 42 CFR Part 484.

This scope of care is distinct from the supportive and non-Medicare services provided under the RSA license. The proposed HHA will focus on post-acute, rehabilitative, and medically necessary skilled services reimbursed

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primarily through Medicare and Medicaid, while the RSA will continue to deliver non-Medicare home-based services within its existing regulatory framework.

2. Please review the organization chart in exhibit one for the proposed new HHA, Quality One Care Home Health, Inc. (QOC), and explain how the HHA organizational chart relates to the existing Quality One Care RSA.

Applicant Response – Completeness Question #2

Quality One Care Home Health, Inc. (the Applicant) clarifies that the organizational chart provided in **Exhibit 1** reflects the structure of the proposed Medicare-certified Home Health Agency (HHA) only and does not depict a combined or consolidated organizational chart for both the HHA and the existing Residential Service Agency (RSA).

While both the existing Residential Service Agency (RSA License No. R3057) and the proposed HHA operate under the same parent corporate entity, they are organized as **distinct functional divisions** to ensure full clinical, administrative, and regulatory compliance with their respective licensure and oversight requirements.

The relationship between the HHA organizational chart and the existing RSA is as follows:

- **Shared Governance:** Both entities report to the same Board of Directors and executive leadership, providing unified corporate governance, strategic direction, and oversight, while maintaining appropriate separation at the operational and licensure levels.
- **Distinct Clinical Leadership:** The proposed HHA will maintain its own dedicated clinical leadership, including an Administrator and Director of Nursing (or equivalent clinical director role), who will be responsible for oversight of HHA operations and compliance with the Medicare Conditions of Participation at 42 CFR Part 484. These roles are separate and distinct from the clinical management and supervision structure of the RSA.
- **Operational Integration with Separation of Services:** Although the HHA will be separately licensed, QOC may utilize certain shared administrative resources, such as human resources, finance, compliance support, and information systems, to promote operational efficiency and financial stability. Clinical operations, service delivery, staff supervision, patient records, documentation, and billing will be maintained separately for the RSA and the HHA to ensure clear regulatory distinction and compliance.

Accordingly, Exhibit 1- HHA organizational chart, demonstrates QOC's ability to leverage its established corporate infrastructure while maintaining clear separation of licensure, clinical oversight, and service delivery between the existing RSA and the proposed Medicare-certified HHA.

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- 3. If it is the same chart as for the RSA, explain how QOC will manage the new services to be provided as a new home health agency. Verify if the same nursing personnel, administrative staff will be used for both organizations.**

Applicant Response – Completeness Question #3

Quality One Care Home Health, Inc. (the Applicant) clarifies that while the proposed Home Health Agency (HHA) will leverage QOC's established corporate infrastructure, it will maintain **clear regulatory and operational separation** from the existing Residential Service Agency (RSA), in accordance with Maryland licensure requirements and the Medicare Conditions of Participation. The organizational chart provided in Exhibit 1 reflects the HHA structure and is **not the same chart used for RSA operations**.

Management of New HHA Services

The proposed HHA will be managed as a distinct clinical division. As described in the response to Completeness Question #2, the HHA will have its own dedicated Administrator and Director of Nursing (DON), who will be responsible for HHA operations, clinical oversight, and compliance with the Medicare Conditions of Participation (42 CFR Part 484). These leaders will ensure adherence to HHA-specific requirements, including OASIS assessments, interdisciplinary care planning, physician orders, quality reporting, and Medicare-compliant clinical documentation.

Staffing Verification

- **Administrative Staff:** QOC will utilize a shared-services model for limited back-office administrative functions, including human resources, finance/payroll, and IT support. Administrative functions specific to Medicare HHA operations, such as Medicare billing, OASIS data submission, quality reporting, and survey readiness, will be performed by staff dedicated to the HHA or by personnel whose time, responsibilities, and costs are clearly allocated to the HHA through documented internal controls.
- **Nursing and Clinical Personnel:** To ensure clinical and regulatory integrity, QOC will maintain separate clinical staffing pools for the HHA and the RSA:
 - **HHA Clinical Staff:** The HHA will employ a dedicated core clinical team, including registered nurses, therapists, and home health aides, who are trained in Medicare home health standards and supervised under HHA-specific clinical leadership.
 - **RSA Clinical Staff:** Existing RSA staff will continue to provide supportive and non-Medicare services under the RSA license (License No. R3057).
- **Cross-Utilization Controls:** While certain clinicians may be credentialed to work for both entities, QOC will treat any cross-utilization as limited and controlled. The Applicant will implement strict internal controls, including time-tracking, payroll allocation, cost-center designation, and supervisory

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documentation, to ensure that staff time, services, and costs are accurately assigned and fully compliant with the applicable license under which services are rendered.

This management and staffing structure ensures that HHA patients receive care that fully meets Medicare's skilled nursing and rehabilitative standards, while maintaining a clear separation from the RSA's supportive care model and preventing any commingling of clinical, financial, or regulatory responsibilities.

4. Your application states "QOC's transition from an RSA to a Medicare-certified Home Health Agency aligns its payer participation with Maryland's demonstrated utilization patterns and ensures broad financial accessibility." (Table B-2D), The RSA and HHA will be two separately licensed entities, define what you mean by transition?

Applicant Response – Completeness Question #4

Quality One Care Home Health, Inc. (the Applicant) clarifies that the term "transition," as used in the application, **does not refer to a legal conversion, modification, or replacement** of the existing Residential Service Agency (RSA) license. The RSA and the proposed Home Health Agency (HHA) will remain **separately licensed, certified, and regulated entities**.

The term "transition" was intended solely to describe QOC's **strategic expansion/entrance** into Medicare-certified home health services, building upon its existing experience in delivering home-based care. Specifically, QOC proposes to establish a new Medicare-certified HHA that **complements, rather than replaces**, the services currently provided under the RSA license.

Through the establishment of the HHA, QOC will expand its service offerings to include Medicare-covered skilled nursing, therapy, and interdisciplinary home health services for patients whose care needs fall within the Medicare home health benefit.

This expansion aligns QOC's overall payer participation with Maryland's demonstrated home health utilization patterns, where Medicare is the predominant payer, while preserving the RSA's role in providing supportive and non-Medicare home-based services.

Accordingly, the RSA will continue to operate independently under its current license (License No. R3057) and approved scope of services, and the proposed HHA will operate as a distinct program with separate licensure, certification, billing, and regulatory oversight.

This clarification confirms that the project involves the **establishment of a new Medicare-certified Home Health Agency**, not a transition of licensure from RSA to HHA.

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5. Please describe in detail the time frame for becoming licensed and certified and compliance with the 18-month time frame required by COMAR 10.24.01.12C.(1)(d).

Applicant Response – Completeness Question #5

Quality One Care Home Health, Inc. (the Applicant) commits to achieving full licensure and certification of the proposed Home Health Agency (HHA) **within the 18-month timeframe required by COMAR 10.24.01.12C(1)(d)**. As the proposed project does not involve construction or renovation, the 18-month implementation period will begin upon issuance of the Certificate of Need (CON).

Because the HHA represents a new service line for an existing corporation with an established office, administrative infrastructure, and operational systems, the Applicant anticipates an efficient and controlled implementation process with no construction-related or facility-based delays. Upon CON approval, QOC proposes the following implementation timeline:

Months 1–3: Post-CON Administrative Setup and Recruitment

- Finalize HHA-specific policies and procedures
- Recruit and onboard the dedicated HHA Administrator and Director of Nursing
- Execute contracts for supplemental therapy services (Physical Therapy, Occupational Therapy, Speech-Language Pathology) and Medical Social Work

Months 4–6: State Licensure Application

- Submit the Maryland Home Health Agency licensure application to the Office of Health Care Quality (OHCQ)
- Finalize IT and Electronic Health Record (EHR) configurations to support OASIS data collection, quality reporting, and Medicare billing

Months 7–10: Staff Training and Initial Patient Admissions

- Complete Medicare-specific orientation and training for the core HHA clinical team
- Admit initial non-Medicare patients, as permitted, to establish the required caseload for the Medicare certification survey

Months 11–14: Medicare Certification

- Submit the CMS-855A Medicare enrollment application
- Undergo the initial Medicare certification survey conducted by OHCQ or an approved accrediting organization
- Address any survey findings and receive the Medicare Provider Agreement

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Months 15–18: Full Operational Status

- Commence full Medicare-certified and Medicaid-certified HHA operations serving Baltimore City, Baltimore County, and Howard County
- Achieve “completed and in operation” status as defined by COMAR 10.24.01.12C(1)(d)

Summary of Compliance

The Applicant anticipates achieving full Medicare-certified operational status within approximately **15 to 16 months** of CON approval, providing a conservative buffer to ensure full compliance with the 18-month regulatory requirement. Based on QOC’s existing infrastructure and regulatory experience as a licensed RSA, the Applicant does not anticipate any impediments to meeting this timeframe.

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Part II – Consistency with Review Criteria at COMAR 10.24.01.08G(3)

10.24.01.08G(3)(a). “The State Health Plan” Review Criterion

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria. (Note: HHA CON review standards are found in COMAR 10.24.16.08).

Note: 10.24.16.05B states, “Jurisdictions with a total population size of 300,000 or more will not be combined with other jurisdictions to create regional service areas.” As a result, all jurisdictional information must be submitted in a way that stands alone and not combined into one population.

Populations and Services

- 6. Please describe how the four new services—Physical Therapy Occupational Therapy, Speech Therapy, and Medical Social Services—in addition to the two existing services of the RSA [nursing and home health aides] will be implemented and integrated to provide quality client care.**

Applicant Response – Completeness Question #6

Quality One Care Home Health, Inc. (the Applicant) will implement and integrate the proposed Home Health Agency (HHA) services through an interdisciplinary, patient-centered care model that complies with the Medicare Conditions of Participation at 42 CFR Part 484 and applicable State Health Plan standards. The proposed HHA services, (Physical Therapy, Occupational Therapy, Speech-Language Pathology, and Medical Social Services), will be delivered in coordination with skilled nursing and home health aide services to ensure comprehensive, high-quality care.

Patients will be referred to the HHA by hospitals, physicians, discharge planners, and community providers, and services will be initiated following physician orders and a comprehensive start-of-care assessment conducted by skilled nursing staff.

Interdisciplinary Care Planning and Oversight

All HHA patients will be admitted under a physician’s order and served pursuant to an individualized Plan of Care. Upon admission, a registered nurse will conduct a comprehensive assessment, including required OASIS evaluations, to identify clinical, functional, rehabilitative, and psychosocial needs. Based on this assessment, appropriate therapy and medical social services will be initiated and coordinated through an interdisciplinary team.

The HHA’s interdisciplinary team will include skilled nursing staff, physical therapists, occupational therapists, speech-language pathologists, medical social workers, and home health aides, as applicable. The team will meet

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regularly, under the oversight of the HHA Director of Nursing, to coordinate care, monitor patient progress, and revise the Plan of Care as needed.

Implementation of New HHA Services

- **Physical Therapy (PT):** Physical therapy services will focus on restoring mobility, improving strength and balance, reducing fall risk, and supporting post-acute recovery following hospitalization or illness. Physical therapists will coordinate closely with skilled nursing staff and home health aides to reinforce mobility goals and ensure safe functional outcomes in the home environment.
- **Occupational Therapy (OT):** Occupational therapy services will address activities of daily living (ADLs), functional independence, home safety, and adaptive strategies. Occupational therapists will collaborate with nursing staff and home health aides to implement care plans that promote patient independence and reduce the risk of injury or rehospitalization.
- **Speech-Language Pathology (SLP):** Speech therapy services will be provided to patients with speech, language, cognitive, or swallowing disorders. Speech-language pathologists will coordinate with nursing staff to manage dysphagia, communication deficits, and cognitive impairments that may affect medication management, nutrition, and overall safety.
- **Medical Social Services (MSW):** Medical social services will support patients and families by addressing psychosocial needs, care coordination, and access to community resources. Medical social workers will assist with care transitions, advance care planning, caregiver support, and linkage to social services, working collaboratively with the clinical team to address social determinants of health that may impact outcomes.

Integration with Skilled Nursing and Home Health Aide Services

Skilled nursing services will serve as the clinical foundation of care, providing ongoing assessment, medication management, disease monitoring, patient education, and coordination of interdisciplinary services. Home health aide services will be provided under nursing supervision to support personal care needs and reinforce therapeutic and safety goals established by the interdisciplinary team.

While the existing RSA provides supportive, non-Medicare home-based services, the proposed HHA will deliver these services within a Medicare-certified framework that emphasizes interdisciplinary coordination, physician oversight, outcome monitoring, and quality improvement.

Quality Assurance and Continuity of Care

The integration of services will be supported through standardized clinical protocols, shared electronic health records, regular interdisciplinary communication, and the HHA's Quality Assessment and Performance Improvement (QAPI) program. This structure ensures that all services are coordinated, patient-centered, and

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responsive to changes in patient condition, thereby promoting quality outcomes, reducing avoidable hospitalizations, and improving patient satisfaction.

The interdisciplinary team will place particular emphasis on care transitions following hospitalization or skilled nursing facility discharge to reduce avoidable readmissions and support safe recovery in the home. Services will be delivered in a culturally and linguistically appropriate manner, with staff training and interpreter resources utilized as needed to ensure effective communication and patient engagement.

7. Describe in detail how the new services will meet the needs of each jurisdiction.

Applicant Response – Completeness Question #7

Quality One Care Home Health, Inc. (the Applicant) proposes to deliver Physical Therapy, Occupational Therapy, Speech-Language Pathology, Medical Social Services, skilled nursing, and home health aide services in a manner that responds to the distinct demographic trends, utilization patterns, and care needs of Baltimore City, Baltimore County, and Howard County, consistent with COMAR 10.24.16.05B, which requires that each jurisdiction be evaluated independently.

The Applicant's service model is grounded in Maryland Health Care Commission (MHCC) utilization data and Maryland Department of Planning (MDP) demographic projections, which demonstrate that demand for home health services is driven primarily by the rapid growth of the senior population and the predominance of Medicare-financed care.

BALTIMORE CITY NEED

Baltimore City exhibits substantial home health utilization driven by a high concentration of older adults and medically complex residents who rely on skilled, home-based services following hospitalization and during periods of chronic disease instability.

Demographic projections show that the population aged 65 and older is increasing at a rate far exceeding overall population growth, a trend that directly correlates with increased home health demand (CON Application: Tables B-2A and B-2B).

MHCC FY 2023 utilization data (MHCC Table 15) further demonstrate that older adults account for the majority of home health clients in the service area, with individuals aged 65 and older representing nearly four out of every five home health users (CON Application: Table B-2C).

These patterns support the need for expanded access to skilled nursing, rehabilitative therapies, and medical social services within Baltimore City.

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The proposed HHA will meet Baltimore City's needs by providing:

- **Skilled nursing services** focused on chronic disease management, wound care, medication oversight, and post-acute recovery
- **Physical and occupational therapy services** to address functional decline, fall risk, and safe performance of activities of daily living in the home
- **Speech-language pathology services** for residents with stroke-related deficits, cognitive impairment, and swallowing disorders
- **Medical social services** to address psychosocial needs, care transitions, and access to community-based resources, including support for residents facing socioeconomic barriers.

These services will be delivered through an interdisciplinary, physician-directed model that emphasizes care coordination and reduces avoidable hospital utilization, consistent with the demonstrated utilization patterns reflected in MHCC data for Baltimore City.

BALTIMORE COUNTY NEED

Baltimore County has a large and aging population with sustained demand for post-acute and rehabilitative home health services. Population projections show steady growth in the 65-and-older cohort, while younger age groups remain stable or decline, indicating a continued shift toward higher-acuity home health needs (CON Application: Tables B-2A and B-2B).

MHCC utilization data (MHCC Table 15) indicate significant use of skilled nursing and therapy services among Baltimore County residents, particularly following hospital and skilled nursing facility discharge, reflecting reliance on home health as a key component of recovery and care continuity (CON Application: Table B-2C).

The proposed HHA will meet Baltimore County's needs by providing:

- **Post-acute skilled nursing and therapy services** to support recovery from hospitalization, surgery, and serious illness
- **Physical and occupational therapy** focused on mobility, strength, balance, and functional independence to prevent institutionalization
- **Speech-language pathology services** for cognitive, communication, and swallowing impairments
- **Medical social services** to assist patients and caregivers with care coordination, discharge planning, and linkage to supportive services.

By expanding Medicare-certified home health capacity, the proposed HHA will enhance access to timely, coordinated services across a geographically diverse jurisdiction and support safe transitions from acute and post-acute settings into the home.

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HOWARD COUNTY NEED

Howard County is characterized by a growing senior population and increasing reliance on home-based services that support aging in place, chronic disease management, and rehabilitative care. Demographic projections show consistent growth in the population aged 65 and older, a trend that is closely associated with increased utilization of skilled home health services (CON Application: Tables B-2A and B-2B).

MHCC FY 2023 data demonstrate meaningful utilization of home health services among Howard County residents, particularly among older adults requiring skilled nursing and therapy services in the home (CON Application: Table B-2C). These utilization patterns support the need for additional Medicare-certified home health capacity to meet current and future demand.

The proposed HHA will meet Howard County's needs by providing:

- **Skilled nursing services** focused on disease management, medication oversight, and patient education
- **Therapy services (PT, OT, and SLP)** to address functional decline, cognitive impairment, and rehabilitative needs
- **Medical social services** to support care coordination, advance care planning, and access to community-based resources

This service mix will support Howard County's emphasis on community-based care alternatives and enable older adults to remain safely in their homes.

Alignment with Utilization and Payer Patterns

Across all three jurisdictions, MHCC data demonstrate that home health utilization is overwhelmingly concentrated among older adults and financed primarily through Medicare. Nearly 70 – 72 percent of home health discharges statewide are Medicare-covered, with Medicaid representing the second-largest payer group (CON Application: Table B-2D). These payer patterns closely align with the age distribution of home health users reflected in the CON Application's Table B-2C.

By establishing a Medicare-certified Home Health Agency that also participates in Medicaid, the Applicant will align its services with Maryland's demonstrated utilization and payer patterns, ensuring broad financial accessibility for older adults, low-income individuals, and medically complex patients.

In conclusion, the proposed Home Health Agency in each jurisdiction (Baltimore City, Baltimore County, and Howard County) will address clearly documented demographic trends and utilization patterns by expanding access to skilled nursing, rehabilitative therapies, and medical social services delivered through an interdisciplinary, physician-directed model. The Applicant's services are specifically designed to meet the needs of aging populations, support safe hospital discharge, reduce avoidable readmissions, and promote aging in place, consistent with MHCC data and Maryland's State Health Plan goals for home health services.

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8. Provide the information in Tables B-2A, 2B, 2C, by jurisdiction, and not combined. Provide responses regarding the demographic information, which is reflective of each jurisdiction, and not the combined area.

Applicant Response – Completeness Question #8

Quality One Care Home Health, Inc. (QOC) acknowledges MHCC’s clarification regarding the distinction between a “**jurisdiction**” and a “**region**,” as outlined in MHCC’s pre-application guidance and follow-up correspondence. A jurisdiction refers to an individual county or Baltimore City, while a region is a multi-jurisdictional service area composed only of jurisdictions with populations under 300,000. Therefore, because **Baltimore City, Baltimore County, and Howard County each exceed 300,000 residents**, they must be evaluated **independently and not combined**, consistent with **COMAR 10.24.16.05B**.

QOC recognizes that the originally submitted Tables **B-2A, B-2B, and B-2C reflected combined, regional data** and therefore did not fully satisfy MHCC’s jurisdiction-specific reporting requirement. Accordingly, the Applicant has **revised and replaced** these tables with **jurisdiction-specific versions**, presenting demographic and utilization information **separately for Baltimore City, Baltimore County, and Howard County**. These jurisdiction-specific tables are submitted as **replacements** for the previously combined Tables B-2A, B-2B, and B-2C.

Data sources used for the jurisdiction-specific tables

- **Tables B-2A and B-2B (Population projections):** Maryland Department of Planning population projections (See Exhibit: Maryland Department of Planning Population Projections).
- **Table B-2C (Home health clients by age):** MHCC FY 2023 Home Health Agency Annual Survey detailed tables – **Table 15** (jurisdiction of residence by age group).

BALTIMORE CITY

Table B-2A (Baltimore City) – Population by Age Cohort (2020–2035)

Year	0–19	20–44	45–64	65+	Total Population
2020	129,700	234,535	136,313	85,155	585,703
2025	125,077	229,652	124,041	90,758	569,528
2030	123,350	226,866	124,582	96,515	571,313
2035	120,351	218,635	137,394	95,439	571,819

Source: Maryland Department of Planning. Population Projections by Age Cohort for Maryland Jurisdictions, 2015–2035 (Revised 2024).

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Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>**BALTIMORE CITY****Table B-2B – Percent Change in Population by Age Cohort**

Age Cohort	2020–2025	2025–2030	2030–2035	2020–2035 Total
0–19	-3.60%	-1.40%	-2.40%	-7.20%
20–44	-2.10%	-1.20%	-3.60%	-6.80%
45–64	-9.00%	0.40%	10.30%	0.80%
65+	6.60%	6.30%	-1.10%	12.10%
Total	-2.80%	0.30%	0.10%	-2.40%

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

Table B-2C (Baltimore City) – Home Health Clients by Age Group (FY 2023)

Age Group	Clients	Percent of Jurisdiction Total
Under 1 yr.	226	0.018
1–4 yrs.	68	0.005
5–14 yrs.	54	0.004
15–24 yrs.	76	0.006
25–44 yrs.	443	0.035
45–64 yrs.	2206	0.176
65–74 yrs.	3768	0.301
75–84 yrs.	3334	0.266
85+ yrs.	2330	0.186
Unknown	6	0
Total	12,511	1

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

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Baltimore City Analysis:

Baltimore City’s demographic profile shows a substantial and growing **65+ population** over the projection period, with corresponding implications for demand for skilled nursing, therapy, and medical social services delivered in the home. MHCC utilization (FY 2023) also shows that the majority of home health clients in Baltimore City are **age 65+**, supporting the need for Medicare-certified home health capacity targeted to older adults and medically complex patients.

BALTIMORE COUNTY

Table B-2A (Baltimore County) – Population by Age Cohort (2020–2035)

Year	0–19	20–44	45–64	65+	Total Population
2020	210,316	275,693	217,589	150,940	854,538
2025	204,363	274,085	205,312	170,361	854,121
2030	198,521	274,620	202,880	186,571	862,592
2035	199,935	275,328	209,390	195,452	880,105

Source: Maryland Department of Planning. Population Projections by Age Cohort for Maryland Jurisdictions, 2015–2035 (Revised 2024).

Table B-2B (Baltimore County) – Percent Change in Population by Age Cohort

Age Cohort	2020–2025	2025–2030	2030–2035	2020–2035 Total
0–19	-2.80%	-2.90%	0.70%	-4.90%
20–44	-0.60%	0.20%	0.30%	-0.10%
45–64	-5.60%	-1.20%	3.20%	-3.80%
65+	12.90%	9.50%	4.80%	29.50%
Total	0.00%	1.00%	2.00%	3.00%

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

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Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>**BALTIMORE COUNTY****Table B-2C (Baltimore County) – Home Health Clients by Age Group (FY 2023)**

Age Group	Clients	Percent of Jurisdiction Total
Under 1 yr.	229	1.10%
1–4 yrs.	175	0.80%
5–14 yrs.	87	0.40%
15–24 yrs.	104	0.50%
25–44 yrs.	486	2.30%
45–64 yrs.	2,884	13.40%
65–74 yrs.	5,262	24.50%
75–84 yrs.	6,628	30.90%
85+ yrs.	5,593	26.10%
Unknown	8	0.00%
Total	21,456	100%

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

Baltimore County Analysis:

Baltimore County’s projections show pronounced growth in the **65+ cohort** through 2035, which aligns with MHCC FY 2023 utilization showing that most home health clients are older adults (especially ages 65–84 and 85+). This demographic and utilization pattern supports demand for skilled nursing, rehabilitation therapies, and care coordination to prevent avoidable hospitalization and support aging-in-place for County residents.

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Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>**HOWARD COUNTY****Table B-2A (Howard County) – Population by Age Cohort (2020–2035)**

Year	0–19	20–44	45–64	65+	Total Population
2020	88,917	105,601	90,154	47,649	332,321
2025	86,255	109,015	91,500	58,930	345,700
2030	84,024	112,294	92,233	70,447	358,998
2035	86,339	112,313	96,124	81,050	375,826

Source: Maryland Department of Planning. Population Projections by Age Cohort for Maryland Jurisdictions, 2015–2035 (Revised 2024).

Table B-2B (Howard County) – Percent Change in Population by Age Cohort

Age Cohort	2020–2025	2025–2030	2030–2035	2020–2035 Total
0–19	-3.00%	-2.60%	2.80%	-2.90%
20–44	3.20%	3.00%	0.00%	6.40%
45–64	1.50%	0.80%	4.20%	6.60%
65+	23.70%	19.50%	15.00%	70.10%
Total	4.00%	3.80%	4.70%	13.10%

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

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Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>**HOWARD COUNTY****Table B-2C (Howard County) – Home Health Clients by Age Group (FY 2023) (MHCC Table 15)**

Age Group	Clients	Percent of Jurisdiction Total
Under 1 yr.	47	0.80%
1–4 yrs.	18	0.30%
5–14 yrs.	18	0.30%
15–24 yrs.	30	0.50%
25–44 yrs.	106	1.80%
45–64 yrs.	649	11.20%
65–74 yrs.	1,249	21.50%
75–84 yrs.	2,089	36.00%
85+ yrs.	1,603	27.60%
Unknown	2	0.00%
Total	5,811	100%

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

Howard County Analysis:

Howard County’s projections show especially rapid growth in the **65+ cohort** through 2035, and MHCC FY 2023 utilization shows that Howard County home health clients are predominantly seniors (65–84 and 85+). This supports the need for Medicare-certified interdisciplinary home health services (skilled nursing, PT/OT/ST, and medical social services) focused on post-acute transitions, chronic disease management, functional improvement, and caregiver support.

These jurisdiction-specific tables are provided to replace the previously combined tri-jurisdiction presentation, and to ensure that demographic and utilization reporting is consistent with MHCC’s jurisdiction-level review expectations.



Revised Table B-2A – Population by Age Cohort (By Jurisdiction)

Revised Table B-2A presents **separate population projections by age cohort** for Baltimore City, Baltimore County, and Howard County for the years 2015–2035, using Maryland Department of Planning population projections. When reviewed independently, the jurisdiction-specific tables demonstrate that:

- Each jurisdiction is experiencing growth in the population aged **65 and older**, although the pace and magnitude of growth vary by jurisdiction.
- The aging trends observed within each jurisdiction have direct implications for future demand for skilled nursing, rehabilitative therapies, and medical social services delivered in the home.

Presenting these projections by jurisdiction provides an accurate demographic foundation for evaluating home health need within each jurisdiction independently.

Revised Table B-2B – Percent Change in Population by Age Cohort (By Jurisdiction)

Revised Table B-2B presents **percent change in population by age cohort separately for each jurisdiction**, rather than as a combined area. These jurisdiction-specific tables demonstrate that:

- Population growth in each jurisdiction is disproportionately concentrated in the **65+ age cohort**.
- Younger and middle-aged cohorts remain relatively stable or decline within each jurisdiction, reinforcing the shift toward increased demand for higher-acuity home health services.

By presenting population change data by jurisdiction, Table B-2B supports a jurisdiction-level assessment of how demographic trends will affect future home health utilization.

Revised Table B-2C – Home Health Clients by Age Cohort (FY 2023, By Jurisdiction)

Revised Table B-2C presents **FY 2023 home health utilization by age cohort separately for Baltimore City, Baltimore County, and Howard County**, based on MHCC Home Health Agency Annual Survey data (Table 15). These jurisdiction-specific utilization tables demonstrate that:

- In **each jurisdiction**, the majority of home health clients are aged **65 and older**.
- Utilization patterns closely mirror the jurisdiction-specific demographic profiles shown in Tables B-2A and B-2B, confirming sustained demand for Medicare-certified home health services within each jurisdiction independently.

All jurisdiction-specific utilization figures are drawn **directly from MHCC FY 2023 Home Health Agency Annual Survey detailed tables** and **have not been estimated, prorated, or extrapolated**.

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Revised Tables B-2A, B-2B, and B-2C Summary

Taken together, the revised Tables **B-2A, B-2B, and B-2C** provide a **jurisdiction-specific demographic and utilization profile** for the region. These replacement tables demonstrate that:

- Each jurisdiction has a growing population of older adults
- Home health utilization within each jurisdiction is heavily concentrated among seniors
- The proposed Medicare-certified Home Health Agency is appropriately designed to meet the documented needs of each jurisdiction independently

9. Provide your proposed HHA admissions policy, describing the admission criteria along with the type of populations and services to be provided. Clearly identify which staff person(s) would be responsible for admissions.

Applicant Response – Completeness Question #9

Quality One Care Home Health, Inc. (the Applicant) will implement a formal Home Health Agency (HHA) admissions policy that complies with the Medicare Conditions of Participation at **42 CFR Part 484** and applicable Maryland licensure requirements. The admissions policy is designed to ensure that patients admitted to the HHA are appropriate for home health services, meet payer eligibility requirements, and can be safely and effectively served in the home setting.

Admission Criteria

Patients will be eligible for admission to the HHA if all of the following criteria are met:

1. Physician Order and Plan of Care

The patient is referred by a physician or other authorized practitioner and has a valid physician order for home health services, with services to be provided pursuant to an individualized Plan of Care.

2. Homebound Status (When Required)

For Medicare-covered services, the patient meets the Medicare definition of homebound, as documented in accordance with Medicare requirements.

3. Need for Skilled Services

The patient requires one or more skilled services, including skilled nursing, physical therapy, occupational therapy, speech-language pathology, and/or medical social services, that can be safely and appropriately delivered in the home.

4. Safe Home Environment

The patient's home environment is determined to be safe for the provision of home health services, or risks can be reasonably mitigated through care planning and coordination.

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5. Payer Eligibility

The patient meets eligibility requirements for coverage under Medicare, Medicaid, or other accepted payers, or has an approved financial arrangement for services.

Populations to Be Served

Consistent with the State Health Plan and demonstrated utilization patterns, the proposed HHA will primarily serve:

- **Older adults**, particularly individuals aged 65 and older
- **Post-acute patients** discharged from hospitals or skilled nursing facilities who require skilled care in the home
- **Individuals with chronic medical conditions** requiring ongoing skilled nursing or rehabilitative services
- **Patients requiring interdisciplinary home health services** coordinated under a physician-directed Plan of Care.

Services will be provided without discrimination and in a culturally and linguistically appropriate manner, consistent with applicable federal and state requirements.

Services to Be Provided

Upon admission, patients may receive one or more of the following services, as ordered by the physician and outlined in the Plan of Care:

- Skilled Nursing Services
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Medical Social Services
- Home Health Aide Services (under nursing supervision)

Admissions Process and Responsible Staff

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The admissions process will be overseen by **the HHA Administrator and the Director of Nursing (DON)**, who will have overall responsibility for ensuring compliance with admission policies and regulatory requirements.

Day-to-day admissions activities will include:

- **Referral intake and screening**, coordinated by designated admissions or intake staff under the supervision of the DON
- **Initial clinical assessment**, conducted by a registered nurse to determine patient eligibility, skilled service needs, and safety of the home environment
- **Verification of physician orders and payer eligibility**
- **Start-of-care assessment**, including required OASIS data collection, completed by qualified clinical staff

Final approval of admission will rest with the **Director of Nursing or designee**, in coordination with the Administrator, to ensure that all regulatory, clinical, and payer requirements are met prior to initiation of services.

Admissions Policy Summary

Through this admissions policy, the Applicant will ensure that patients admitted to the proposed HHA are appropriate for home health services, receive care consistent with physician orders and Medicare requirements, and are served by an interdisciplinary team capable of meeting their clinical and psychosocial needs. This structured admissions process supports quality care delivery, regulatory compliance, and effective use of home health resources across each proposed jurisdiction.

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Financial Accessibility – Payment Assistance Resources

The applicant states that the financial team will assist clients with coverage options. What payment assistance resources are available outside of Medicaid and Medicare

Applicant Response – Financial Accessibility

Quality One Care Home Health, Inc. (the Applicant) is committed to promoting financial accessibility to medically necessary home health services and will implement financial assistance practices consistent with a Charity Care and sliding fee framework, as applicable to home health services and payer requirements.

The Applicant's financial team will assist patients in identifying available coverage options and payment assistance resources **outside of Medicare and Medicaid**, as outlined below.

Commercial and Managed Care Coverage

The proposed Home Health Agency (HHA) will participate, as feasible, with commercial insurance plans and Medicare Advantage organizations that include home health benefits. The financial team will:

- Verify coverage and benefits, including coverage limitations and authorization requirements, prior to admission.
- Explain patient financial responsibility, including deductibles and co-payments.
- Coordinate with payers to minimize delays in access to care and ensure continuity of services.

For patients enrolled in Medicare Advantage plans, the HHA will coordinate authorization and coverage determinations with the applicable managed care organizations to support timely access to covered home health services.

Self-Pay Services and Private Payment Arrangements

For patients who are uninsured or whose services are not fully covered by insurance, the Applicant will offer private-pay options. Consistent with a sliding fee approach, the financial team will:

- Provide transparent information regarding service charges.
- Consider patient financial circumstances when establishing payment arrangements.
- Work with patients to identify manageable payment plans when appropriate.

These practices are intended to reduce financial barriers while maintaining operational and regulatory compliance.

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Charity Care and Community-Based Resources

While home health services are primarily financed through third-party payers, the Applicant will maintain policies consistent with Charity Care principles, including:

- Non-discriminatory access to medically necessary services.
- Assistance with benefit eligibility and enrollment referrals.
- Referral to external financial assistance resources when direct coverage is unavailable.

When applicable, the financial team will assist patients in identifying and accessing community-based or charitable resources that may help offset care-related expenses, such as nonprofit organizations, disease-specific foundations, faith-based organizations, or local assistance programs. These resources are **not administered by the HHA**; staff provide referral and navigation support only.

External Financial Assistance and Support Resources

In addition to internal payment options, the Applicant's financial team will assist patients in identifying and accessing external resources, including:

- **Maryland State Health Insurance Assistance Program (SHIP)**
Free, unbiased counseling to help individuals understand Medicare, Medicare Advantage, and supplemental coverage options.
<https://aging.maryland.gov/Pages/SHIP.aspx>
- **Maryland Health Connection**
Enrollment assistance for commercial insurance and Medicaid eligibility screening.
<https://www.marylandhealthconnection.gov>
- **Disease-Specific and Nonprofit Foundations**
Referrals to condition-specific charitable organizations that may provide financial assistance related to chronic illness management, medication costs, or supportive services.
- **Community and Faith-Based Organizations**
Referrals to local organizations that may offer short-term assistance with care-related expenses or supportive services.

Insurance Counseling and Benefit Navigation

The Applicant's financial staff will assist patients in understanding insurance eligibility and, when appropriate, provide referrals to external insurance counseling resources, including SHIP or other community-based enrollment support services, to help patients explore future coverage options.

Through benefit verification, sliding fee-aligned private-pay options, referrals to community-based and charitable resources, and insurance navigation support, the Applicant will promote financial accessibility and assist patients



in identifying viable payment options outside of Medicare and Medicaid. These efforts support equitable access to medically necessary home health services while maintaining compliance with payer and regulatory requirements.

Fees and Time Payment Plan

- 10. Table D states the fees are from Table 20 of the Home Health Survey. MHCC staff finds that table to be: “Percent Distribution of Home Health Visits by Jurisdiction of Residence, Payment Source and Geographic Region.” The service type is not included in the table. Please explain how this fee was calculated and show the calculations for each jurisdiction.**

Applicant Response – Completeness Question #10

MHCC staff is correct that the source citation included under **Table D – Projected Private-Pay Fees** was inaccurate. The reference to **MHCC Table 20** was made in error.

As noted, **MHCC Table 20** of the FY 2023 Maryland Home Health Agency Annual Survey reports the percent distribution of home health agency visits by jurisdiction of residence, payment source, and geographic region and does **not** report average per-visit charges by service discipline. Accordingly, MHCC Table 20 was **not used** to calculate the projected private-pay fees shown in Table D.

Correct MHCC Data Sources and Fee Development Methodology

The projected private-pay rates presented in **Table D** were developed using a combination of **MHCC utilization and cost data, market comparables, and internal cost modeling**, rather than a single MHCC table reporting charges by discipline. Specifically, the projected fees were informed by the following:

- **Review of prevailing private-pay fee schedules** charged by existing Maryland home health agencies serving Baltimore City, Baltimore County, and Howard County, to reflect current market pricing practices in comparable urban and suburban jurisdictions
- **Discipline-specific cost and utilization benchmarks** reported in the MHCC FY 2023 Home Health Agency Annual Survey, including:
 - Table 9 – Total Visits and Average Cost per Visit by Discipline and Home Health Agency: Maryland, used to inform reasonable per-visit cost expectations by service type; and
 - Tables 14 and 19 – Total Number of Home Health Agency Visits by Jurisdiction of Residence, Payment Source, and Geographic Region, used to understand visit volume, service mix, and operating context across Baltimore City, Baltimore County, and Howard County
- **Discipline-specific cost considerations**, informed by MHCC utilization and staffing data, including Table 11 – Full-Time Equivalents for Administrative and Patient Care Personnel by Home Health Agency: Maryland, and reflecting staffing costs by discipline, visit length and frequency, clinical supervision and documentation requirements, travel time, and administrative overhead

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- **QOC's internal cost modeling**, which integrates MHCC FY 2023 utilization and cost benchmarks with Maryland home health market comparables to establish **reasonable, transparent, and regionally consistent per-visit private-pay rates**.

Uniform Application of Fees

The resulting fees shown in Table D represent **projected, uniform private-pay charges per visit** that QOC proposes to apply consistently across its authorized service area. Because MHCC does not publish jurisdiction-specific average private-pay charges by discipline, the proposed rates are **not calculated directly from jurisdictional percentage distributions** and do not require separate calculations by jurisdiction.

Correction to Table D Source Citation

QOC will revise the source note for **Table D – Projected Private-Pay Fees** to remove the reference to MHCC Table 20 and to accurately reflect that the projected private-pay fees are informed by **MHCC FY 2023 utilization and cost tables and Maryland home health market comparables**, rather than a table reporting average charges by discipline.

Revised Source Line for Table D

Source: QOC analysis informed by MHCC FY 2023 Maryland Home Health Agency Annual Survey Tables 9, 11, 14, and 19, and Maryland home health private-pay market comparables.

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Charity Care and Sliding Fee Scale

11. Please describe the process used, in question E(1), to determine probable eligibility for charity care. In your response, address: how requests are made (orally or in writing) and the required documentation.

Applicant Response – Completeness Question #11

Description of the Probable Eligibility Determination Process

Quality One Care Home Health, Inc. (QOC) uses a **two-stage charity care eligibility process** – a probable (preliminary) determination followed by a final determination – to ensure that financial considerations do not delay access to medically necessary home health services, consistent with COMAR 10.24.16.08E(1).

This process is described across **Exhibit 4 (Charity Care & Sliding Fee Scale Policy)** and the **Charity Care Assessment & Financial Assistance Policy**, which together govern intake, documentation, and eligibility determination.

How Requests Are Made

Requests for charity care or sliding fee scale assistance may be made orally or in writing and may occur at any time, including:

- At referral or intake
- During the initial assessment
- At the time of billing
- At any point during services if a client's financial circumstances change

Requests may be initiated by the client, the client's legally authorized representative, or identified by QOC staff when financial hardship is apparent. Oral requests are accepted, documented by staff, and followed by assistance in completing a written financial assistance application.

This process is described in Exhibit 4 – Application Process and reinforced in the Charity Care Assessment & Financial Assistance Policy, Sections V and VIII.

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Eligibility Determination Required Documentation

To assess financial need, QOC requests documentation reasonably necessary to evaluate eligibility, which may include:

- Proof of household income (e.g., pay stubs, Social Security, SSI, or disability benefit statements)
- Proof of household size
- Federal income tax return, if available
- Proof of insurance status or Medicaid application/denial, if applicable
- Documentation of financial hardship or extraordinary medical expenses, where relevant

QOC staff assist clients in obtaining documentation and make reasonable efforts to verify eligibility when documents are temporarily unavailable, as stated in Exhibit 4 – Application Process and Assessment Policy Section VIII.

a. Is a preliminary determination made within two days, with final determination made upon a complete application? If so, describe where in Exhibit 4, the Charity Care & Sliding Fee Scale Policy, it states that a preliminary determination is made within two days.

Applicant Response – Completeness Question #11(a)

Preliminary and Final Determination Timeframes

Yes. A **preliminary (probable) eligibility determination is made within two (2) business days**, with a final determination made after receipt of complete documentation.

Where This Is Stated in the Policies

The **two-business-day probable eligibility requirement** is explicitly stated in the **Charity Care Assessment & Financial Assistance Policy**, including:

- **Section III (Public Notification – Required Notice Language)**, which states that “Probable eligibility will be determined within two business days of a request for assistance or an application for Medical Assistance”; and
- **Section V (Determination of Probable Eligibility)**, which states that QOC will make a probable eligibility determination within two business days of a request for charity care, submission of a financial assistance application, or submission of a Medicaid application.

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Exhibit 4 (Charity Care & Sliding Fee Scale Policy) complements this requirement by stating that:

- Applications will be processed within defined timeframes
- Services will not be denied or delayed while eligibility is pending
- Approved discounts may be applied retroactively

Together, these policies establish both the **two-day preliminary determination** and the **final determination upon receipt of complete documentation**.

Distinction Between Preliminary and Final Determinations

- **Preliminary (Probable) Determination:**
A provisional determination based on available information (including self-reported income, household size, insurance status, or Medicaid-pending status) used to prevent delays in care.
- **Final Determination:**
A confirmation or adjustment of eligibility made after receipt and review of full documentation, establishing the client's final financial responsibility, if any.

Both determinations are documented in the client's record and communicated to the client or the client's representative in writing, in accordance with QOC policy.

b. Clarify how such documentation forms are similar or different than in the complete information used in making the final determination.

Applicant Response – Completeness Question #11(b)

Documentation Used for Preliminary vs. Final Eligibility Determinations

The documentation used for preliminary and final determinations is **similar in type but different in completeness**, consistent with COMAR requirements.

Preliminary (Probable) Eligibility Documentation

For purposes of making a probable eligibility determination within two business days, QOC may rely on:

- Oral or written self-attestation of income and household size
- One readily available income indicator, if available
- Medicaid application status (including "Medicaid Pending"), and/or
- Intake or assessment information indicating financial hardship

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Complete documentation is **not required** to issue a preliminary determination. The purpose is to allow medically necessary services to begin without delay.

Final Eligibility Documentation

The final determination requires a **complete application**, which may include:

- Verification of income (multiple pay stubs, benefits statements, or tax returns, if available)
- Verification of household size
- Medicaid denial or coverage determination, if applicable
- Additional documentation needed to confirm eligibility under the sliding fee scale.

Relationship Between the Two

- Both determinations rely on the same documentation categories
- The preliminary determination uses limited, readily available information
- The final determination confirms eligibility based on complete documentation and governs long-term financial responsibility.

Throughout this process, QOC assists clients with documentation and ensures that care is not denied or delayed while eligibility is finalized, as stated in **Exhibit 4** and the **Assessment Policy**.

Exhibit 4 – Charity Care & Sliding Fee Scale Policy should be read in conjunction with QOC’s **Charity Care Assessment & Financial Assistance Policy**, which sets forth the detailed procedures and timelines for probable and final eligibility determinations, including the two-business-day preliminary determination requirement. QOC’s **Charity Care Assessment & Financial Assistance Policy** has been included as part of this completeness response package.

12. Please provide a copy of your proposed Public Notice, consistent with your charity care and reduced fee policies.

Applicant Response – Completeness Question #12

Public Notice – Charity Care and Reduced Fee Policies

Quality One Care Home Health, Inc. (QOC) hereby provides a copy of its proposed **Public Notice** (available in English and Spanish), which is consistent with QOC’s **Charity Care & Sliding Fee Scale Policy (Exhibit 4)** and complies with COMAR 10.24.16.08E. The notice informs clients and the public of QOC’s commitment to providing services regardless of ability to pay, the availability of charity care, reduced fees, and time payment plans, and the process for requesting financial assistance. In addition to English and Spanish written notices, QOC provides interpreter services at no cost to clients who speak other languages commonly spoken in the service area.

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Phone: +1 (301) 658-7141 / Fax: +1 (301) 658-2328

Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>

QOC Charity Care Public Notice (English)

NOTICE TO PATIENTS

Quality One Care Home Health, Inc. (QOC) provides home health services to all eligible individuals **regardless of ability to pay**. QOC does not discriminate on the basis of race, color, creed, religion, gender, age, sexual orientation, national origin, disability, or financial status.

If insurance coverage is not available or does not fully cover the cost of services, patients or their guarantors may be responsible for payment. **Financial assistance is available** to individuals who are unable to pay for care.

QOC offers the following financial assistance options, consistent with its written policies:

- **Charity care** for eligible individuals
- **Reduced fees through a sliding fee scale**, based on household income and family size
- **Time payment plans** for individuals who do not qualify for full charity care but are unable to pay the full cost of services at one time

A **probable eligibility determination** for charity care or reduced fees will be made **within two (2) business days** of a request for assistance or an application for Medical Assistance. Final eligibility determinations are made upon receipt of a complete application. Assistance amounts are based on **Federal Income Poverty Guidelines**.

Interpreter services are available at no cost.

For more information or to request an application, please contact:

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QOC Charity Care Public Notice (Spanish)

AVISO A LOS PACIENTES

Programa de Asistencia Financiera y Atención de Caridad

Quality One Care Home Health, Inc. (QOC) proporciona servicios de atención médica domiciliaria a todas las personas elegibles **independientemente de su capacidad de pago**. QOC no discrimina por motivos de raza, color, credo, religión, género, edad, orientación sexual, origen nacional, discapacidad o situación financiera.

Si el seguro médico no está disponible o no cubre completamente el costo de los servicios, el paciente o su garante puede ser responsable del pago. **La asistencia financiera está disponible** para las personas que no puedan pagar el costo total de la atención.

QOC ofrece las siguientes opciones de asistencia financiera, de conformidad con sus políticas escritas:

- **Atención de caridad** para personas que cumplan con los criterios de elegibilidad;
- **Descuentos mediante una escala de tarifas variables**, basados en el tamaño del hogar y los ingresos familiares; y
- **Planes de pago a plazos** para personas que no califican para atención de caridad total pero no pueden pagar el costo completo de los servicios de una sola vez.

Se realizará una **determinación preliminar de elegibilidad** para atención de caridad o tarifas reducidas **dentro de dos (2) días hábiles** a partir de la solicitud de asistencia o de una solicitud de Asistencia Médica. La determinación final se realizará una vez que se reciba una solicitud completa. Los montos de asistencia se basan en las **Guías Federales de Pobreza**.

Los **servicios de interpretación están disponibles sin costo alguno**.

Para obtener más información o solicitar una solicitud de asistencia financiera, comuníquese con:

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In addition to the full Public Notice provided above, QOC also utilizes an abbreviated notice for posting and inclusion in admission materials, consistent with its charity care and reduced fee policies.

Abbreviated Charity Care Public Notice

NOTICE TO PATIENTS

This practice serves all patients regardless of ability to pay.
Charity care, reduced fees, and payment plans are available.

Discounts are offered based on family size and income.

Interpreter services are available at no cost.

For more information, contact our Intake/Billing Office at (301) 658-7141, email info@qualityonecare.com, or visit www.qualityonecare.com.

Thank you.

AVISO PARA PACIENTES

Este establecimiento de salud atiende a todos los pacientes independientemente de su capacidad de pago.

La atención de caridad, las tarifas reducidas y los planes de pago están disponibles.

Se ofrecen descuentos según el tamaño de la familia y los ingresos.

Servicios de interpretación disponibles sin costo.

Para obtener más información, comuníquese con nuestra oficina al (301) 658-7141, envíe un correo electrónico a info@qualityonecare.com, o visite www.qualityonecare.com.

Gracias.

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13. Question E(2): The applicant states that notices outlining eligibility criteria, application procedures, and available financial assistance will be posted prominently in QOC's administrative office and client facing areas. Given that an HHA is a home-based service and clients are primarily referred from medical settings, it is unlikely that clients will visit the administrative office directly. What specific "client-facing areas" are being referenced, and how will these postings effectively reach clients who do not typically come into the office?

Applicant Response – Completeness Question #13

Posting and Dissemination of Charity Care Notices

Quality One Care Home Health, Inc. (QOC) acknowledges that, as a **home-based service provider**, clients do not typically visit the agency's administrative office. Accordingly, QOC's reference to "client-facing areas" includes **points of contact and materials through which clients routinely receive information during referral, intake, admission, and ongoing service delivery**, rather than walk-in public spaces.

Client-Facing Areas Referenced

For purposes of compliance with COMAR 10.24.16.08E(2), QOC's client-facing areas include:

- **Admission and intake materials**, including patient welcome packets and financial disclosure documents provided to clients at the start of services
- **Client-facing written materials**, such as billing statements, notices of financial responsibility, and payment-related correspondence
- **Electronic communications**, including email and electronic intake documents provided to clients or their representatives
- **QOC's website**, which includes information on financial assistance, charity care, reduced fees, and time payment options
- **Direct interactions between QOC staff and clients**, including intake, assessment, and care coordination discussions conducted by administrative or clinical staff

How Notices Reach Clients Who Do Not Visit the Administrative Office

To ensure that charity care and reduced fee information effectively reaches clients who do not physically visit the administrative office, QOC disseminates its Public Notice through multiple channels:

- The **full Public Notice** is included in admission materials provided to all clients at the start of services
- An **abbreviated Public Notice** (in English and Spanish) is included in patient-facing documents and may be provided as a standalone handout during intake or assessment

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- Information regarding financial assistance is **verbally communicated** to clients or their representatives during intake and admission, with staff available to assist in submitting requests or applications
- Notices are provided in **English and Spanish**, and interpreter services are available at no cost for clients who speak other languages commonly spoken in the service area
- QOC also includes information regarding the availability of charity care, reduced fees, and time payment plans in **client-facing marketing and outreach materials**, including online content and, where appropriate, locally distributed materials such as community newsletters, magazines, and newspapers, to ensure broad awareness of financial assistance options
- Clients may request additional information or applications by phone, email, or through QOC's website

Administrative Office Posting

Consistent with COMAR requirements, QOC also posts its charity care and reduced fee notices in its administrative office for visibility to staff, visitors, and any clients or representatives who may visit the office. However, QOC's primary dissemination methods are designed to ensure that **all clients receive notice regardless of whether they physically visit the office.**

14. The application form (Exhibit 4E) provided for determination of eligibility for charity care contains a question about the citizenship status of an applicant. The Commission does not accept forms containing this question. Please provide an application form that does not ask about citizenship status.

Applicant Response – Completeness Question #14

Charity Care Application Form – Citizenship Question

Quality One Care Home Health, Inc. (QOC) acknowledges the Commission's comment regarding the inclusion of a citizenship status question in the previously submitted Charity Care & Financial Assistance Application Form (Exhibit 4E).

QOC has **revised Exhibit 4E to remove any question regarding citizenship status.** The updated application form determines eligibility for charity care, sliding fee scale discounts, and time payment arrangements **solely on the basis of household income, household size, assets, expenses, and related financial information**, consistent with COMAR requirements and Commission guidance.

A **revised Charity Care & Financial Assistance Application Form**, which does not request citizenship or immigration status information, is submitted herewith as **Revised Exhibit 4E - Charity Care Application Form.**

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15. What protocol is followed when client needs exceed the charity care allotment, given QOC's stated commitment to providing services regardless of ability to pay?

Applicant Response – Completeness Question #15

Protocol When Client Needs Exceed the Charity Care Allotment

Quality One Care Home Health, Inc. (QOC) is committed to ensuring access to medically necessary home health services regardless of an individual's ability to pay, consistent with COMAR 10.24.16.08E. At the same time, QOC maintains internal controls to responsibly manage its charity care resources and ensure the ongoing sustainability of services.

When client needs for charity care exceed the annual charity care allotment projected in the application, QOC follows a **structured review and escalation protocol**, as outlined below.

Ongoing Monitoring and Internal Review

QOC tracks charity care utilization on an ongoing basis, including the number of charity care clients served, the number of charity care visits provided, and the associated cost of care. This information is reviewed regularly by management to monitor performance against projected charity care commitments.

If charity care utilization approaches or exceeds the projected allotment, QOC initiates an internal review to assess:

- The clinical necessity and urgency of continued services
- Available alternative coverage options for the client (e.g., Medicaid eligibility, retroactive Medical Assistance, or other public benefits)
- The availability of reduced-fee or time payment options for clients who do not qualify for full charity care
- The impact of continued charity care provision on the agency's financial capacity.

Client-Level Decision-Making and Alternatives

When appropriate, QOC takes the following steps on a **client-specific basis**:

- Continues services for clients with **medically necessary and time-sensitive care needs** while eligibility for Medicaid or other assistance is being pursued
- Applies **sliding fee scale discounts or time payment plans** for clients who no longer qualify for full charity care but remain unable to pay the full cost of services
- Assists clients with **applications for Medicaid or other public assistance programs**, including referrals to appropriate agencies or resources

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- Coordinates with referring providers and community partners, **when clinically appropriate and in the context of an established discharge or transition plan**, to ensure continuity of care and avoid gaps in medically necessary services

Commitment to Access and Continuity of Care

QOC does not discontinue services solely because the charity care allotment has been exceeded. In such circumstances, QOC prioritizes maintaining continuity of care and avoiding disruption of medically necessary services while alternative coverage or payment options are actively pursued. Decisions regarding continuation or transition of care are based on **clinical appropriateness, patient safety, and continuity of care considerations**, rather than financial status alone.

When services cannot be continued indefinitely under charity care, QOC ensures that clients receive appropriate notice, assistance with alternative arrangements, and referrals to other providers or resources, consistent with its discharge planning policies and applicable regulations.

Financial Oversight and Sustainability

QOC's charity care policy and internal review process are designed to balance its commitment to access with responsible financial management. This approach allows QOC to continue serving indigent and low-income clients while maintaining the financial stability necessary to operate as a Medicare-certified home health agency.

QOC's approach is designed to ensure that financial considerations do not become the sole driver of care decisions and that clients are not left without medically necessary home health services due to inability to pay.

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Financial Feasibility

16. Explain how competitive QOC will be with the existing Home Health Agencies that provide a greater volume of comprehensive home health care services.

Applicant Response – Completeness Question #16

Financial Feasibility – Competitive Positioning

Quality One Care Home Health, Inc. (QOC) will be competitive with existing home health agencies that provide higher volumes of comprehensive services by operating a **focused, quality-driven, and financially disciplined service model**, rather than competing on scale or volume alone.

Targeted Service Delivery Model

Unlike larger, multi-regional home health agencies that rely on high visit volumes to support fixed administrative structures, QOC's operational model emphasizes:

- **Targeted service delivery** within its authorized service area
- **Disciplined, incremental growth** aligned with staffing capacity and demonstrated community demand
- A focus on **high-quality skilled nursing, therapy, and clinical support services** delivered efficiently in the home.

This approach allows QOC to remain competitive and financially viable without requiring the scale or utilization levels of higher-volume providers.

Market Context and Quality-Based Competition

In publishing the applicable CON Review Schedule and State Health Plan standards, MHCC identified the Baltimore City, Baltimore County, and Howard County region as an area with **insufficient choice of quality-performing home health agencies**, reflecting access and market concentration considerations. QOC's proposed services are responsive to this identified need and are designed to expand patient and provider choice through a **client-first, quality-focused model of care**, rather than volume-based competition.

QOC's competitive positioning is grounded in its emphasis on clinical excellence, care coordination, responsiveness, and continuity of care. By adding an additional high-performing provider option in a region where consumer choice has been identified as limited, QOC enhances competition in a manner that supports MHCC's objectives of improving access, quality, and patient-centered outcomes.

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Workforce and Operational Efficiency

QOC's competitiveness is further supported by:

- A **flexible staffing model** that aligns clinician deployment with actual service demand
- Competitive compensation and scheduling practices designed to support **recruitment and retention** in a constrained workforce environment
- Lean administrative operations that reduce overhead while maintaining compliance with Medicare Conditions of Participation and accreditation standards.

These efficiencies enable QOC to deliver services in a cost-effective and sustainable manner comparable to existing providers.

Payer Mix and Revenue Stability

QOC's financial feasibility is supported by a **balanced and diversified payer mix**, including Medicare, Medicaid, commercial insurance, managed care, and private pay. This revenue structure allows QOC to remain financially stable while serving a mix of medically complex and financially vulnerable clients.

Importantly, QOC does not rely on capturing large volumes from existing providers to achieve viability. Instead, it anticipates serving:

- Clients experiencing **capacity constraints or access delays** at higher-volume agencies
- Clients requiring **more individualized care coordination**
- Clients referred by hospitals, physicians, and community providers seeking additional high-quality placement options.

Complementary Role in the Service Area

QOC's proposed services are intended to **complement, not displace**, existing home health agencies. By adding capacity, service flexibility, and a quality-focused alternative, QOC enhances patient choice and supports continuity of care without materially impacting the financial stability of established providers with larger scale or broader geographic reach.

Conclusion

Through disciplined growth, operational efficiency, workforce alignment, a balanced payer mix, and a client-centered model of care, QOC will be financially feasible and competitively positioned to operate alongside higher-volume home health agencies. By expanding meaningful consumer choice and emphasizing quality-driven service delivery in a region identified by MHCC as having limited options, QOC supports the State Health Plan's goals of access, competition, and patient-centered care while maintaining sustainability and avoiding adverse impacts on existing providers.

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17. The copy of your HHA admission and discharge policy, Exhibit 12, refers to western Maryland, and not the three jurisdictions in the application. Please provide corrected policies.

Applicant Response – Completeness Question #17

Admission and Discharge Policy – Service Area Reference

Quality One Care Home Health, Inc. (QOC) acknowledges the Commission’s comment regarding the service area reference in the previously submitted Admission and Discharge Policy (Exhibit 12).

QOC has revised Exhibit 12 to remove references to Western Maryland and to clarify that admissions are limited to patients residing within QOC’s MHCC-approved home health service area, as authorized under its Certificate of Need and applicable licensure. This revision reflects that the policy is intended to govern organizational admission and discharge practices rather than identify specific jurisdictions.

A revised Admission and Discharge Policy reflecting this correction is submitted herewith as **Revised Exhibit 12**.

18. Provide a more complete description of all assumptions that “fed” the revenue and expense tables, and the rationale behind those assumptions.

Applicant Response – Completeness Question #18

Financial Feasibility: Revenue and Expense Assumptions

Quality One Care Home Health, Inc. (QOC) developed the revenue and expense projections presented in Part IV, Tables 1, 2B, 4, and 5 of the CON application using a consistent set of **operational, utilization, reimbursement, and staffing assumptions**. These assumptions are conservative, internally consistent, and aligned with MHCC reporting requirements, Maryland reimbursement benchmarks, and QOC’s proposed service model. The key assumptions and their rationale are described below.

Financial Executive Summary

The financial projections for the proposed Quality One Care Home Health, Inc. project demonstrate a financially feasible, conservatively structured start-up that aligns projected service volume, staffing, and expenses with realistic market conditions in the proposed service area. The project requires limited start-up capital, funded entirely through cash equity, and does not rely on debt financing. Revenue growth is driven solely by gradual increases in patient volume rather than assumed reimbursement escalation, with explicit recognition of contractual allowances, charity care obligations, and bad debt. Staffing levels scale proportionally with utilization and reflect prevailing Maryland home health wage and productivity norms. Operating margins remain positive throughout

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the projection period, demonstrating QOC's ability to sustain operations while meeting its access, quality, and charity care commitments within its MHCC-approved service area.

I. Capital and Start-Up Cost Assumptions (Table 1 – Project Budget)

Table 1 reflects **limited start-up capital costs**, consistent with QOC's plan to operate as a non-institutional, office-based home health agency without new construction or renovation.

Key assumptions include:

- **No new construction or renovation costs**, as QOC will operate from leased administrative space
- **Movable equipment costs of \$5,000**, representing basic office, IT, and clinical support equipment
- **Contingency allowance of \$20,000**, included to conservatively account for unforeseen start-up expenses
- **Legal and consulting costs** associated with CON application preparation, licensure, and operational setup
- **Working capital of \$44,000**, funded entirely through cash equity, sufficient to support early operations prior to revenue stabilization.

No debt financing, interest expense, or donated land assumptions are included.

II. Utilization and Volume Assumptions (Table 2B – Statistical Projections)

Table 2B projects utilization for the proposed project only and assumes **gradual ramp-up** to full utilization over the first three projection years.

Client and Visit Assumptions

- Unduplicated clients increase from **100 (2026)** to **330 (2028)**
- Total visits increase from **1,162 (2026)** to **3,033 (2028)**
- Billable visits represent the majority of total visits, with non-billable visits reflecting care coordination, supervisory, and administrative activities typical of home health operations

Discipline Mix

The projected visit distribution by discipline reflects realistic care patterns:

- Skilled Nursing visits account for the largest share
- Therapy and aide visits scale proportionally with nursing volume
- Medical social work and speech therapy volumes remain modest, consistent with typical utilization

These assumptions are aligned with MHCC utilization patterns and do not assume aggressive market capture.

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III. Revenue Assumptions (Table 4 – Revenues)

1. Gross Patient Service Revenue

Gross revenue is derived directly from:

- Projected billable visits (Table 2B); multiplied by
- Conservative per-visit reimbursement assumptions by payer category.

Revenue growth from **\$162,750 (2026)** to **\$426,025 (2028)** is driven solely by volume growth, not price escalation. All projections are presented in current dollars and do not assume inflationary reimbursement increases or expense escalation beyond volume-driven growth. No non-operating income is assumed in the projections.

2. Payer Mix Assumptions

The payer mix remains **stable across all projection years**, reflecting a balanced referral base:

- Medicare: 55%
- Medicare Advantage: 10%
- Medicaid: 15%
- Medicaid MCO: 5%
- Commercial Insurance: 10%
- Self-Pay: 5%

This mix is consistent across both **revenue and visit distributions** and does not rely on a disproportionately favorable payer composition. The payer mix is held constant across the projection period to reflect a stable referral base and to avoid reliance on speculative shifts toward more favorable reimbursement categories.

3. Contractual Allowances, Charity Care, and Bad Debt

Table 4 explicitly accounts for revenue reductions:

- **Contractual allowances** reflect Medicare, Medicaid, and managed care reimbursement limitations
- **Charity care** reflects QOC's Charity Care & Sliding Fee Scale Policy
- **Bad debt allowances** are conservatively estimated and increase proportionally with revenue

Net patient service revenue is therefore appropriately discounted to reflect realistic collections. Charity care levels are projected conservatively and increase proportionally with service volume, with the understanding that actual charity care may fluctuate based on community need.

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IV. Expense Assumptions (Table 4 – Expenses)

1. Staffing and Salary Costs

Salary and wage expenses are driven by the staffing model detailed in Table 5 and increase proportionally with projected visit volume:

- Total salary and benefit expense increases from **\$82,000 (2026)** to **\$198,000 (2028)**;
- Benefits are calculated at **27% of wages**, consistently applied across all years.

No below-market wage assumptions are used.

2. Staffing Model and Productivity (Table 5)

Table 5 shows disciplined, incremental staffing growth:

- Clinical and administrative FTEs increase gradually as volume increases
- RN, therapy, aide, and supervisory staffing align with visit volumes by discipline
- Productivity assumptions are explicitly stated and reasonable for home health operations

The staffing model avoids overstaffing in early years and supports operational scalability.

3. Other Operating Expenses

Other expenses include:

- Contractual services
- Supplies
- Administrative overhead
- General operating costs

These expenses increase from **\$23,500 (2026)** to **\$41,700 (2028)**, reflecting higher visit volumes and staffing levels, not fixed cost inflation. No depreciation, amortization, or interest expense is assumed.

V. Income and Financial Sustainability

Income from operations remains positive in all projected years:

	2026	2027	2028
Income	\$16,400	\$63,300	\$79,400

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The projections demonstrate that QOC can operate sustainably while absorbing contractual adjustments, charity care obligations, and conservative staffing costs.

VI. Rationale and Internal Consistency

All assumptions feeding the revenue and expense tables are:

- Internally consistent across Tables 1, 2B, 4, and 5
- Based on volume-driven growth rather than optimistic pricing
- Scaled to staffing capacity and operational readiness
- Aligned with MHCC reporting requirements and Maryland home health market conditions

These assumptions support QOC's ability to achieve financial feasibility while delivering high-quality, accessible home health services within its MHCC-approved service area.

19. For the project Budget, what is included in "other" costs.

Applicant Response – Completeness Question #19

Project Budget – "Other" Costs

In Table 1 (Project Budget), the "Other" cost category reflects **limited, one-time start-up expenses** necessary to establish the proposed Home Health Agency and does not include ongoing operating costs.

Specifically, "Other" costs include:

- **Licensing, certification, and regulatory fees**, including costs associated with Maryland home health licensure and compliance requirements
- **Professional and consulting services** related to operational setup, policy development, compliance preparation, and accreditation readiness
- **Information technology and administrative start-up expenses** not classified as movable equipment, such as software setup, system configuration, and initial implementation costs
- **Miscellaneous administrative start-up expenses** incurred prior to commencement of patient services.

No construction, renovation, real estate acquisition, debt service, or ongoing operating expenses are included in the "Other" category.

All amounts reflected are **one-time, non-recurring start-up costs** and are fully accounted for in the total project budget.

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20. MHCC staff have several questions regarding the budget for staffing.

Applicant Response – Completeness Question #20

Staffing Assumptions and Budget Clarifications

Quality One Care Home Health, Inc. (QOC) appreciates MHCC staff's detailed review of the staffing projections and provides the following clarifications regarding salary budgeting, staffing roles, productivity assumptions, and operational workflows.

- a) **It appears that the budget for salaries does not match the FTE level of staffing proposed. The information requested in the Excel CON table set, Table L, should help correct this discrepancy.**

The apparent discrepancy between the salary budget and proposed FTE staffing levels reflects the use of **blended staffing models and phased hiring**, rather than fully staffed positions at the beginning of each projection year.

Specifically:

- Staffing levels shown in Table 5 represent **average FTEs over the course of each year**, not peak staffing
- Salary expenses in Table 4 reflect **actual projected payroll costs**, accounting for:
 - Partial-year hiring
 - Incremental onboarding aligned with visit growth
 - Use of flexible staffing arrangements where appropriate
- Table L (Excel CON table set) further clarifies the relationship between projected visit volumes, staffing hours, and compensation assumptions.

QOC will revise and resubmit Table L to ensure full alignment between FTE levels, hours worked, and total salary expense across all staffing categories.

- b) **Trained coders for OASIS and HHCAHPS data collection and submissions to CMS are required, please explain why is there no coder included in the staffing projections?**

QOC acknowledges the requirement for accurate and timely OASIS and HHCAHPS data collection and submission to CMS. Dedicated coder FTEs are not separately identified in the staffing projections because:

- OASIS data collection is performed by **licensed clinical staff (primarily RNs)** at the point of care

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- OASIS review, validation, and submission functions are incorporated into the responsibilities of **clinical supervisory staff and administrative personnel**, supported by compliant electronic health record (EHR) systems
- HHCAHPS survey administration is performed through **approved third-party vendors**, consistent with industry practice, rather than in-house staff

Accordingly, coder-related functions are embedded within existing clinical, supervisory, and contracted service roles rather than reflected as standalone FTE positions.

c) Explain how the Home Health Aide staffing of 0.75 FTE is sufficient to provide the estimated hours of services to 3 counties.

The projected Home Health Aide (HHA) staffing level of approximately **0.75 FTE** is sufficient to support the estimated service volume because:

- HHA visits represent a **limited proportion of total visits** in the early projection years, as shown in Table 2B
- The projected HHA visit volume is concentrated among a **subset of clients**, not uniformly distributed across all counties
- HHA productivity assumptions reflect standard visit lengths and reasonable daily visit capacity
- HHA services are scheduled efficiently within defined geographic clusters to minimize travel inefficiencies

As overall visit volume increases, HHA staffing is designed to scale incrementally in proportion to demand, as reflected in later projection years. As reflected in Table 2B, projected aide visits represent a modest share of total visits in the early projection years, allowing coverage with less than one average annual FTE.

d) The application shows an incremental increase in the FTE of physical therapists that will be hired/contracted. Please describe the hiring process for these individuals?

The incremental increase in Physical Therapist (PT) FTEs reflects QOC's plan to utilize a **hybrid employment and contracting model**, which is standard in home health operations.

The hiring process includes:

- Engagement of **per diem and contract physical therapists** to meet early demand
- Transition to additional employed FTEs as visit volume stabilizes
- Recruitment through established professional networks, referrals, and regional staffing agencies
- Credentialing, background checks, and onboarding in compliance with Medicare Conditions of Participation and state licensure requirements

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This approach allows QOC to match therapy staffing closely to utilization trends while maintaining flexibility and cost control.

e) Is transportation time included in the calculation of FTEs needed to serve this population?

Yes. **Transportation and travel time are included** in the calculation of FTE requirements. FTE calculations are based on total paid hours, inclusive of direct care, travel time, documentation, and care coordination, consistent with the 2,080-hour annual FTE standard reflected in Table 5.

Specifically:

- Productivity assumptions incorporate reasonable allowances for travel between patient homes
- Scheduling practices are designed to cluster visits geographically within the approved service area
- Urban and suburban travel patterns were considered in estimating visit capacity
- FTE calculations reflect total paid hours, inclusive of travel, documentation, and care coordination activities.

These assumptions are consistent with prevailing Maryland home health operational norms.

Staffing Summary

Collectively, the staffing projections reflect:

- Phased, volume-driven hiring
- Use of flexible staffing and contracted services where appropriate
- Embedded administrative and clinical support functions
- Conservative productivity and travel assumptions

QOC will ensure that Table L and any related exhibits clearly reflect these assumptions and reconcile staffing levels with projected salary expenses.

21. Has the need for contractual part-time staff been included in the project budget and how will that need impact the budget?

Applicant Response – Completeness Question #21

Contractual Part-Time Staffing Assumptions and Budget Impact

Quality One Care Home Health, Inc. (QOC) has incorporated the use of contractual and part-time staffing into the project budget in a limited and controlled manner, consistent with the staffing projections and expense assumptions presented in Part IV, Tables 4 and 5 of the CON application.

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As reflected in **Table 5 (Staffing Information)**, QOC's projected staffing model relies primarily on employed clinical and administrative staff, with no routine reliance on contract staff reflected as separate FTEs. However, **limited use of contractual or part-time personnel is anticipated as an operational flexibility measure**, particularly during periods of census fluctuation, temporary coverage needs, or short-term specialty service demand.

Budget Treatment and Impact

The **financial impact of contractual and part-time staffing is already included** in the project budget as follows:

- Any anticipated use of contractual staff is incorporated within “**Contractual Services**” and “**Other Operating Expenses**” categories in **Table 4 (Revenues and Expenses)**
- No additional capital costs or separate staffing line items are required for contractual personnel
- The projections do **not assume routine or ongoing dependence on higher-cost contract labor** and therefore do not materially increase salary or benefit expenses beyond those shown in the tables

Operational Rationale

QOC's staffing approach prioritizes:

- **Employed staff for core clinical and administrative functions**, ensuring continuity of care and quality oversight; and
- **Targeted, short-term contractual staffing**, used sparingly to support start-up ramp-up, temporary coverage, or specialty needs without committing to permanent FTE increases.

This approach allows QOC to:

- Maintain financial discipline during early operations
- Scale staffing appropriately as utilization grows
- Avoid unnecessary fixed labor costs that could negatively impact financial feasibility.

Conclusion

The need for contractual part-time staff has been **appropriately anticipated and accounted for** within the existing expense projections. This staffing flexibility does **not materially impact the overall project budget**, does not alter projected staffing FTE levels, and supports QOC's ability to operate efficiently while maintaining high-quality service delivery within its MHCC-approved service area.

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22. Please include an analysis of the average number of visits that are expected to be provided to a client for each service line, and how that compares with existing providers in the region.

Applicant Response – Completeness Question #22

Average Visits per Client by Service Line and Comparison to Existing Providers

Quality One Care Home Health, Inc. (QOC) analyzed the projected utilization data presented in Part IV, Table 2B of the CON application to estimate the average number of visits per client by service line and to assess how these projections compare to utilization patterns observed among existing home health agencies serving the Baltimore City, Baltimore County, and Howard County region.

QOC calculated the expected average number of visits per client for each service line using the projected unduplicated client counts and projected visits by discipline reported in Table 2B (Statistical Projections – Proposed Project).

Projected Average Visits per Client by Service Line

The averages below are calculated as: **Projected visits by discipline ÷ Unduplicated clients** (by year).

Service Line	Projected Year		
	2026 (100 Clients)	2027 (225 Clients)	2028 (330 Clients)
Skilled Nursing	7.24 (724/100)	6.31 (1,420/225)	5.00 (1,650/330)
Home Health Aide	1.51 (151/100)	1.47 (330/225)	1.45 (480/330)
Physical Therapy	0.75 (75/100)	0.60 (135/225)	0.77 (255/330)
Occupational Therapy	0.70 (70/100)	0.64 (145/225)	0.55 (180/330)
Speech Therapy	0.06 (6/100)	0.07 (15/225)	0.06 (20/330)
Medical Social Work	0.24 (24/100)	0.24 (55/225)	0.20 (65/330)
Total Across Services	10.50 visits/client	9.33 visits/client	8.03 visits/client

Based on Table 2B, QOC projects 330 unduplicated clients and 2,755 billable visits in the first full year at full utilization (2028), resulting in an overall average of approximately **8.4 visits per client across all service lines**. This level of utilization reflects a conservative, skilled-nursing-led service model and is consistent with community-based home health practice.

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The projected distribution of visits by discipline yields the following approximate average visits per client:

- **Skilled Nursing:** approximately 5.0 visits per client
- **Home Health Aide:** approximately 1.5 visits per client
- **Physical Therapy:** approximately 0.8 visits per client
- **Occupational Therapy:** approximately 0.5 visits per client
- **Medical Social Work:** approximately 0.2 visits per client
- **Speech Therapy:** minimal utilization, reflecting episodic and supplemental use

This utilization pattern reflects QOC's emphasis on skilled nursing oversight, appropriate use of therapy services, and limited reliance on ancillary disciplines except when clinically indicated.

Comparison with Existing Providers in the Region (MHCC FY 2023 utilization baseline)

MHCC FY 2023 utilization for the Baltimore City, Baltimore County, and Howard County region shows the following **overall average visits per client** (all disciplines combined), calculated as **total visits ÷ total unduplicated clients**:

- **Baltimore City:** 284,010 visits / 12,511 clients = **~22.7 visits/client**
- **Baltimore County:** 206,770 visits / 12,111 clients = **~17.1 visits/client**
- **Howard County:** 37,499 visits / 3,006 clients = **~12.5 visits/client**
- **Three-jurisdiction total:** 528,279 visits / 27,628 clients = **~19.1 visits/client**

How QOC compares:

QOC's projected total visits per client across the listed service lines (about **10.5** in 2026, **9.3** in 2027, **8.0** in 2028) are conservative relative to the FY 2023 regional experience described above (approximately **12.5–22.7 visits/client** across the three jurisdictions).

QOC's projected visit intensity is consistent with, and in many cases more conservative than, utilization patterns reported by existing home health agencies in the region, particularly those operating under therapy-driven or episodic care models. The projected averages do not assume high therapy utilization, extended aide hours, or aggressive service intensity, and instead reflect:

- Physician-directed plans of care
- Patient acuity and functional need
- Payer coverage limitations
- Prevailing Maryland home health utilization norms

MHCC's jurisdiction-level utilization tables used for regional benchmarking report total clients and total visits for each jurisdiction, but they do not break out average visits per client by discipline/service line at the jurisdiction level in the same way Table 2B does. Accordingly, QOC's discipline-specific "visits per client" metrics above are

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presented as QOC's projected service intensity by service line, while the MHCC comparison provides the regional all-discipline service intensity baseline for existing providers.

By maintaining moderate average visits per client, QOC's projections avoid reliance on elevated service intensity to achieve financial feasibility and are consistent with sustainable staffing levels and realistic reimbursement expectations.

Clinical Flexibility and Scalability

Actual visit frequency for individual clients will vary based on physician orders, patient acuity, and clinical progress. QOC's projections are intentionally conservative and scalable, allowing for appropriate adjustments in visit intensity while remaining consistent with the CON-approved utilization framework and staffing capacity.

Clarification on Total Billable Visits

Table 2B reports a total of 2,755 billable visits in 2028. The discipline-specific visit counts referenced above sum to 2,650 visits; the remaining difference reflects other billable visits reported in Table 2B (e.g., "Other Visits (Please Specify)" or similar non-discipline-specific reporting categories). These visits do not materially affect the average visits-per-client calculations by primary service line.

Conclusion

QOC's projected average visits per client are intentionally conservative and structured to allow for operational scalability. Actual visit intensity will be determined by physician orders, patient acuity, clinical need, and applicable payer coverage, and may vary by service line over time. Any adjustments to visit patterns will remain consistent with QOC's CON-approved utilization framework and staffing capacity and will not rely on increased service intensity to achieve financial feasibility. QOC's lower projected visits per client reflect a start-up ramp-up period, a skilled-nursing-led care model, and the absence of therapy-intensive episodic programs common among larger incumbent agencies.

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Financial Solvency

23. The information submitted in the financial statements for the existing RSA operations indicate net income has declined over each of the past three years. The totals are:

Applicant Response – Completeness Question #23

Financial Solvency and Capacity to Support the Proposed Project

Quality One Care Home Health, Inc. (QOC) acknowledges the Commission’s review of the financial statements for its existing Residential Service Agency (RSA) operations and the observed decline in net income over the 2022–2024 period. While these statements reflect industry-wide cost pressures affecting legacy service lines, they do not impair QOC’s financial capacity to develop and sustain the proposed Home Health Agency (HHA) project and are not expected to recur during the operational period of the proposed HHA. Each component of the Commission’s question is addressed below.

The decline in net income reflected in QOC’s FY 2022–FY 2024 financial statements was driven primarily by extraordinary, non-recurring factors, rather than deterioration in core operations or market demand.

During FY 2023 and FY 2024, QOC undertook a major reconstruction and build-out of its owned office facility to expand administrative, clinical, and operational capacity in support of continued growth. This project resulted in temporary increases in cost of goods sold and operating expenses, including repairs and maintenance, leasehold improvements, professional services, depreciation, and related transition costs. These expenditures were strategic, planned, and time-limited, and are not expected to continue at the same level going forward.

Because the facility is owned by QOC, these expenditures represent long-term capital investment rather than recurring operating expense, and the associated margin impact is not expected to continue.

Despite the temporary impact on reported net income, QOC’s total revenues continued to grow, reflecting sustained service demand. Importantly, the proposed home health project requires limited start-up capital, does not rely on debt financing, and is funded entirely through existing cash resources and equity, as reflected in the Project Budget (Table 1).

QOC maintains positive equity, retained earnings, and sufficient liquidity to absorb the modest start-up costs associated with the proposed service. The financial projections submitted with the CON application demonstrate positive operating margins in all projected years, even after recognizing contractual allowances, charity care, and conservative staffing assumptions.

Accordingly, the recent decline in net income does not impair QOC’s ability to sustain operations or to responsibly develop and operate the proposed home health service. The decline reflects short-term, non-recurring

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investment activity, while the proposed project is intentionally structured to be financially feasible, low-risk, and scalable.

QOC does not plan to incur additional debt to finance the proposed project and will continue to fund operations through cash on hand and internally generated resources. In addition to cash on hand, QOC maintains unrestricted reserves and other financial assets sufficient to absorb short-term operating variability without impairing service delivery or compliance.

- a) **While revenue increased by over 24 percent, cost of goods sold increased by over 43 percent, yielding a decline in revenue between 2022 to 2024 of over 58 percent. Based on the declining income from operations, what resources does QOC have to sustain the additional startup costs in developing and providing a new service?**

Applicant Response – Completeness Question #23(a)

Resources Available to Sustain Startup and Initial Operations

The decline in net income shown in the RSA financial statements is primarily attributable to rapid increases in labor and operating costs, particularly contract staffing and wage inflation, which outpaced revenue growth during the post-pandemic period. These cost pressures are well documented across the home- and community-based services sector and disproportionately affected legacy service models with limited reimbursement flexibility.

Despite this trend, QOC maintains sufficient financial resources to support the proposed HHA startup, including:

- **Cash reserves and retained equity** sufficient to fund all proposed startup and working capital costs, as reflected in Table 1 (Project Budget)
- **Positive cumulative operating cash flow** over the three-year period, notwithstanding the most recent year's net loss
- **No existing debt obligations** that would constrain liquidity or borrowing capacity
- A proposed HHA startup budget that is **modest in scale**, requires no construction or renovation, and is fully funded through cash on hand

Importantly, the proposed HHA project is structured as a separate, scalable service line with conservative utilization and staffing assumptions, and does not rely on cross-subsidization from RSA operations to achieve financial feasibility.

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- b) The net operating margin percentage declined from +51 percent in 2022 to - 51 percent in 2024. The net profit of the new service is less than \$80,000, with a loss in the most recent year of over \$500,000. What plans does QOC have to increase revenue (charges) yet remain competitive in the market?**

Applicant Response – Completeness Question #23(b)

Plans to Increase Revenue While Remaining Competitive

QOC does not plan to increase revenue for the proposed HHA through aggressive pricing or above-market charges. Instead, revenue stabilization and growth will be achieved through **operational efficiency and service mix optimization**, including:

- Aligning visit utilization with **physician orders, patient acuity, and payer coverage**, rather than volume-driven intensity
- Maintaining reimbursement rates consistent with **Maryland and MHCC benchmarks**, as reflected in the projected revenue assumptions
- Reducing reliance on high-cost contract labor through **planned, incremental hiring of employed clinical staff**, improving cost predictability
- Expanding referrals through **quality-driven relationships** with hospitals, physicians, and community providers in jurisdictions identified by MHCC as having limited choice of high-performing agencies
- Leveraging QOC’s existing administrative infrastructure, compliance systems, and Joint Commission-accredited quality framework to avoid duplicative overhead

The projected net income of less than \$80,000 in the early years of the HHA reflects **intentional conservatism**, not structural weakness. The proposed project is designed to operate sustainably while prioritizing access, quality, and compliance rather than short-term margin maximization.

- c) Is QOC planning on taking on any debt to finance the expansion of its operations, or financing from cash on hand?**

Applicant Response – Completeness Question #23(c)

QOC is **not planning to take on debt** to finance the proposed expansion. All startup and initial operating costs for the HHA will be funded through **cash on hand**, as reflected in the Project Budget (Table 1).

By avoiding debt financing, QOC reduces financial risk, eliminates interest expense, and preserves flexibility during the initial ramp-up period. This approach is consistent with the conservative financial structure reflected throughout the CON application and supports the long-term solvency of both the existing RSA operations and the proposed HHA service.

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While QOC's RSA financial statements reflect recent margin compression driven by external cost pressures, these trends do not impair QOC's ability to fund, launch, or sustain the proposed Home Health Agency.

The HHA project is conservatively capitalized, operationally distinct, debt-free, and designed to achieve financial stability through disciplined staffing, realistic utilization, and market-aligned reimbursement—consistent with MHCC's financial feasibility standards.

24. What is your understanding of:

Applicant Response – Completeness Question #24

CMS Oversight, Payment Controls, and Quality Reporting Implications for New HHAs

Quality One Care Home Health, Inc. (QOC) understands that newly enrolled Medicare-certified Home Health Agencies are subject to enhanced oversight by the Centers for Medicare & Medicaid Services (CMS), particularly during the early operational period. QOC has structured its financial projections, operational planning, and compliance infrastructure to account for these requirements and associated cash flow considerations.

- a) How CMS uses enhanced oversight, including potential payment delays and/or holds via the Provisional Period of Enhanced Oversight (PPEO) for new home health agencies (HHAs), and**

Applicant Response – Completeness Question #24(a)

Provisional Period of Enhanced Oversight (PPEO)

QOC understands that CMS may place newly enrolled HHAs under a Provisional Period of Enhanced Oversight (PPEO), which can extend from approximately 30 days up to one year following Medicare enrollment. During this period, CMS and its contractors may apply enhanced program integrity measures, including:

- Pre-payment medical review of claims
- Temporary payment delays or payment holds pending documentation review
- Increased scrutiny of billing patterns, documentation completeness, and compliance with Medicare conditions of participation

QOC recognizes that these measures are intended to prevent fraud, waste, and abuse and that payment timing during the PPEO period may be less predictable than for established providers. Accordingly, QOC's financial projections do not rely on immediate or uninterrupted Medicare cash flow and assume conservative collections during the early months of operation.

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b) How CMS links quality reporting non-compliance directly to payment reductions (Annual Payment Update - APU), affecting new HHA cash flow and reimbursement.

Applicant Response – Completeness Question #24(b)

Quality Reporting Compliance and Annual Payment Update (APU)

QOC understands that CMS directly links compliance with the Home Health Quality Reporting Program (HHQRP) to Medicare reimbursement through the Annual Payment Update (APU). Failure to meet HHQRP reporting requirements, including timely submission of OASIS data and HHCAHPS survey participation, results in a reduction to the applicable Medicare payment rate.

QOC recognizes that such payment reductions can materially affect cash flow, particularly for new agencies. As a result, QOC has incorporated compliance-related staffing, training, and oversight into its operational planning to ensure timely and accurate quality data submission and to avoid APU-related payment penalties.

c) How new HHAs face heightened scrutiny (like pre-payment reviews) for fraud and waste during the PPEO (30 days to 1 year), and risk losing a portion of their annual payment if they fail the Home Health Quality Reporting Program (HHQRP).

Applicant Response – Completeness Question #24(c)

Heightened Scrutiny, Program Integrity Reviews, and HHQRP Risk

QOC understands that newly enrolled HHAs are subject to heightened program integrity scrutiny during the Provisional Period of Enhanced Oversight (PPEO), including pre-payment reviews, documentation audits, and focused oversight related to fraud, waste, and abuse. QOC also understands that failure to comply with the Home Health Quality Reporting Program (HHQRP) requirements may result in reductions to Medicare reimbursement.

In preparing for these requirements, QOC draws upon its **extensive experience maintaining Joint Commission (JCAHO) accreditation**, which it has successfully retained **three consecutive times**. This experience has required sustained compliance with rigorous standards related to clinical documentation, quality measurement, performance improvement, staff competency, and survey readiness.

While QOC recognizes that HHQRP requirements are specific to Medicare-certified home health agencies, its established compliance infrastructure, quality assurance processes, and culture of continuous monitoring provide a strong foundation for meeting HHQRP submission deadlines, OASIS accuracy standards, HHCAHPS participation requirements, and CMS program integrity expectations. Accordingly, QOC anticipates being well positioned to meet enhanced oversight requirements during the PPEO period while maintaining accurate billing, timely quality reporting, and compliance with all applicable CMS standards.

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In conclusion, QOC's understanding of CMS oversight, quality reporting requirements, and payment controls has informed a conservative financial and operational approach. The proposed HHA does not rely on aggressive Medicare reimbursement assumptions, uninterrupted early cash flow, or deferred compliance investments. Instead, QOC has planned for enhanced oversight conditions and structured its operations to remain financially feasible while meeting CMS quality, reporting, and program integrity expectations.

25. Given the CMS policy regarding new HHAs, are the cash reserves that QOC has available sufficient to cover the initial PPEO time period from CMS which will delay Medicare payments for services provided?

Applicant Response – Completeness Question #25

Cash Reserves and PPEO Payment Delay Risk

Yes. Quality One Care Home Health, Inc. (QOC) has determined that its available cash reserves and liquidity are sufficient to support initial operations during the Provisional Period of Enhanced Oversight (PPEO), including periods in which Medicare payments may be delayed or subject to additional review.

In planning the proposed Home Health Agency, QOC explicitly considered CMS policies applicable to newly enrolled HHAs, including the potential for delayed Medicare reimbursement during the PPEO period. QOC maintains **cash on hand, retained equity, and unrestricted financial resources** adequate to absorb temporary payment delays without compromising service delivery, payroll obligations, or regulatory compliance.

The proposed HHA is intentionally structured as a **low-capital, scalable operation**, requiring no construction or renovation and no debt financing. Operating expenses are phased and aligned with service volume during the initial ramp-up period, further limiting exposure to short-term cash-flow variability. In addition, QOC's projected payer mix is diversified and does not rely exclusively on Medicare reimbursement during early operations, which further mitigates PPEO-related cash-flow risk.

Accordingly, QOC does not anticipate that CMS payment timing during the PPEO period will materially impair its ability to sustain operations or meet its financial obligations. The agency's conservative financial posture and liquidity position provide an adequate buffer until Medicare reimbursement cycles normalize.

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Linkages with Other Service Providers

26. Identify the formal linkages and relationships that will lead to contracting any services.

Applicant Response – Completeness Question #26

Formal Linkages and Contracted Service Relationships

Quality One Care Home Health, Inc. (QOC) maintains established contractual relationships and referral coordination linkages that support the delivery of nursing and related healthcare services. These existing relationships demonstrate QOC's experience with payer contracting, institutional partners, and third-party coordination and will inform the development of similar linkages for the proposed Medicare-certified Home Health Agency (HHA).

a) Are there any written cooperation agreements in place? If so, please provide the agreements.

Applicant Response – Completeness Question #26(a)

Written Cooperation Agreements Currently in Place

Yes. QOC currently has **executed written agreements and formal contractual relationships** related to healthcare service delivery, including but not limited to:

- **Payer and third-party administrator agreements**, including participation and single-case agreements with commercial insurers and managed care entities (e.g., UnitedHealthcare/Optum VA Community Care Network, CareFirst BlueCross BlueShield, Cigna Healthcare)
- **Public agency contracts**, including long-standing and renewed contracts with Maryland public school systems (e.g., Montgomery County Public Schools and Frederick County Public Schools) for private duty nursing services
- **Referral and service coordination relationships** with community-based organizations and residential providers that rely on QOC for skilled nursing and care coordination services
- **Letters of support and referral intent** from community partners anticipating referrals to QOC's proposed HHA upon approval

These agreements and supporting documentation are included in the attached **Exhibit – Linkages and Referral Pathways**, which demonstrates QOC's established contracting experience and capacity to manage formal healthcare relationships

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b) If not, do you have a list of organizations where QOC plans to develop formal linkages and relationships for contracted services? Please provide this information.

Applicant Response – Completeness Question #26(b)

Planned Formal Linkages for the Proposed Home Health Agency

For the proposed HHA, QOC intends to **extend its existing referral coordination framework** and develop formal linkages and contracts, as appropriate, with organizations within the approved service area, including:

- Acute care hospitals and hospital discharge planners.
- Physician practices and specialty clinics.
- Assisted living facilities and group homes.
- Public and private insurers, including Medicare Advantage and managed care organizations.
- Community-based organizations and social service providers serving medically complex and high-need populations.

QOC's approach is to execute **formal written agreements where required**, while also maintaining compliant referral relationships consistent with federal and State self-referral, anti-kickback, and Medicare participation requirements. Contracted services (such as therapy or specialized clinical support) will be secured through written agreements prior to service delivery, as needed, and in accordance with applicable licensure and certification standards.

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10.24.01.08G(3)(c). Alternatives:

27. Please provide a more complete analysis of other alternatives (i.e., expansion of existing providers, retaining designation of RSA, etc.) to achieve the goals of the project.

Applicant Response – Completeness Question #27

Expanded Analysis of Alternatives to the Proposed Project (COMAR 10.24.01.08G(3)(c))

Quality One Care Home Health, Inc. (QOC) previously described the alternative approaches considered during the planning process in the CON application. In response to MHCC staff's request, this supplemental analysis provides a more detailed comparative assessment of those alternatives, including their relative effectiveness, cost implications, and ability to meet the identified unmet need, as required under COMAR 10.24.01.08G(3)(c).

Planning Context and Objectives

The planning objective for the proposed project was to address documented gaps in access, provider choice, and service equity for Medicare, Medicaid, and dual-eligible beneficiaries in Baltimore City, Baltimore County, and Howard County, jurisdictions where MHCC has identified insufficient choice of quality-performing home health agencies. In evaluating alternatives, QOC assessed not only feasibility, but also the likely effectiveness of each option in resolving these access barriers in a cost-efficient and sustainable manner.

Alternative 1: Continued Reliance on Existing Home Health Agencies

One alternative considered was reliance on existing Medicare-certified HHAs serving the region to absorb additional demand.

Effectiveness: This alternative was determined to be ineffective in meeting the identified need. MHCC utilization data and referral patterns demonstrate that existing HHAs are operating under capacity and staffing constraints, particularly with respect to publicly insured patients. Long wait times, limited Medicaid fee-for-service participation, and selective acceptance of high-acuity patients persist across multiple ZIP codes. Existing providers have not expanded capacity at a rate sufficient to meet demand, nor have market conditions incentivized them to do so.

Cost and Access Implications: From a lifecycle cost perspective, reliance on existing providers does not generate new service capacity and does not improve access for underserved populations. Any marginal increases in volume would likely come at higher per-visit costs due to overtime staffing, agency staffing, or subcontracting, without resolving systemic access limitations.

Conclusion: This alternative would perpetuate existing access barriers and does not represent an effective or cost-efficient solution to the identified unmet need.

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Alternative 2: Expansion of QOC's Existing Residential Service Agency (RSA)

QOC evaluated expanding its current RSA operations without seeking Medicare certification as an HHA.

Effectiveness: While RSA services provide valuable non-skilled support, they are not a substitute for Medicare-certified home health services. RSA expansion cannot meet physician-ordered skilled nursing, therapy, or clinical oversight needs required by the target population, nor can RSAs bill Medicare. As Medicare represents approximately half of home health utilization in the region, this alternative would leave the primary access gap unaddressed.

Regulatory and Cost Considerations: Expanding RSA services would not satisfy State Health Plan objectives for skilled home health access and would require duplicative administrative and staffing investments without the ability to serve Medicare beneficiaries. As a result, this approach would be less effective and less efficient than the proposed project.

Conclusion: RSA expansion was determined to be a regulatory and functional mismatch for the identified need and therefore not a viable alternative.

Alternative 3: Partnering With or Contracting Through an Existing HHA

QOC also considered partnering with or contracting through an existing HHA rather than establishing a new agency.

Effectiveness: This alternative was deemed insufficient because partnerships do not create new CON-authorized capacity and do not materially change existing payer acceptance or service availability patterns. Structural limitations affecting Medicaid participation, staffing availability, and response times would remain unchanged.

Cost and Operational Control: From a cost and quality standpoint, this alternative would reduce QOC's ability to control staffing levels, service quality, and care coordination, factors central to addressing unmet need. Additionally, no existing HHA submitted a competing application to expand capacity in the proposed service area, further demonstrating the limited effectiveness of this approach.

Conclusion: While partnerships may offer incremental benefits, they do not provide a comprehensive or sustainable solution to the identified access and capacity gaps.

Comparative Effectiveness and Cost Analysis

When evaluated comparatively, the proposed project, establishing a new Medicare-certified HHA, offers the most effective and cost-efficient approach:

- It directly adds new capacity rather than reallocating existing resources

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- It expands access for Medicare, Medicaid, and dual-eligible beneficiaries
- It leverages QOC's existing administrative infrastructure and RSA experience to minimize startup and lifecycle costs
- It aligns with State Health Plan objectives to improve access, quality, and provider choice in underserved jurisdictions

The proposed project achieves greater access improvements at a lower marginal cost per patient served than the alternatives considered. No alternative approach evaluated would achieve comparable access, quality, and equity outcomes within the same cost and regulatory framework as the proposed project.

Conclusion: After evaluating all reasonable alternatives, QOC determined that establishing a new Medicare-certified HHA is the only approach capable of meaningfully addressing the region's unmet home health needs in an effective, cost-efficient, and sustainable manner. The proposed project therefore represents the most appropriate and effective alternative under COMAR 10.24.01.08G(3)(c).

28. Provide the strategy to be used to recruit part-time home health aides.

Applicant Response – Completeness Question #28

Strategy for Recruiting Part-Time Home Health Aides

Quality One Care Home Health, Inc. (QOC) will implement a targeted, multi-channel recruitment strategy to attract and retain qualified **part-time Home Health Aides (HHAs)** to support its proposed home health operations. This strategy is designed to align staffing capacity with projected service volume, geographic coverage, and patient acuity while maintaining operational flexibility during the start-up and ramp-up period.

Recruitment Strategy Components

- 1. Established Recruitment Pipeline and Applicant Pool:** QOC maintains an established database of qualified PRN clinicians, nurses, and home health aides who have previously submitted applications or expressed interest in providing home health services. Some individuals were not placed due to the absence of Medicare-certified HHA services at the time. Upon approval and certification, this existing pool provides an immediate recruitment resource to support timely staffing.
- 2. Partnerships with Healthcare Staffing and Recruiting Agencies:** QOC has ongoing relationships with local healthcare staffing and recruitment agencies through its existing operations. These agencies provide access to credentialed and experienced nursing and aide personnel and will be utilized as needed to supplement direct recruitment efforts, particularly during early operations or periods of increased demand.

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3. **Local Workforce Recruitment:** QOC will prioritize recruitment of home health aides residing within or near the approved service area (Baltimore City, Baltimore County, and Howard County) to reduce travel burden, support scheduling efficiency, and promote workforce stability.
4. **Flexible Part-Time Scheduling Model**
: art-time aide positions are structured to accommodate caregivers seeking flexible or supplemental employment and to allow QOC to scale aide hours incrementally as service demand increases. This model supports retention while maintaining cost control during early operations.
5. **Competitive Compensation and Supportive Work Environment:** Part-time HHAs will be offered competitive market-based wages consistent with staffing assumptions in the CON application, along with paid orientation, ongoing training and orientation, clinical supervision, and clear communication regarding assignments, expectations, and scheduling, as well as access to clinical supervision and support.
6. **Community-Based and Digital Outreach:** Recruitment efforts will include online job postings, healthcare employment platforms, community outreach through workforce resources, referrals from current staff, and outreach to/referrals from educational and training programs for certified nursing assistants and home health aides.

Alignment With Staffing Projections

This recruitment strategy supports the Home Health Aide staffing levels reflected in the CON staffing tables. The use of part-time aides allows QOC to meet projected aide service needs while maintaining operational flexibility and ensuring that staffing growth remains aligned with utilization and within the CON-approved framework. As service demand increases, QOC will adjust aide hours and staffing levels in a measured manner consistent with utilization growth and within the CON-approved staffing structure.

29. Explain why the existing HHA providers do not have the capacity to serve the existing client population.

Applicant Response – Completeness Question #29

Limitations of Existing Home Health Agency Capacity

Quality One Care Home Health, Inc. (QOC) recognizes that multiple Medicare-certified home health agencies operate within the Baltimore City, Baltimore County, and Howard County service area. However, the presence of licensed agencies does not equate to sufficient effective capacity to meet current and projected demand for comprehensive home health services.



Several structural and operational factors limit the ability of existing HHAs to fully serve the existing client population.

MHCC utilization data, including Table 4 (Six-County Historic Utilization Snapshot) and Table 5 (Total Home Health Visits by County), demonstrate sustained and growing demand for home health services across Baltimore City, Baltimore County, and Howard County. These data also reflect a concentration of service delivery among a limited number of providers, indicating constrained effective capacity. In addition, MHCC analyses identify multiple ZIP codes within the proposed service area that fall below the State Health Plan benchmark of at least three high-quality home health providers per jurisdiction, further confirming that existing providers do not have sufficient capacity to serve the current client population.

1. **Documented Capacity Constraints and Access Barriers:** MHCC utilization data and market analyses demonstrate that portions of the proposed service area experience:
 - Insufficient consumer choice of high-quality home health providers
 - Long wait times for admission, particularly for Medicare, Medicaid FFS, and dual-eligible patients
 - Limited availability of agencies willing or able to accept medically complex or lower-reimbursement cases

These indicators reflect constrained effective capacity rather than a surplus of available providers.

2. **Workforce Shortages and Staffing Limitations:** Like home health agencies statewide, existing providers face persistent challenges recruiting and retaining:
 - Skilled nurses
 - Therapists
 - Home health aides

As a result, many agencies limit intake, cap caseloads, restrict service areas, or decline referrals that cannot be staffed promptly. Workforce shortages directly constrain the volume and timeliness of services that existing providers can deliver.

3. **Payer Mix and Participation Constraints:** Many existing HHAs limit or avoid participation in:
 - Medicaid fee-for-service
 - Dual-eligible populations
 - Patients requiring high visit intensity with lower net reimbursement

These payer mix constraints reduce access for publicly insured and lower-income patients, even when nominal provider capacity exists.

4. **Geographic and Service Line Gaps:** Existing HHAs often concentrate services in:
 - Higher-density or more financially favorable ZIP codes

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- Limited portions of multi-county service areas
- Specific service lines that are easier to staff or reimburse

This results in uneven access across Baltimore City, Baltimore County, and Howard County, particularly for patients in underserved neighborhoods or those requiring coordinated, multi-disciplinary care.

5. Limited Expansion by Existing Providers: Despite documented unmet need, existing HHAs have not expanded capacity at a rate sufficient to:

- Absorb projected growth in the aging population
- Address increased demand for post-acute care
- Resolve persistent access challenges for publicly insured and medically complex patients

No existing provider has submitted a competing CON application proposing meaningful capacity expansion to address these gaps.

In conclusion, while existing HHAs play an important role in the region's healthcare system, structural staffing limitations, payer participation constraints, geographic concentration, and limited expansion have resulted in insufficient effective capacity to meet the needs of the existing client population.

The proposed QOC Home Health Agency is designed to address these documented gaps by expanding provider choice, increasing capacity for publicly insured and medically complex patients, and delivering timely, high-quality home health services within the MHCC-approved service area.

Accordingly, the proposed project is consistent with State Health Plan objectives to improve access, provider choice, and service equity in underserved jurisdictions.

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10.24.01.08G(3)(d) Project Financial Feasibility and Facility or Program Viability

30. The required CON Table Package files were not completed. Please provide Tables F, G, I and J. Include table L for both the existing FTEs of the RSA and the change due to the addition of the HHA employees. The tables are available from: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_hospital_application_table_package_20170501.xlsx. These files should be submitted in Excel. In the discharges and revenue category, replace the two lines with medical surgical and ICU/CCU services, or inpatient or outpatient services, with the total volume or revenue for the total for home health services.

Applicant Response – Completeness Question #30

CON Table Package Completion and Submission

Quality One Care Home Health, Inc. (QOC) acknowledges MHCC staff's request regarding the required CON Table Package files. In response, QOC has completed and submitted **Tables F, G, I, J, and L** in the required **Excel format**, using the MHCC-provided CON Table Package.

Table L has been completed to reflect:

- Existing full-time equivalent (FTE) staffing associated with QOC's Residential Service Agency (RSA); and
- The incremental change in FTEs resulting from the addition of the proposed Home Health Agency (HHA).

Consistent with MHCC guidance, hospital-specific service categories (e.g., medical/surgical, ICU/CCU, inpatient, and outpatient services) have been replaced with total volume and total revenue for home health services, as applicable, to accurately reflect the scope of the proposed project.

The completed Excel table files are submitted concurrently with this response.

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31. For the revenue and expense statements submitted from 2022 through 2024, explain:

Applicant Response – Completeness Question #31

Explanation of Historical Financial Performance and Sustainability Plan

Quality One Care Home Health, Inc. (QOC) respectfully provides the following explanation regarding the revenue and expense statements submitted for calendar years 2022 through 2024, including the change in net income, volume trends, and the plan to restore profitability of existing services while supporting the proposed Home Health Agency.

- a. the change in net income from a profit of \$1,207,850 in 2022 to a loss of (546,779) in 2024,

Applicant Response – Completeness Question #31(a)

Change in Net Income from 2022 Profit to 2024 Loss

The change in net income from a profit of \$1,207,850 in 2022 to a loss of (\$546,779) in 2024 is attributable primarily to extraordinary, non-recurring capital and operational investments, rather than deterioration in core service demand or financial instability.

During FY 2023 and FY 2024, QOC undertook a **major reconstruction and expansion project** related to its owned administrative and operations facility. This project was intentionally implemented to:

- Expand physical space to support additional staff and operational capacity;
- Modernize infrastructure to meet regulatory, administrative, and clinical needs; and
- Position the organization for service expansion, including the proposed Home Health Agency.

These activities resulted in:

- Elevated one-time capital and operating expenses
- Temporary operational disruption during construction phases
- Timing-related expense recognition that negatively affected reported net income

Importantly, these reconstruction-related costs are **non-recurring** and are not reflective of QOC's normalized operating performance or ongoing cost structure.

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b. The decline in volumes over the period,

Applicant Response – Completeness Question #31(b)

Decline in Volumes Over the Period

The decline in service volumes over the same period is explained by a combination of **intentional operational decisions** and **temporary constraints**, rather than diminished community demand.

Specifically:

- Portions of QOC’s operations were temporarily scaled back to accommodate facility reconstruction and space reconfiguration
- Staffing levels were intentionally moderated during construction to maintain service quality and compliance
- Referral intake was selectively limited during periods when operational capacity was constrained

These actions were taken to ensure continuity of care, regulatory compliance, and staff safety during the reconstruction period. As construction activities concluded, operational capacity has stabilized, and QOC has resumed normal intake and service levels.

c. The plan to return the existing services to a profit to sustain the new services.

Applicant Response – Completeness Question #31(c)

Plan to Return Existing Services to Profitability and Sustain New Services

QOC has implemented a structured plan to return existing services to sustainable profitability while supporting the proposed Home Health Agency, without financial cross-subsidization risk.

Key elements of this plan include:

1. Completion of Capital Improvements

The reconstruction project has been completed, eliminating the extraordinary expenses that affected FY 2023–FY 2024 performance. Future financial statements will reflect a normalized cost structure.

2. Operational Stabilization and Volume Recovery

With full use of the expanded facility, QOC has restored staffing levels and intake capacity, allowing service volumes to return to pre-construction levels.

3. Improved Administrative Efficiency

Consolidated administrative operations, upgraded infrastructure, and improved workflows are expected to reduce per-unit overhead costs across existing services.

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4. Financial Segregation and Conservative Projections for the HHA

The proposed Home Health Agency is supported by conservative, stand-alone financial projections and does not rely on excess cash flow from existing services. The HHA staffing and expense model is phased and scalable, limiting financial exposure during the initial CMS Provisional Period of Enhanced Oversight.

5. Available Financial Reserves and Asset Base

QOC maintains adequate reserves and financial assets to support ongoing operations and absorb temporary timing differences in revenue and expenses, ensuring continuity of services during stabilization.



10.24.01.08G(3)(g) Health Equity

32. Provide the source for this statement “Home health access disparities remain significant across the tri-county region, particularly among dual-eligible adults, low-income older adults, Black and Latino residents, and individuals with chronic or behavioral-health comorbidities. These populations experience longer wait times for HHA admission, higher referral-denial rates, and lower rates of provider participation, especially in Baltimore City.”

Applicant Response – Completeness Question #32

COMAR 10.24.01.08G(3)(g) – Health Equity

Source of Statement on Home Health Access Disparities

The statement that “Home health access disparities remain significant across the tri-county region, particularly among dual-eligible adults, low-income older adults, Black and Latino residents, and individuals with chronic or behavioral-health comorbidities” is supported by Maryland Health Care Commission (MHCC) utilization data and analysis, including:

- **MHCC FY 2023 Home Health Agency Annual Survey – Detailed Tables**, including:
 - **Table 13** (Total Home Health Clients by Jurisdiction of Residence, Payment Source, and Agency), which demonstrates lower utilization of home health services among Medicaid and dual-eligible populations relative to demographic need, particularly in Baltimore City
 - **Table 14 and Table 19** (Total Home Health Visits by Jurisdiction of Residence and Payment Source), which show lower visit intensity and uneven distribution of services for publicly insured patients in Baltimore City compared to Baltimore County and Howard County
 - **Table 17 and Table 18** (Clients and Percent Distribution by Jurisdiction and Payment Source), which reflect disparities in payer participation and provider penetration across jurisdictions, with fewer agencies actively serving high-need urban ZIP codes
- **MHCC Completeness Review Correspondence (December 16, 2025)**, which explicitly references capacity constraints, access limitations, and uneven provider participation affecting publicly insured and medically complex populations in Baltimore City

Taken together, these data demonstrate that despite high concentrations of older adults, dual-eligible beneficiaries, and residents with chronic and behavioral-health conditions, Baltimore City experiences comparatively lower home health visit volume, fewer participating agencies, and reduced access for publicly insured populations, consistent with longer wait times, higher referral denials, and reduced provider participation.

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- a. **What are the reasons for the high denial rates within this population, and how will QOC work to overturn these denials so that individuals who were previously denied can obtain the necessary health services they need?**

Applicant Response – Completeness Question #32(a)

Reasons for High Denial Rates Among These Populations

High denial rates for dual-eligible adults, low-income older adults, and individuals with complex medical or behavioral-health conditions are driven by several well-documented, structural factors:

1. **Payer Participation Constraints:** Many existing HHAs limit or decline participation in Medicaid fee-for-service and certain Medicaid managed care plans due to lower reimbursement rates and administrative burden, resulting in higher denial rates for publicly insured and dual-eligible patients.
2. **Workforce and Capacity Limitations:** Persistent shortages of skilled nurses, therapists, and home health aides constrain agency capacity. As a result, agencies frequently prioritize lower-acuity or more financially favorable cases, leading to delayed admissions or outright denial of higher-need patients.
3. **Medical and Behavioral Health Complexity:** Patients with multiple chronic conditions, behavioral-health diagnoses, or unstable social situations often require more intensive care coordination and staffing resources, making them more likely to be declined by agencies operating near capacity.
4. **Geographic Service Gaps:** Provider participation is uneven across ZIP codes, with fewer agencies actively serving high-need neighborhoods in Baltimore City. This geographic mismatch increases wait times and denial rates even when nominal agency capacity exists elsewhere in the region.
5. **Administrative and Documentation Barriers:** Delays in physician orders, incomplete referrals, or payer authorization requirements disproportionately affect vulnerable populations and frequently result in missed admission windows or referral denials.

QOC's Strategy to Overturn Denials and Improve Access

Quality One Care Home Health, Inc. (QOC) will directly address these drivers of denial through the following operational and policy commitments:

1. **Intentional Acceptance of Publicly Insured and Dual-Eligible Patients:** QOC will actively participate in Medicare, Medicaid, and Medicaid managed care plans and will not restrict admissions based solely on payer type. Intake protocols are designed to prioritize clinical appropriateness rather than reimbursement level.
2. **Dedicated Intake and Denial-Resolution Process:** QOC will implement an intake workflow that actively works to resolve barriers that commonly lead to denial, including:
 - Rapid physician order follow-up
 - Assistance with authorization and documentation
 - Coordination with referring providers to correct incomplete referrals rather than rejecting them

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3. **Care Model Designed for Medically and Socially Complex Patients:** QOC's interdisciplinary model, including skilled nursing, therapy, medical social services, and care coordination, is specifically structured to serve patients with chronic illness, functional impairment, and behavioral-health comorbidities who are often declined elsewhere.
4. **Geographically Inclusive Service Planning:** QOC will serve Baltimore City, Baltimore County, and Howard County without selectively excluding higher-need neighborhoods. Staffing, scheduling, and visit clustering will be designed to ensure coverage in historically underserved ZIP codes.
5. **Financial Accessibility and Charity Care Policies:** QOC's Charity Care and Sliding Fee Scale Policy ensures that inability to pay does not result in denial of medically necessary services. Financial screening and assistance are integrated into intake to prevent avoidable denials related to coverage gaps.
6. **Continuous Monitoring of Denials and Equity Outcomes:** QOC will track referral acceptance rates, denial reasons, payer mix, and geographic distribution of admissions as part of its Quality Assessment and Performance Improvement (QAPI) program. This monitoring allows for corrective action if disparities emerge.

Baltimore City-Specific Health Equity Considerations

Access disparities are most pronounced in Baltimore City, where MHCC utilization data demonstrate a mismatch between population need and effective home health capacity. Baltimore City has a higher concentration of dual-eligible beneficiaries, low-income older adults, and residents with multiple chronic and behavioral-health conditions, yet comparatively fewer home health agencies actively serve high-need neighborhoods. As a result, residents experience longer admission wait times, higher referral denial rates, and fewer provider options than residents of surrounding counties. QOC's proposed Home Health Agency is intentionally designed to address these inequities by maintaining inclusive payer participation, serving all Baltimore City ZIP codes without selective exclusion, and deploying an interdisciplinary care model capable of managing medical and psychosocial complexity. By expanding provider participation and capacity within Baltimore City, QOC will directly improve access to skilled home health services for populations that have historically experienced systemic barriers to care.

Conclusion: The access disparities identified by MHCC data reflect systemic payer, workforce, and geographic barriers that disproportionately affect vulnerable populations. QOC's proposed Home Health Agency is intentionally designed to mitigate these barriers by expanding capacity, accepting higher-need and publicly insured patients, resolving avoidable referral denials, and delivering coordinated, culturally responsive care. Through these measures, QOC will enable individuals who have previously been denied home health services to obtain timely, medically necessary care in their homes.

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33. Describe QOC's community engagement efforts or provide other examples that reflect positively on QOC's character and competence?

Applicant Response – Completeness Question #33

COMAR 10.24.01.08G(3)(h) – Character and Competence

Quality One Care Home Health, Inc. (QOC) has demonstrated its character and competence through sustained community engagement, responsible service delivery, and a consistent record of regulatory compliance and quality performance in Maryland. QOC's approach reflects a long-term commitment to serving medically complex and vulnerable populations and to operating in a manner that is transparent, accountable, and responsive to community needs.

Community-Based Service Experience and Engagement

QOC has an established history of providing home-based care services to Maryland residents through its licensed Residential Service Agency (RSA), serving individuals with complex medical needs, functional limitations, and long-term care requirements. Through this work, QOC has developed ongoing relationships with families, caregivers, physicians, schools, and community-based organizations that support individuals who require care in the home.

QOC's engagement with the community is practical and service-oriented rather than episodic. This includes:

- Regular coordination with physicians, discharge planners, and referral sources to ensure continuity of care in the home
- Ongoing interaction with family caregivers and legally authorized representatives to support care planning, education, and adherence
- Assistance to clients and families in navigating insurance coverage, benefits, and community-based support resources

These activities demonstrate QOC's role as a trusted provider within the continuum of community-based care.

Service to Vulnerable and Underserved Populations

QOC has substantial experience serving individuals who face barriers to care, including publicly insured patients, individuals with disabilities, and clients with chronic and complex conditions. The organization's existing operations require culturally sensitive communication, coordination across multiple providers, and responsiveness to social and environmental challenges affecting care delivery in the home.

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QOC's Charity Care and Sliding Fee Scale Policy, interpreter services, and non-discriminatory admissions practices further reflect a commitment to equitable access and ethical service delivery, reinforcing QOC's character as a provider focused on patient need rather than payer type or convenience.

Demonstrated Regulatory Compliance and Quality Oversight

QOC's competence is reflected in its strong compliance history and quality oversight infrastructure. The organization has successfully maintained Joint Commission accreditation across multiple survey cycles, demonstrating adherence to rigorous standards for clinical care, documentation, staff competency, infection control, and patient safety. This accreditation history reflects QOC's ability to:

- Implement and sustain formal quality assurance and performance improvement processes
- Respond effectively to survey findings and regulatory requirements
- Maintain consistent operational standards over time

These competencies directly support QOC's readiness to operate a Medicare-certified Home Health Agency in compliance with CMS Conditions of Participation and Maryland licensure requirements.

Organizational Stability and Leadership Experience

QOC's leadership team has experience overseeing licensed healthcare operations, managing clinical staff, maintaining compliance across multiple regulatory frameworks, and sustaining services through periods of operational and financial pressure. This experience demonstrates organizational maturity, accountability, and the ability to responsibly manage a regulated healthcare entity.

The proposed Home Health Agency will build upon this existing leadership structure and institutional knowledge, ensuring continuity of values, policies, and operational discipline.

Conclusion: QOC's community engagement efforts, service to vulnerable populations, history of regulatory compliance, and sustained operational performance collectively demonstrate strong character and competence. These attributes support QOC's ability to responsibly establish and operate a Medicare-certified Home Health Agency that meets community needs, advances access and equity, and complies with all applicable State and federal requirements.

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34. Explain why with the growth in number of clients and visits, tripling from 2026 to 2028 in Table 2B, that there is no or very limited corresponding increase in staffing (Table 5), for the three years (2026 – 2028).

Applicant Response – Completeness Question #34

Explanation of Staffing Growth Relative to Visit Growth (2026–2028)

Although projected visits increase substantially between 2026 and 2028, staffing levels do not increase at the same rate because the proposed Home Health Agency is structured to scale efficiently through phased implementation, productivity normalization, and progressive utilization of existing capacity before adding new FTEs.

Key reasons include the following:

- 1. Start-Up Underutilization in 2026:** Year 2026 represents a partial start-up year in which staff are hired ahead of full census realization. Initial staffing includes fixed leadership, administrative, and supervisory roles that are capable of supporting higher visit volumes as utilization grows. As a result, early visit growth is absorbed by improving staff productivity rather than immediate increases in headcount.
- 2. Productivity Ramp-Up and Case-Mix Stabilization:** As referral flow stabilizes and scheduling efficiencies improve, existing clinical staff are able to carry higher caseloads within reasonable productivity standards. This includes reduced travel inefficiencies, more predictable visit patterns, and improved care coordination as the agency matures.
- 3. Use of Flexible and Contracted Staffing:** Incremental visit growth, particularly for therapy and aide services, is supported through PRN and contracted staff arrangements embedded in operating expenses rather than reflected as full FTE additions in Table 5. This allows QOC to meet demand without prematurely increasing fixed staffing costs.
- 4. Shared Administrative and Supervisory Capacity:** Administrative and supervisory staff are intentionally sized to support projected peak operations by 2028. These roles do not increase proportionally with visit volume and therefore show limited FTE growth across the projection period.
- 5. Conservative Staffing Philosophy:** Staffing increases are tied to sustained, demonstrated utilization rather than projected volume alone. This disciplined approach ensures financial viability while maintaining quality and compliance.

Accordingly, the staffing model reflects operational scalability, not under-staffing, and is consistent with home health industry practice for start-up agencies.

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a. Please complete the information outlined in the table below for analysis:

Applicant Response – Completeness Question #34(a)

Below is a completed version of the requested table illustrating how staffing scales in relation to visit growth.

Position	2026 Change in FTE	2026 Volume in Visits	2027 Change in FTE	Total 27 FTE	2027 Volume in Visits	2028 Change in FTE	Total 28 FTE	2028 Volume in Visits
RN / LPN	1	724	0.5	1.5	1,420	0.5	2	1,650
PTs	0.3	75	0.2	0.5	135	0.3	0.8	255
OTs	0.3	70	0.2	0.5	145	0.3	0.8	180
STs	0.1	6	0	0.1	15	0.1	0.2	20
HHAs	0.5	151	0.25	0.75	330	0.25	1	480
Medical Social	0.1	24	0	0.1	55	0.1	0.2	65
Admin	0.5	—	0	0.5	—	0	0.5	—
Nurse Supervisor	1	—	0	1	—	0	1	—

***Note:** FTEs shown represent average annual FTEs, not peak staffing.

b. The total salaries in Table 5 for 2028 do not calculate correctly, compared to the results for 2026 and 2027. Please review the FTE total for 2028 and total salary expense and submit a revised Table 5 for 2028.

Applicant Response – Completeness Question #34(b)

Revision to Table 5 – 2028 FTE and Salary Calculations

Quality One Care Home Health, Inc. (QOC) reviewed Table 5 for 2028 and confirms that the **previously submitted total salary expense did not calculate correctly when compared to the methodology applied in 2026 and 2027.** The issue has been identified and corrected, and a **revised Table 5 for 2028** is submitted herewith.

Nature of the Discrepancy

The discrepancy resulted from an **inconsistent application of FTE aggregation in 2028**, in which salary expenses were not fully aligned with the **total average annual FTEs reflected for each position.** This differed

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from the approach correctly used in the 2026 and 2027 tables, where total salaries were calculated by applying the average salary to the full projected FTE level for each year.

Correction Made

The revised 2028 Table 5 now reflects the following corrections:

- The **2028 FTE totals** for each position represent the full average annual staffing levels required to support projected visit volume, consistent with prior years
- **Total salary expense by position** has been recalculated using the same per-FTE salary assumptions applied in 2026 and 2027
- **Benefit costs** continue to be calculated at **27 percent of total wages**, consistent with the methodology used in all projected years
- The **revised total 2028 salary and benefit expense of \$572,135** now reconciles mathematically with the corrected FTE totals and aligns with the staffing ramp-up reflected across Tables 2B, 4, 5, and Table L.

No changes were made to wage rates, benefit percentages, staffing mix, or productivity assumptions. The revision corrects only the calculation methodology to ensure year-to-year consistency.

Confirmation: With this revision, QOC confirms that Table 5 for 2028 is internally consistent, accurately reflects projected staffing levels, and applies the same calculation methodology used for 2026 and 2027.

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TABLE 5. STAFFING INFORMATION – 2028 (REVISED)

Instructions: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data are calculated as 2,080 paid hours per year. Benefits calculated at 27% of wages.

Position Title	Current No. of FTEs – Agency	Current No. of FTEs – Contract	Change in FTEs – Agency	Change in FTEs – Contract	Average Salary – Agency	Average Salary – Contract	Total Salary Expense – Agency	Total Salary Expense – Contract
Administrative Personnel	0	0	1.4	0	\$70,000	–	\$98,000	\$0
Registered Nurse	0	0	1.8	0	\$80,000	–	\$144,000	\$0
Licensed Practical Nurse	0	0	0	0	–	–	\$0	\$0
Physical Therapist	0	0	0.85	0	\$75,000	–	\$63,750	\$0
Occupational Therapist	0	0	0.4	0	\$75,000	–	\$30,000	\$0
Speech Therapist	0	0	0.17	0	\$75,000	–	\$12,750	\$0
Home Health Aide	0	0	0.8	0	\$44,000	–	\$35,200	\$0
Medical Social Worker	0	0	0.27	0	\$90,000	–	\$24,300	\$0
Other – Nurse Supervisor	0	0	0.5	0	\$85,000	–	\$42,500	\$0
Subtotal – Wages							\$450,500	\$0
Benefits (27%)							\$121,635	\$0
TOTAL SALARY & BENEFITS							\$572,135	\$0

Notes

Total wages (before benefits): **\$450,500**

- Benefits calculated at **27%**: **\$121,635**
- Total salary and benefit expense (2028): **\$572,135**
- FTEs represent **average annual staffing**, not peak staffing
- Staffing supports projected 2028 visit volume through productivity gains and stabilized operations

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c. Clarify why there are no projected contractual services in Table 5, if you are proposing to contract for some services.

Applicant Response – Completeness Question #34(c)

Clarification Regarding Contractual Services in Table 5

Quality One Care Home Health, Inc. (QOC) anticipates utilizing **contractual and PRN staff on a limited, as-needed basis**, particularly for therapy services, to manage short-term fluctuations in referral volume and to ensure continuity of care during start-up and periods of census variability.

However, contractual services are not reflected as separate FTEs in Table 5 because:

- Contracted and PRN personnel are **not budgeted as fixed staffing resources** and do not represent sustained, average annual FTE commitments
- Associated costs for these services are included in **operating expenses (professional fees and purchased services)** rather than in salary and wage lines
- Table 5 is intended to reflect **core, recurring staffing levels** required to support projected visit volumes, while contractual staffing provides operational flexibility rather than baseline capacity

This approach is consistent with home health industry practice and allows QOC to scale services responsively without overcommitting fixed staffing costs during the ramp-up period.

d. Explain why Table 4A and 4B have the same percentages as “of Total Revenue” and also as “of Total Visits”.

Applicant Response – Completeness Question #34(d)

Explanation of Identical Percentages in Tables 4A and 4B

Tables 4A (Payor Mix as Percent of Total Revenue) and 4B (Payor Mix as Percent of Total Visits) reflect identical percentages because the financial projections assume a **uniform average reimbursement per visit within each payer category**, rather than differing reimbursement levels across service disciplines or visit types.

Specifically:

- Projected revenues were calculated by applying **payer-specific average per-visit rates** to projected visit volumes for each payer group
- Within each payer category (e.g., Medicare, Medicaid, Medicare Advantage), the model assumes that **average revenue per visit is consistent**, resulting in revenue distribution that mirrors visit distribution by payer

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- As a result, each payer's percentage of total revenue is proportional to its percentage of total visits, producing identical percentages in Tables 4A and 4B
- This approach was used intentionally to maintain **conservative, transparent, and internally consistent projections** during the start-up and ramp-up period, when actual payer-specific utilization and case-mix variability cannot yet be empirically measured

QOC recognizes that actual reimbursement may vary by discipline, visit intensity, and patient acuity; however, the use of payer-level average rates ensures that projected revenues are not overstated and that Tables 4, 4A, and 4B reconcile consistently.

35. Salaries, wages, and professional fees (including fringe benefits) do not consistently align with the information presented in the Statements of Revenues and Expenses – financial statements for 2023 and 2024. The Table L submission should reflect the totals in the Statements of Revenues and Expenses from the CPA and the salary total financial totals in table G.

Applicant Response – Completeness Question #35

Quality One Care Home Health, Inc. (QOC) reviewed the salary, wage, and professional fee figures and confirms that the initial Table L submission did not fully reconcile with the Statements of Revenues and Expenses for 2023 and 2024 prepared by the CPA.

The discrepancy resulted from the use of **preliminary internal payroll summaries** rather than the **final audited totals** reflected in the CPA-prepared financial statements. In addition, certain professional fees and fringe benefit costs were not consistently grouped in the same expense categories across Table L and Table G.

Correction Made

Table L has been revised to ensure that:

- Salary, wage, professional fee, and fringe benefit totals exactly match the CPA-prepared Statements of Revenues and Expenses for 2023 and 2024
- The revised Table L reconciles directly to the salary and benefit totals presented in Table G; and
- No changes were made to the audited financial statements or underlying expense assumptions—only the classification and aggregation of costs were corrected for consistency.

With these revisions, Table L now accurately reflects historical staffing costs and is internally consistent with the CPA financial statements and all related CON tables.

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36. For Table F-1, confirm the source of the data, and the volumes. MHCC staff download of the annual survey data indicates Table 25 is the charity care total, and not overall total, of visits by jurisdiction. Table 19 has HHA visits by payer and jurisdiction, and Table 23 has HHA visits by age and jurisdiction.

Applicant Response – Completeness Question #36

Quality One Care Home Health, Inc. (QOC) reviewed Table F-1 and confirms that the table incorrectly cites MHCC Annual Survey Table 25 as the source for total home health visits by jurisdiction. As MHCC correctly notes, Table 25 reports charity care visits only, not total home health utilization.

Correction to Table F-1

The visit volumes shown in the previously submitted Table F-1 (Baltimore City: 284,010; Baltimore County: 206,770; Howard County: 37,499) were derived from Table 25, which reflects charity care visits, and therefore should not have been presented as total home health visits.

Table F-1 has been revised and resubmitted to reflect the correct data sources, as follows:

- **Total Home Health Agency visits by jurisdiction and payer** are now sourced from **MHCC Annual Survey Table 19** (Total Number of Home Health Agency Visits by Jurisdiction of Residence, Payment Source, and Geographic Region);
- **Age-based utilization by jurisdiction**, where applicable, is sourced from **Table 23** (Total Number of Home Health Agency Visits by Jurisdiction of Residence, Age Group, and Geographic Region); and
- **Table 25** is used **only for charity care analyses** and is no longer referenced as a source of total visit volume.

Resulting Update

The revised Table F-1 now reflects **overall home health visit volumes by jurisdiction**, consistent with MHCC Annual Survey Tables 19 and 23, and no longer relies on charity care-only data. This correction ensures that Table F-1 accurately represents total utilization and aligns with MHCC's published survey methodology.

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Table F-1 (REVISED)

Summary of FY 2023 Total Home Health Utilization
(Baltimore City, Baltimore County, Howard County)

Jurisdiction	Total Home Health Visits (FY 2023)
Baltimore City	179,005
Baltimore County	315,476
Howard County	83,372
Tri-County Total	577,853

Source: Maryland Health Care Commission (MHCC) – Home Health Agency Annual Survey,

*Table 19: Total Number of Home Health Visits by Jurisdiction of Residence, Payment Source, and Geographic Region, FY 2023.

Note: This table reflects total home health visits derived from MHCC Annual Survey Table 19. Prior versions incorrectly referenced Table 25, which reports charity care visits only.

37. For Table F-2: Explain how this was calculated? Table 20 from the Annual Survey is titled, “Percent Distribution of Home Health Visits by Jurisdiction of Residence, Payment Source and Geographic Region: Maryland, Fiscal Year 2023.” This does not correspond to the data presented in Table F-2. MHCC staff download indicates that table 9 has “Total Visits and Average Cost Per Visit by Discipline and Home Health Agency,” which is the closest to what you provided in the tables.

Applicant Response – Completeness Question #37

Quality One Care Home Health, Inc. (QOC) reviewed Table F-2 and confirms that the source citation in the table was incorrect. As MHCC correctly notes, MHCC Annual Survey Table 20 reports percent distribution of visits by payer and geography and does **not** provide average per-visit reimbursement or cost data by service type.

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Correct Data Source and Calculation Method

The per-visit reimbursement figures shown in Table F-2 were calculated using MHCC Annual Survey Table 9 (Total Visits and Average Cost per Visit by Discipline and Home Health Agency, FY 2023), which is the appropriate source for discipline-specific average per-visit amounts.

Specifically:

- Average per-visit amounts by service type (skilled nursing, therapy disciplines, medical social work, and home health aide) were derived from Table 9 statewide averages
- These averages were used as proxy reimbursement assumptions for projection purposes in the absence of payer-specific, discipline-level reimbursement tables
- Table 20 was not used in calculating the figures presented in Table F-2 and should not have been cited as the source

Correction Made

Table F-2 has been revised and resubmitted to:

- Correctly cite **MHCC Annual Survey Table 9 (FY 2023)** as the data source
- Remove the reference to Table 20
- Ensure consistency between Table F-2 and the service-level cost and utilization assumptions used throughout the financial projections

No changes were made to the per-visit figures themselves; the correction reflects **proper source attribution and alignment with MHCC survey methodology**.

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Email: info@qualityonecare.com / Web: <http://www.qualityonecare.com>**Table F-2 (REVISED)**

Maryland Statewide Average Per-Visit Cost by Discipline (FY 2023)

Service Type	Statewide Average Cost per Visit (FY 2023)
Skilled Nursing	\$126.48
Physical Therapy	\$136.92
Occupational Therapy	\$141.72
Speech Therapy	\$154.61
Medical Social Work	\$175.42
Home Health Aide	\$58.31

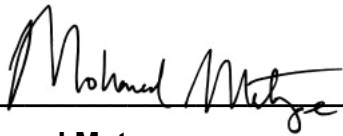
Source: Maryland Health Care Commission (MHCC) – Home Health Agency Annual Survey – Table 9: Total Visits and Average Cost per Visit by Discipline and Home Health Agency, FY 2023.

Note: Prior versions of Table F-2 incorrectly referenced MHCC Table 20, which reports percent distribution of visits by payer and geography. This revised table reflects statewide average per-visit costs derived from MHCC Table 9.

AFFIRMATION

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

Date: 01/31/2026



Mohamed Matope

CEO & Director

Quality One Care Home Health, Inc.

Exhibits & Supportive Documents

Revised
Admissions & Discharge Policy



QOC HHA Admission and Discharge Policy

I. PURPOSE

The purpose of this policy is to ensure that all patients referred to or receiving services from Quality One Care Home Health, Inc. (“QOC”) are admitted and discharged in a consistent, patient-centered, clinically appropriate, and legally compliant manner. This policy guides the full continuum of care, from referral to admission through discharge, to ensure:

- Equitable access to care
- High-quality, evidence-based service delivery
- Safe and efficient transitions between care settings
- Protection of patient rights
- Compliance with Medicare Conditions of Participation (42 CFR 484), COMAR 10.24.16.08, COMAR 10.24.01.08G(3), and Joint Commission standards

QOC is committed to serving **adult patients**, including those with **high-acuity or medically complex needs**, and will not refuse admission based on complexity, disability, or ability to pay. QOC may serve pediatric patients as clinically appropriate and based on staffing competencies and program capability.

II. SCOPE

This policy applies to:

- All clinical and administrative staff involved in the referral, intake, admission, care delivery, discharge, documentation, or coordination of services
- All patient populations (adult, pediatric, high-acuity, chronic, post-acute, palliative, etc.)
- All disciplines (RN, LPN, PT, OT, ST, MSW, Home Health Aide)
- All payer types (Medicare, Medicare Advantage, Medicaid, Medicaid Waiver, commercial insurance, workers’ compensation, private pay, charity care/discounted care)

III. POLICY STATEMENT

QOC will provide timely, appropriate, and patient-centered admission and discharge processes that:

- Prioritize safety, quality, and continuity of care



- Ensure access to services regardless of ability to pay (see Exhibit 4 – Charity Care and Sliding Fee Scale Policy)
- Actively involve patients, families, and caregivers in all decisions
- Maintain compliance with all regulatory requirements
- Coordinate care with physicians, hospitals, and community providers
- Prevent inappropriate/unsafe discharge or abandonment of patients
- Support the highest possible clinical outcomes and patient satisfaction
- Begin discharge planning at admission and update throughout the episode of care
- Follow CMS and COMAR requirements for documentation and notification

IV. DEFINITIONS

Admission:

The formal acceptance of a patient for home health services based on medical necessity, physician order, eligibility, and agency capacity.

Discharge:

The completion or termination of home health services, either due to goal attainment, transition of care, patient choice, physician order, or specific clinical or safety reasons.

Interdisciplinary Team (IDT):

Registered Nurses, Licensed Practical Nurses, Physical Therapists, Occupational Therapists, Speech Therapists, Medical Social Workers, Home Health Aides, and administrative or clinical leadership collaborating on patient care.

Plan of Care (POC):

Comprehensive treatment plan ordered and approved by a physician in accordance with Medicare requirements (CMS Form 485 or electronic equivalent).

Homebound Status:

CMS criterion for Medicare patients indicating that leaving home requires considerable effort or assistance (not required for pediatric or certain Medicaid populations).

High-Acuity Patient:

A patient requiring complex clinical management (e.g., ventilator, tracheostomy, IV infusion, complex wound care, enteral feeding).

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Medically Necessary Services:

Services required to treat illness, injury, or disability, ordered by a physician, and provided by qualified clinicians.

Patient Rights:

The legal and ethical rights afforded to all patients, detailed in QOC's Patient Rights & Responsibilities Policy (provided at admission).

V. ADMISSION PRINCIPLES

QOC admits patients in a manner that ensures:

- Timely access to medically necessary care
- Patient and family involvement in decision-making
- Equitable access regardless of payor, diagnosis, disability, or complexity
- Clinical appropriateness and safety
- Compliance with physician orders and regulatory requirements
- Immediate initiation of discharge planning to ensure continuity of care

QOC will **not** refuse admission based solely on:

- High-acuity or complexity of condition
- Disability or cognitive impairment
- Age (including pediatric or geriatric)
- Ability or inability to pay (see Charity Care Policy)
- Payor type (including Medicaid, Medicare, and uninsured)
- Geographic location within approved service area (Frederick, Carroll, Washington, Allegany, Garrett Counties)

VI. ADMISSION CRITERIA

A patient will be admitted when **all of the following apply**:

1. Clinical Eligibility

- The patient requires **skilled services** (nursing or therapy) as defined by CMS or payor
- The service is **medically necessary** to treat an illness or condition
- The patient's needs can be **safely met at home**
- The patient (or legal guardian) provides **informed consent**

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2. Physician Involvement

- A **physician or allowed practitioner** (MD, DO, NP, PA) orders home health services
- The physician agrees to **review and sign the Plan of Care (POC)**
- The physician collaborates with QOC throughout the episode

3. Payor Eligibility

QOC accepts:

- Medicare
- Medicare Advantage
- Medicaid & Medicaid Waiver
- Commercial insurance
- Worker's compensation
- Private pay
- Veterans programs
- Charity care/discounted care (when eligible)

Inability to pay, by itself, is not a reason to deny admission.

4. Service Area

The patient must reside within QOC's **MHCC-approved home health service area**, as authorized under its Certificate of Need and applicable licensure.

5. Homebound Status (Medicare-specific)

- Medicare patients must meet CMS homebound criteria unless exempt
- Pediatric, Medicaid waiver, or private insurance patients may not need to be homebound

6. Agency Capability

QOC must have the qualified staff, equipment, and resources to meet patient's needs safely and effectively.



VII. SPECIAL POPULATIONS SERVED

A. High-Acuity Patients

QOC accepts medically complex patients requiring:

- Tracheostomy care
- Ventilator support (invasive or non-invasive)
- Enteral or parenteral feeding
- IV infusion therapy
- Complex wound care
- PICC/central line management
- Ostomy care
- Post-operative care
- Chronic disease management (CHF, COPD, diabetes, dementia, oncology, etc.)

B. Pediatric Patients

QOC admits infants, children, and adolescents with:

- Congenital or genetic disorders
- Neuromuscular or neurological impairments
- Tracheostomy or ventilator dependence
- Feeding tube or nutritional support
- Failure to thrive
- Post-NICU/PICU transition
- Technology dependence or ongoing skilled needs

Pediatric admission includes:

- Consent from parent/legal guardian
- Collaboration with pediatric specialists or primary care provider
- Consideration of school or daycare coordination
- Age-appropriate safety and developmental assessment
- Inclusion of family training and education

C. Behavioral and Cognitive Considerations

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QOC admits patients with cognitive or behavioral health conditions **when care can be delivered safely**.

QOC may involve social work, behavioral health providers, or caregivers as needed to ensure safety and cooperation.

VIII. REFERRAL & INTAKE PROCESS

QOC receives referrals from:

- Hospitals and discharge planners
- Skilled nursing and rehab facilities
- Physicians and specialists
- Case managers
- Medicaid waiver programs
- Insurance plans/managed care organizations
- Schools or pediatric programs
- Families or self-referrals

Intake Staff Responsibilities:

- Collect clinical information, demographics, and insurance details
- Confirm physician order or request one
- Screen for skilled need and appropriateness
- Verify service area eligibility
- Identify urgency (routine vs. priority vs. same day)
- Communicate with clinical management for high-acuity cases
- Explain services, patient rights, and financial policies
- Initiate benefits verification and authorization

No patient will be denied admission due to incomplete paperwork at referral.

Intake staff will assist patients/families in gathering necessary documentation.

IX. CLINICAL REVIEW & APPROVAL

An RN or Clinical Director reviews every referral to determine:

- Clinical appropriateness
- Required discipline(s)



- Complexity and staffing needs
- Safety considerations
- Need for special equipment or supplies
- Any potential risk factors
- Need for interdisciplinary team collaboration

The **Director of Nursing** and/or **Administrator** must approve any high-acuity or unusual cases to ensure staffing and resource readiness.

X. RAPID ADMISSION & HOSPITAL COORDINATION

To support hospital throughput and reduce readmissions:

- Standard admission begins **within 48 hours** of referral
- **Same-day or next-day** start of care for urgent or high-priority patients
- QOC may conduct **hospital or facility pre-discharge visits**
- QOC collaborates directly with hospital case managers or physicians
- QOC accepts referrals **7 days/week**
- QOC maintains an **on-call nurse** for urgent clinical coordination

This rapid, flexible admission model supports MHCC goals for timely post-acute transitions.

XI. INITIAL ASSESSMENT

A **comprehensive, in-home assessment** is performed by an RN or qualified therapist and includes:

- Physical exam and clinical status
- Functional, cognitive, and psychosocial assessment
- Medication reconciliation
- Pain and symptom management
- Fall risk evaluation
- Home safety and environmental review
- Social determinants of health (transportation, support, financial)
- Patient and caregiver education needs

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- Cultural or language needs
- Emergency and contingency plans

For Medicare patients: OASIS assessment is completed as required.

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XII. PLAN OF CARE (POC)

Following assessment, the clinician develops a patient-centered Plan of Care that includes:

- Diagnoses and clinical goals
- Types and frequency of services
- Interventions and treatment plan
- Equipment, supplies, or technology needs
- Safety measures and caregiver training
- Discharge planning considerations
- Interdisciplinary coordination

The POC is:

- Reviewed, approved, and signed by the physician (CMS Form 485 or EHR equivalent)
- Reviewed every 60 days or sooner if the condition changes
- Updated based on patient progress and/or new orders



DISCHARGE POLICY

I. Discharge Planning

- Discharge planning starts **at admission** and is updated at every IDT review.
- The clinician discusses likely discharge goals, criteria, and needs with the **patient/caregiver and physician**; updates the plan of care as the condition evolves.
- Planning prioritizes **safety, continuity, patient goals/preferences, and timely transition** to the appropriate level of care.

II. Discharge Criteria

A patient may be discharged when one or more apply:

1. **Goals achieved / no further skilled need**
 - Wound closed; medication stabilized; therapy goals met.
2. **Maximum practical benefit reached**
 - Plateau despite appropriate interventions; transition to maintenance/outpatient.
3. **Patient choice / refusal / transfer**
 - Patient elects to stop services or move to another HHA/SNF/assisted living/hospice.
4. **Physician order to discontinue home health**
 - Document order and clinical rationale.
5. **Hospitalization or death**
 - If no return expected, complete discharge, if return expected place on hold per payor rules.
6. **Unsafe environment / staff safety risk (last resort)**
 - After reasonable mitigation (family conference, MSW involvement, care plan adjustments), physician notified; safe alternative arranged.
7. **Nonadherence that makes care unsafe or ineffective (last resort)**
 - After documented education, problem-solving, and MD involvement, determine if alternate setting/provider is safer.

Important: QOC **does not discharge** simply because care is complex, costly, time-consuming, or because reimbursement is low/denied.

III. Discharge Protections & Patient Rights

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- Patients are informed of rights at admission (see **Patient Rights & Responsibilities Policy**).
- QOC ensures **no abandonment**: a **safe alternative** (another provider or level of care) is offered/arranged whenever possible.
- Language/communication needs are accommodated; teach-back used to confirm understanding of discharge instructions.

IV. Medicare Requirements (NOMNC & Appeals)

For Medicare/MA patients:

- Provide the **Notice of Medicare Non-Coverage (NOMNC)** within required timeframes prior to planned discharge.
- Inform patients of their **right to appeal** through the QIO; continue services as required pending decision.
- Document timing, delivery, and patient understanding of NOMNC and any appeals.
- Coordinate with the plan/QIO and physician during appeal; maintain safe care until determination.

V. Discharge Notification & Orders

- **Planned discharges:**
 - Notify patient/family **verbally and in writing**; document consent/understanding.
 - Notify and obtain **physician order** prior to discharge (unless patient refuses services).
 - Give **advance notice** (generally ≥ 48 hours) when feasible.
- **Urgent discharges (safety/behavioral risk):**
 - Notify physician **immediately**; document risks and mitigation; ensure safe transition where possible.

VI. Transfer to Another Agency/Level of Care

- With patient consent, QOC coordinates transfer to another HHA, SNF, IRF, LTACH, outpatient clinic, hospice, or community program.
- QOC provides a **warm handoff**: direct clinician-to-clinician communication whenever possible, and timely transmission of the discharge/transfer summary and relevant records.

VII. Discharge Summary



Complete within 48 hours of discharge (matches your prior policy). Summary includes:

- Reason for discharge and type (planned, transfer, refusal, hospitalization, death)
- Patient condition/status at discharge (clinical, functional, psychosocial)
- Services provided and **goals achieved/not achieved** with rationale
- **Medications** at discharge; outstanding orders/monitoring needs
- Education provided; caregiver competence/teach-back confirmed
- **Equipment/supplies** in home; vendor contacts
- Referrals made (e.g., outpatient PT, wound clinic, MSW, community resources)
- **Follow-up appointments** (PCP/specialist) and who scheduled them
- Physician notification and final orders
- NOMNC/appeal information (when applicable)
- Contact information for questions post-discharge

VIII. Continuity of Care & Post-Discharge Follow-up

- Provide written discharge instructions (plain language; patient's preferred language).
- Send discharge summary and key documents to the **physician/next provider** promptly.
- **Follow-up calls:**
 - **Day 3** to confirm safety, meds, wound/therapy plan, equipment in place.
 - **Day 7** to reassess status, barriers, and address problems—helps reduce readmissions.
- For high-risk patients (e.g., CHF, COPD, complex wounds), consider an extra check-in within **24–48 hours**.

IX. Documentation Standards

- Document all notifications, patient/caregiver education, physician communications, NOMNC/appeal steps, and handoffs.
- File the discharge summary and related artifacts in the **EHR within 48 hours**.
- Use standardized checklists to ensure completeness and consistency.

X. Roles & Responsibilities

- **Primary Clinician (RN or lead therapist):** coordinates discharge plan; completes summary; educates patient/caregiver.
- **Physician/Allowed Practitioner:** reviews progress; issues discharge/transfer orders; collaborates on plan.

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- **Therapists (PT/OT/ST):** update functional status, equipment needs, and outpatient plans.
- **Medical Social Worker:** addresses psychosocial barriers; links to community resources; assists with safe disposition.
- **Home Health Aide:** provides input on daily function/self-care; reinforces education.
- **Intake/Scheduling/Billing:** finalize logistics, benefits, and notify payor as needed.

XI. Quality & Compliance Integration

- Admission timeliness, unplanned discharges, appeals, readmissions within 30 days, and post-discharge call completion are tracked in **QAPI**.
- **Case reviews** are performed on discharges related to safety/nonadherence to ensure appropriate mitigation steps were taken and no abandonment occurred.
- Trends inform staff education, process improvement, and resource allocation.

XII. Policy Governance

- Reviewed at least **annually**; updated to maintain compliance with **CMS Conditions of Participation (42 CFR 484.50 & 484.58)**, **COMAR 10.24.16.08 A/B/G/I/K**, and **Joint Commission** standards.
- Staff receive training on any changes; compliance is monitored via chart audits and QAPI metrics.



APPEALS, DOCUMENTATION, QUALITY, GOVERNANCE

I. Patient Appeals & Grievances

Patients have the right to voice concerns without fear of retaliation.

QOC maintains a **formal grievance and appeal process** consistent with Medicare Conditions of Participation and QOC's **Patient Rights & Responsibilities Policy**.

Patients may appeal:

- Denial of admission
- Proposed discharge or reduction in services
- Quality concerns
- Staff behavior or communication
- Any aspect of their care

Appeal process:

1. Patient/family may submit verbally or in writing.
2. QOC leadership reviews within **5 business days**.
3. A written response is provided with findings and resolution.
4. Unresolved issues may be escalated to **external agencies** (e.g., MDH, MHCC, CMS, Joint Commission).

For Medicare beneficiaries:

- QOC will provide the **Notice of Medicare Non-Coverage (NOMNC)** before discharge.
- Patients have the right to a **fast appeal** through the **Quality Improvement Organization (QIO)**.
- QOC will comply with all QIO determinations and continue care as required during appeals.

II. Documentation Requirements

QOC maintains complete and accurate records for all admissions and discharges in accordance with CMS, COMAR, and Joint Commission requirements. Documentation includes:

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- Referral and intake data
- Initial and comprehensive assessments
- Home safety and environmental evaluations
- Plan of Care (physician-signed and updated)
- Interdisciplinary notes and communications
- Discharge planning activities
- Physician notifications and orders
- NOMNC and appeal documentation (if applicable)
- Final discharge summary (completed within **48 hours**)
- Referrals and handoff documentation
- Patient education and follow-up contact

All documentation is securely maintained in the Electronic Health Record (EHR).

III. Quality Assurance & Performance Improvement (QAPI) Integration

QOC uses admission and discharge data to monitor and improve performance.

The following indicators are reviewed regularly:

Admission-related Metrics:

- Time from referral to admission (48-hour target / same-day options)
- Admission delays and root causes
- High-acuity and pediatric admissions

Discharge-related Metrics:

- Discharge reasons by category (goals met, patient refusal, transfer, safety)
- Unplanned discharges
- 30-day hospital readmission rates
- Discharge documentation timeliness (<48 hours)
- Post-discharge follow-up completion (Day 3 and Day 7)
- Medicare appeals and outcomes

Quality & Patient Experience:

- Patient/caregiver satisfaction
- Continuity of care outcomes



- Identified barriers to care
- Staff competency and training needs
- Opportunities for improvement

Actions from QAPI may include:

- Staff education or re-training
- Process changes
- Policy updates
- Resource allocation
- Collaboration with referral partners

IV. Staff Training & Competencies

All staff involved in referral, admission, service delivery, and discharge are trained on:

- This Admission & Discharge Policy
- Patient Rights & Responsibilities
- CMS Conditions of Participation
- COMAR 10.24.16 standards
- Documentation requirements
- Communication protocols
- Cultural competence and health equity
- Pediatric and high-acuity care processes (as applicable)

Training is provided:

- During orientation
- Annually
- As needed based on QAPI findings or regulatory changes

Competency is validated through:

- Skills checklists
- Direct observation
- Chart audits
- Performance reviews

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V. Policy Review & Governance

This policy is reviewed **annually** by:

- Director of Nursing / Clinical Director
- Administrator / Executive Leadership
- QAPI Committee
- Compliance Officer (if applicable)

Revised Exhibit
QOC Charity Care & Financial
Assistance Application Form

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**CHARITY CARE & FINANCIAL ASSISTANCE
APPLICATION FORM**

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

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

SECTION 1 — APPLICANT INFORMATION

Name: _____

Date of Birth: ____ / ____ / ____

Social Security Number: — _____

Home Address: _____

City _____ State _____ ZIP _____

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

Email: _____

Marital Status: Single Married Separated Divorced Widowed

Preferred Language: _____

Interpreter Needed: Yes No

Employer: _____

Employer Address: _____

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SECTION 2 — HOUSEHOLD MEMBERS

List all members of your household, including yourself.

Name	Age	Relationship	Income (Monthly)

SECTION 3 — MEDICAL ASSISTANCE / INSURANCE STATUS

Have you applied for Medicaid/Medical Assistance? Yes No

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

Status: Pending Approved Denied

Do you receive any state or county assistance? Yes No

If Yes, Describe:

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SECTION 4 — MONTHLY INCOME

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

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

Total Monthly Income: _____

SECTION 5 — ASSETS

Liquid Assets

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

Total Liquid Assets: _____

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Other Assets

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

SECTION 6 — MONTHLY EXPENSES

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

Total Monthly Expenses: _____

Do you have unpaid medical bills? Yes No

If yes, for what service(s)? _____

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

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SECTION 7 — DOCUMENTATION CHECKLIST

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

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

SECTION 8 — CERTIFICATION & SIGNATURE

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

Applicant Signature: _____

Date: ____ / ____ / ____

Relationship to Patient/Client (if not applicant): _____

Submit completed application and documentation to:

Quality One Care Home Health, Inc.

RE: Client Financial Services Department

Address: 9221 Colesville Road, Silver Spring, MD 20910

Phone: 301-658-7141 / Fax: 301-658-2328

Email: info@qualityonecare.com

Charity Care & Charity Care Assessment Policies

QOC Quality One Care



Home Health, Inc

9221 Colesville Road, Silver Spring, MD 20910

PH: 301 658-7141 / Fax: 301 658-2328

Charity Care and Sliding Fee Scale Policy

I. PURPOSE

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

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

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

II. POLICY STATEMENT

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

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



III. DEFINITIONS

Charity Care:

Medically necessary services provided **at no cost** to eligible patients with income $\leq 100\%$ FPL or those who demonstrate financial hardship.

Discounted Care:

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

Financial Hardship:

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

Uninsured Patient:

An individual without any third-party health insurance coverage.

Underinsured Patient:

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

Household Income:

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

Family Size:

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

Medically Necessary Services:

Skilled home health services ordered by a physician and delivered under a plan of care.

IV. ELIGIBILITY CRITERIA

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

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

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

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

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

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

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

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

VI. APPLICATION PROCESS

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

How to Apply:

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

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QOC Responsibilities:

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

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

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

VII. PAYMENT PLANS

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

What to Expect:

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

VIII. COMMUNICATION OF POLICY

QOC will make this policy available:

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

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

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IX. NON-DISCRIMINATION

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

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

Eligibility is based solely on financial need and medical necessity.

X. CONFIDENTIALITY

All financial and personal information submitted by the patient is:

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

XI. REPORTING AND COMPLIANCE

QOC will:

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



Charity Care Assessment & Financial Assistance Policy

I. PURPOSE

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

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

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

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

II. POLICY STATEMENT

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

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

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

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

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III. PUBLIC NOTIFICATION

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

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

Required Notice Language:

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

IV. PAYMENT EXPECTATIONS & TIME-PAYMENT PLANS

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

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

V. DETERMINATION OF PROBABLE ELIGIBILITY

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

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

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

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

Probable Eligibility Guidance:

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

Clients will receive written communication of probable eligibility determination.

VI. FINAL ELIGIBILITY DETERMINATION

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

VII. SLIDING FEE SCALE

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

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VIII. DOCUMENTATION REQUIREMENTS

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

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

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

IX. STAFF RESPONSIBILITIES & TRAINING

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

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

X. RECORDKEEPING & COMPLIANCE

QOC will maintain records of:

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

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

XI. POLICY REVIEW

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

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XII. REGULATORY AUTHORITY

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

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

XIII. DEFINITIONS

Charity Care: Free or discounted services provided to eligible clients based on financial hardship.

Sliding Fee Scale: A structured discount schedule tied to Federal Poverty Level (FPL) income brackets.

Probable Eligibility: A preliminary determination made within two business days based on available information.

Financial Hardship: A circumstance in which a client lacks sufficient income or assets to pay for medically necessary care.

Medicaid Pending: Status given to a client who has applied for Medical Assistance but has not yet received a determination.

XIV. SLIDING FEE SCALE

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

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

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

XV. PATIENT RIGHTS

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All clients receiving services from QOC have the right to:

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

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

XVI. APPEALS AND RECONSIDERATION

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

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

XVII. DOCUMENTATION & RETENTION REQUIREMENTS

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

XVIII. ANNUAL REVIEW & APPROVAL AUTHORITY

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

IX. NON-RETALIATION ASSURANCE

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

Revised Table 5
Staffing Information

QOC Quality One Care



Home Health, Inc

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PH: 301 658-7141 / Fax: 301 658-2328

TABLE 5. STAFFING INFORMATION – 2028 (REVISED)

Instructions: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project. FTE data are calculated as 2,080 paid hours per year. Benefits calculated at 27% of wages.

Position Title	Current No. of FTEs – Agency	Current No. of FTEs – Contract	Change in FTEs – Agency	Change in FTEs – Contract	Average Salary – Agency	Average Salary – Contract	Total Salary Expense – Agency	Total Salary Expense – Contract
Administrative Personnel	0	0	1.4	0	\$70,000	–	\$98,000	\$0
Registered Nurse	0	0	1.8	0	\$80,000	–	\$144,000	\$0
Licensed Practical Nurse	0	0	0	0	–	–	\$0	\$0
Physical Therapist	0	0	0.85	0	\$75,000	–	\$63,750	\$0
Occupational Therapist	0	0	0.4	0	\$75,000	–	\$30,000	\$0
Speech Therapist	0	0	0.17	0	\$75,000	–	\$12,750	\$0
Home Health Aide	0	0	0.8	0	\$44,000	–	\$35,200	\$0
Medical Social Worker	0	0	0.27	0	\$90,000	–	\$24,300	\$0
Other – Nurse Supervisor	0	0	0.5	0	\$85,000	–	\$42,500	\$0
Subtotal – Wages							\$450,500	\$0
Benefits (27%)							\$121,635	\$0
TOTAL SALARY & BENEFITS							\$572,135	\$0

Notes

Total wages (before benefits): **\$450,500**

- Benefits calculated at **27%**: **\$121,635**
- Total salary and benefit expense (2028): **\$572,135**
- FTEs represent **average annual staffing**, not peak staffing
- Staffing supports projected 2028 visit volume through productivity gains and stabilized operations

Exhibit
Linkages & Referral Pathways

**Current
Community Linkage & Partnerships**



SINGLE CASE AGREEMENT

This Single Case Agreement (“Agreement”) is made as of the date set forth below by and between **Johns Hopkins HealthCare (“JHHC”)** on behalf of the **Payor** identified on Exhibit A hereto and **Provider** identified on Exhibit A. JHHC and Provider hereby agree as follows:

1. **Purpose.** Provider does not participate in Payor’s provider network. The purpose of this Agreement is for Provider to provide Designated Covered Services identified on Exhibit A to Payor’s Covered Person in exchange for the reimbursement set forth herein. Covered Services are services that are covered under Payor’s program. Designated Covered Services are those Covered Services which Provider may provide under this Agreement.
2. **Policies and Standards.** Upon execution of this Agreement, Provider agrees to ensure that its providers and staff will provide health care services in accordance with the policies and standards established by JHHC and Payor.
3. **Services to be Provided Under This Agreement.** This Agreement only applies to the Covered Services described in Exhibit A the Designated Covered Services. Any additional services must be separately agreed upon and authorized.
4. **Compensation.** Provider will be compensated in accordance with the rates specified for Designated Covered Services. Provider will be responsible for billing JHHC electronically or using appropriate claim forms for Provider’s provision of services hereunder as further set forth on Exhibit A. Provider shall have one- hundred eighty (180) days from the date of service to submit a clean claim. In the event the Provider fails to submit a clean claim within this time frame, neither JHHC nor the Covered Person shall be responsible to the Provider for the claim amount, and the Provider shall not bill JHHC or the Covered Person. In cases where there is coordination of benefits (COB), if Payor is primary, the fee contained in Exhibit A of this Agreement will be paid. If Payor is secondary, JHHC, on behalf of Payor, will pay the difference between the amount paid by the primary carrier and the fee contained in Exhibit A, if applicable.
5. **Payment Terms.** JHHC shall pay clean and uncontested claims which are accompanied by all necessary documentation within thirty (30) days of receipt. To the extent required by law, interest at the rate set forth therein, pro-rated for any portion of a month shall be paid beginning with the thirty-first (31st) day on the amount of any undisputed claim that remains unpaid after thirty (30) days following receipt of such undisputed claim.
6. **Hold Harmless.** Provider agrees to accept the compensation payable under this Agreement as payment in full for services rendered hereunder, except for applicable copayments, coinsurance and deductibles. Provider agrees that, in no event including, but not limited to, non-payment by JHHC, non-funding by Payor, insolvency or breach of this Agreement, will Provider seek payment, remuneration or reimbursement from Covered Person for (i) any amount payable to Provider under the terms of this Agreement, (ii) the difference between the Provider’s billed or customary charges and the amount payable under this Agreement or (iii) services which are determined to be medically unnecessary under the utilization management program of JHHC. This provision shall not prohibit collection of copayments, deductibles or coinsurance amounts in accordance with the terms of the applicable JHHC policy. This provision shall survive the termination of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Covered Person.



This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Covered Person.

- 7. **Insurance.** Provider agrees to maintain policies of comprehensive general and professional liability insurance.
- 8. **Confidentiality.** The terms of this Agreement shall not be disclosed to third parties.
- 9. **Notices.** All notices hereunder by either party to the other shall be in writing, delivered personally, by certified or registered mail, return receipt requested, or by Federal Express or Express Mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to JHHC: Johns Hopkins HealthCare, LLC
7231 Parkway Drive, Suite 100
Hanover, MD 21076


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

Provider

Johns Hopkins HealthCare LLC

Mohamed Matope

Provider's Signature

By: 

Mohamed Matope

Provider's Printed Name

Name: Anita DeSimone-Veach

Director

Provider's Title

Title: Senior Director of Provider Relations & Network Development

Date: 04/21/2023 **Date:** 4/21/2023

- 10. **Assignment.** Neither party shall assign their responsibilities under this Agreement without the prior written consent of the other party.

The parties have agreed to the foregoing terms on the date listed on the attached



780 Shiloh Road, MS-1.700
Plano, TX 75074

Jun. 4, 2020

QUALITY ONE CARE HOME HEALTH, INC
info@qualityonecare.com

Re: Welcome to the Veterans Affairs Community Care Network!

Dear Mohamed Matope:

On behalf of UnitedHealthcare, I want to personally thank you for joining the Department of Veterans Affairs (VA) Community Care Network (CCN) administered by Optum.

As you get started as a VA CCN participating care provider, here are a few next steps and resources to help you better understand how you are helping to serve Veterans in your community.

Your Participation Agreement

We're including a copy of your executed Participation Agreement for tax ID number **900715209**, signed by both you and UnitedHealthcare. The agreement for VA CCN is effective on **06/15/2020**.

Review the VA CCN provider materials at provider.vacommunitycare.com.

You'll find information and training on the unique VA CCN requirements. Resources include:

- VA CCN Provider Manual
- Regional maps and deployment schedules
- Claims processing guidelines
- Training resources and educational guides
- Frequently asked questions
- Quick reference guides
- Medication prescribing information
- VA fee schedule

To get started, you can also view the Department of Veterans Affairs Community Care Network Overview video at provider.vacommunitycare.com > Training & Guides > Self-Service Resources and Educational Videos.

Get ready to deliver care.

- Delivery of care to Veterans under your VA CCN participation agreement begins when you receive a referral from VA. You'll start getting VA referrals after you're in the VA system as a participating VA CCN provider, which could take up to 30 days from your participation start date.
- Optum is the third-party administrator for VA CCN Regions 1, 2 and 3. Your office should only schedule appointments with Veterans and bill Optum when the network on the VA referral is CC Network 1, CC Network 2 or CC Network 3. The VA CCN Provider Manual shows an example of a referral.

- The training and resources at **provider.vacommunitycare.com** can help your office staff identify VA CCN-related appointments. This will help ensure accurate registration and claim submission, which will help ensure timely payments from Optum.

We're Here to Help

If you have questions, please call your region's CCN Provider Services – the regional state list is at **provider.vacommunitycare.com** > News & Announcements:

- Region 1: 888-901-7407
- Region 2: 844-839-6108
- Region 3: 888-901-6613

CCN Provider Services is available from 8 a.m. – 6 p.m. provider's local time, Monday –Friday, excluding federal holidays. Thank you.

Sincerely,

Lizette R Arthur

Lizette R Arthur
United Healthcare VACCN Contractor

Enclosures

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance Company, UnitedHealthcare of New York, Inc., UnitedHealthcare Insurance Co. of New York, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Pennsylvania, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc., UnitedHealthcare of Washington, Inc., Optimum Choice, Inc., Oxford Health Insurance, Inc., Oxford Health Plans (NJ), Inc., Oxford Health Plans (CT), Inc., All Savers Insurance Company or other affiliates. Administrative services provided by OptumHealth Care Solutions, LLC, OptumRx, Oxford Health Plans LLC, United HealthCare Services, Inc. or other affiliates. Behavioral health products provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.

PCA-1-20-00261-OPTUM-LTR_02182020

© 2020 United HealthCare Services, Inc.

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

AGREED BY:

X QUALITY ONE CARE HOME HEALTH, INC	Address to be used for giving notice under the agreement:
Signature: <small>DocuSigned by:</small> <i>Mohamed Matope</i>	Street: 12510 Prosperity Dr, suite # 320
Print Name: <small>F54B2D4EB25C40E...</small> MOHAMED MATOPE	City: silverspring
DBA (if applicable):	State: MD
Date: 4/21/2020	Zip Code: 20904
Email: mmatope@qualityonecare.com	TIN: 900715209
National Provider Identification (NPI) Number:	1528351285

UnitedHealthcare Insurance Company contracting on behalf of itself, UnitedHealthcare of the Mid-Atlantic, Inc., MD-Individual Practice Association, Inc., Optimum Choice, Inc. and its other affiliates, as signed by its authorized representative:	
Signature: <i>Andrew Rich</i>	
Print Name: <small>9A14262W2FR7D...</small> Andrew Rich	
Date: 5/20/2020	
For office use only: 7385920	
Month, day and year in which agreement is first effective: 06/15/2020	

NON-PAR RATE NEGOTIATION AGREEMENT

October 13, 2025

VIA EMAIL: [REDACTED]

Mohamed Matope

Quality One Care Home Health

9221 Colesville Road

Silver Spring, MD 20910

Re: Member Name; [REDACTED] Date of Birth [REDACTED]: Member Identification Number:
[REDACTED].

Dear Mohamed Matope:

The purpose of this letter is to provide written confirmation of the authorization for private duty nursing services for [REDACTED] (the "Member") as prescribed by the attending physician, as follows:

- CareFirst BlueCross BlueShield, hereinafter referred to as "Corporation", has been advised that the Member shall begin receiving care from Community Care Nursing Services (Provider Name), hereinafter referred to as "Non-Par Provider", on October 2, 2025.

At this time and confirmed hereby, care has been authorized for in-network reimbursement under the Member's health benefit policy in effect for dates of service October 2, 2025 through December 31, 2025 or when Member has reached their maximum benefit level, whichever is earlier. Corporation and Non-Par Provider agrees to an all-inclusive rate of Sixty dollars (\$60.00) per hour and which care/services shall include visits by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) for the following:

- S9123/S9124 8 hours per day of PDN 10/2/2025 to 12/31/2025
- Reimbursement payments will be made directly to Non-Par Provider. Non-Par Provider agrees to look solely to Corporation for payment of the reimbursement agreed upon and that the Member and all others will be held harmless from claims for any and all services rendered pursuant to this authorization, with the exception of
 - applicable Member liability such as coinsurance, copayments, deductibles and non-covered items or services; and
 - Payments made by Corporation to Member prior to the implementation of this Agreement.
- Provider understands and acknowledges this is a one-time agreement applicable only to this Member and does not establish a precedent for future participating provider negotiations with Corporation.
- To ensure accurate processing of claims, Non-Par Provider agrees to attach a copy of this letter to the claim(s) and submit the claim(s) to:

Christine Miller
CareFirst BlueCross BlueShield
Liaison, Claims, Large Group SBU/Mail Stop NAS-60
10 Commerce Drive
Cumberland, MD 21502
W- 301-777-6051 / f 410-505-2497
Email: Nonparclaimsprocessing@carefirst.com

AUDIT RIGHTS

CareFirst shall have the right to audit any claims or payments, made pursuant to this agreement, and to effectuate its rights of recovery as stated below.

RIGHT OF RECOVERY

In the event that billings, made pursuant to the terms herein, result in overpayments or errant payments CareFirst shall have the right to recover such payments.

If this information does not accurately or adequately document the agreement regarding services for the Member, please contact Kendra Symonette Phone:410-872-3821. Otherwise, please sign where indicated below, and return a signed copy (via fax) to Kendra’s attention at 410-505-6978 as soon as possible.

Sincerely,



Jay Simmons,
VP Provider Networks Contracting

Provider Name

By: Mohamed Matope
(Signature)

Name: Mohamed Matope
(Print)

Title: Director

Date: 10/17/2025

Federal Tax ID: 90-0715209

NPI: 1528351285



NON-PAR RATE NEGOTIATION AGREEMENT

June 28, 2024

VIA FACSIMILE: 301-658-2328

Mohamed Matope

Quality One Care Home Health

9221 Colesville Road

Silver Spring, MD 20910

Re: Member Name; [REDACTED] Date of Birth [REDACTED] Member Identification Number:
[REDACTED]

Dear Mohamed Matope:

The purpose of this letter is to provide written confirmation of the authorization for private duty nursing services for [REDACTED] (the "Member") as prescribed by the attending physician, as follows:

- CareFirst BlueCross BlueShield, hereinafter referred to as "Corporation", has been advised that the Member shall begin receiving care from Community Care Nursing Services (Provider Name), hereinafter referred to as "Non-Par Provider", on June 8, 2024.

At this time and confirmed hereby, care has been authorized for in-network reimbursement under the Member's health benefit policy in effect for dates of service June 8, 2024 through September 8, 2024 or when Member has reached their maximum benefit level, whichever is earlier. Corporation and Non-Par Provider agree to an all-inclusive rate of Sixty dollars (\$60.00) per hour and which care/services shall include visits by a Licensed Practical Nurse (LPN) or Registered Nurse (RN) for Twelve (12) hours of private duty nursing services per day, Sunday through Saturday for Three (3) months. Codes S9123 and S9124 only.

- HCPCS/CPT Code T1001 at an allowed amount of \$200.00 per visit (approved for 1 visit per month)
- Reimbursement payments will be made directly to Non-Par Provider. Non-Par Provider agrees to look solely to Corporation for payment of the reimbursement agreed upon and that the Member and all others will be held harmless from claims for any and all services rendered pursuant to this authorization, with the exception of
 - applicable Member liability such as coinsurance, copayments, deductibles and non-covered items or services; and
 - Payments made by Corporation to Member prior to the implementation of this Agreement.
- Provider understands and acknowledges this is a one-time agreement applicable only to this Member and does not establish a precedent for future participating provider negotiations with Corporation.
- To ensure accurate processing of claims, Non-Par Provider agrees to attach a copy of this letter to the claim(s) and submit the claim(s) to:

Christine Miller
CareFirst BlueCross BlueShield
Liaison, Claims, Large Group SBU/Mail Stop NAS-60
10 Commerce Drive
Cumberland, MD 21502

W- 301-777-6951 / F 410-505-2497
Email: Nonparclaimsprocessing@carefirst.com

AUDIT RIGHTS

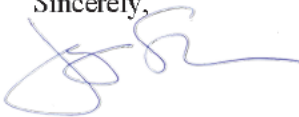
CareFirst shall have the right to audit any claims or payments, made pursuant to this agreement, and to effectuate its rights of recovery as stated below.

RIGHT OF RECOVERY

In the event that billings, made pursuant to the terms herein, result in overpayments or errant payments CareFirst shall have the right to recover such payments.

If this information does not accurately or adequately document the agreement regarding services for the Member, please contact Makia Dorrah Phone:410-872-3502. Otherwise, please sign where indicated below, and return a signed copy (via fax) to Makia's attention at 410-505-6978 as soon as possible.

Sincerely,



Jay Simmons,
VP Provider Networks Contracting

Provider Name

By: Mohamed Matope
(Signature)

Name: _____
(Print)

Title: _____

Date: _____

Federal Tax ID: _____

NPI: _____

December 3, 2025

VIA EMAIL ONLY

Quality One Care Home Health Inc.
Attn: Mohamed Matope
9221 Colesville Rd
Silver Spring, MD 20910
mmatope@qualityonecare.com

Dear Mr. Matope:

Subject: RFP No. 4290.5, Private Duty Nursing Services for Students with Special Needs

This letter is to inform you that the above referenced contract will expire on December 31, 2025. In accordance with the General Conditions, paragraph entitled Contract Term Montgomery County Public Schools (MCPS) would like to pursue the extension of this contract through June 30, 2026. **This will be the last possible extensions.**

Please indicate below your approval or disapproval and return the original to this office signed by an official authorized to enter into contracts with MCPS.

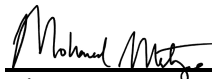
Your response is required via email to Saudy Espinal, Buyer II at saudy_espinaldeveloz@mcpsmd.org Once all responses are evaluated MCPS staff may make a recommendation to the Board of Education to extend the contract or decide to re-bid the contract. If the contract is extended, you will be notified after Board of Education action by a copy of a contract amendment.

In an effort to maintain the most accurate supplier records possible, please provide the most current company W9 as per publication released by the IRS (Rev. 10-2018). In addition, the Contractor Response Form is required each year and must be completed prior to providing services. Please email contractorobligation@mcpsmd.org for additional information.

It has been a pleasure doing business with you and we look forward to another successful year.


We/I agree to extend the contract

We/I do not wish to extend the contract


Signature

Director
Title

12/15/2025
Date

Sincerely,

Angela McIntosh-Davis, Director
Department of Procurement

AMD: se
Copy to: Bid File

September 17, 2024

VIA EMAIL ONLY

Quality One Care Home Health, Inc.
Att: Mohamed Matope
9221 Colesville Rd
Silver Spring, MD 20910
mmatope@qualityonecare.com

Dear Mr. Matope:

Subject: RFP No. 4290.5, Private Duty Nursing Services for Students with Special Needs

This letter is to inform you that the above referenced contract term was **expired** on **06/30/2024**. In accordance with the General Conditions, paragraph entitled Contract Term; Montgomery County Public Schools (MCPS) would like to pursue a one-year extension of this contract. **Through 06/30/2025**. If there are any changes please submit with your response. This will be the second of three one-year option(s) to extend the contract.

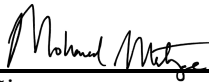
Please indicate below your approval or disapproval and return to this office signed by an official authorized to enter into contracts with MCPS. Your response is required within 10 days of receipt of this letter via email to saudy_espinaldeveloz@mcpsmd.org once your response is received and evaluated MCPS staff may make a recommendation to the Board of Education to extend the contract or decide to re-bid the contract. If the contract is approved by the Board of Education a contract amendment will be issued.

In an effort to maintain the most accurate supplier records possible, we require that you submit your company's most recent W9 with your response. In accordance with Maryland Law any person who enters into a contract with a county board of education "may not knowingly employ an individual to work at a school" if the individual is a registered sex offender. Criminal background checks, including fingerprinting, and identification badges are required as part of this process. Please follow the instructions under the following link.

<https://www.montgomeryschoolsmd.org/departments/procurement/contractors/>

We/I agree to extend the contract

We/I do not wish to extend the contract



Director

09/18/2024

Signature

Title

Date

Sincerely,

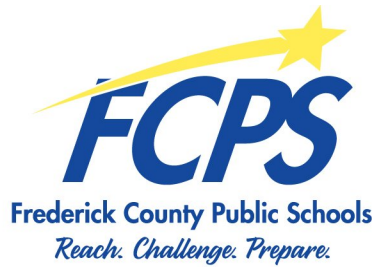


Angela McIntosh-Davis, CPPB, Director
Division of Procurement

AMD: SE

Copy to: Bid File

Purchasing Office
191 South East St.
Frederick, Maryland 21701
240-586-7502 phone
240-586-7501 fax



Bill Meekins CPPB, CPPO, NIGP-CPP, CSBO,
CPCP, Purchasing Manager
**Kim Miskell, CSBO, Assistant Purchasing
Manager**
Roy McHaffa, CPP, CPDW, Purchasing Agent
David Guzman, Purchasing Agent

August 13, 2024

Quality One Care Home Health, Inc.
9221 Colesville Road,
Silver Spring, MD 20910
Attn: Mohamed Matope, CEO
Email: msmatope@gmail.com

Ref: Contract Modification RFP 22MISC13, Contract Service Agencies for Private Duty Nursing

Dear Mr. Matope:

Please be advised Frederick County Public Schools is seeking an amendment to contract RFP 22MISC13, Contract Service Agencies for Private Duty Nursing to include the following requirement:

Page 34, Section II, 10. PROCEDURE FOR ORDERING SERVICES, BILLING AND PAYMENT PROCEDURES, #f. is being amended as follows:

- f. Firms shall invoice monthly and shall provide an itemized listing of work classification used in accordance with their Form of Proposal and Assignment Form. Only one month's billing should be included on each invoice; i.e., February and March nursing assignments should be on separate invoices. **Additionally, the Verification of Services Form must be completed, signed and submitted with monthly invoice(s). Incomplete or missing Verification of Services Form will delay the processing of the invoice(s).**

Your continued interest in serving the Frederick County Public Schools is appreciated. Should you have any questions concerning this matter, please contact me at (240) 586-7502.

Sincerely,

Kim Miskell

Kim Miskell, CSBO
Assistant Purchasing Manager

It is mutually agreed that the above referenced contract be amended for the remainder of the contract term (through June 30, 2026), with all other terms and conditions in the original contract unchanged.

Quality One Care Home Health, Inc.

Frederick County Public Schools:

Name: _____

Name: _____

Title: _____

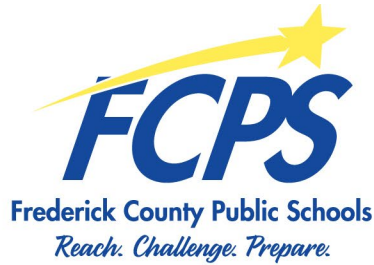
Title: _____

Signature: Mohamed Matope

Signature: _____

Attachment

Purchasing Office
191 South East St
Frederick, Maryland 21701
301-644-5208 phone
301-644-5213 fax



Bill Meekins CPPB, CPPO, NIGP-CPP, CSBO,
CPCP, Purchasing Manager
**Kim Miskell, CSBO, Assistant Purchasing
Manager**
Roy McHaffa, CPP, CPDW, Purchasing Agent
David Guzman, Purchasing Agent

May 30, 2024

Quality One Care Home Health, Inc.
Mohamed Matope, CEO
9221 Colesville Road,
Silver Spring, MD 20910
msmatope@gmail.com

Ref: Notice of Renewal – RFP 22MISC13, Contract Agencies for Private Duty Nursing

Dear Mr. Matope:

Please be advised that on May 29, 2024, your company was part of a multi-vendor renewal by the Board of Education of Frederick County for RFP 22MISC13, Contract Agencies for Private Duty Nursing.

The renewal term will be effective from July 1, 2024 through June 30, 2026, with no renewal options remaining.

As stated in the specifications, please send the following documents within the next ten days:

- A current Certificate of Insurance in accordance with the coverage requirements listed in the bid document.

Your continued interest in serving the Frederick County Public Schools is appreciated. Should you have any questions concerning this matter, please contact me at (301) 644-5208 or kimberly.miskell@fcps.org.

Sincerely,

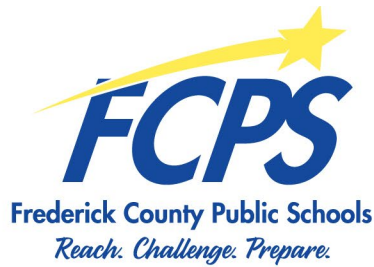
Kim Miskell

Kim Miskell
Assistant Purchasing Manager

KM/kl

cc: Jenifer Waters, Health Service Specialist
Bid File

Purchasing Office
191 South East St
Frederick, Maryland 21701
301-644-5208 phone
301-644-5213 fax



Bill Meekins CPPB, CPPO, NIGP-CPP,
CSBO, CPCP, Purchasing Manager
Kim Miskell, CSBO, Assistant Purchasing
Manager
Roy McHaffa, Purchasing Agent

July 19, 2022

Quality One Care Home Health, Inc.
Mohamed Matope, CEO
9221 Colesville Road,
Silver Spring, MD 20910
mamatope@gmail.com

Ref: Notice of Award – RFP 22MISC13, Contract Agencies for Private Duty Nursing

Dear Mr. Matope:

Please be advised that on July 13, 2022, your company was part of a multi-vendor award by the Board of Education of Frederick County for RFP 22MISC13, Contract Agencies for Private Duty Nursing.

The initial contract term shall be effective from date of award through June 30, 2024, with one two-year renewal term available.

As stated in the specifications, please send the following documents within the next ten days:

- A current Certificate of Insurance in accordance with the coverage requirements listed in the bid document.
- A current W-9.

Your continued interest in serving the Frederick County Public Schools is appreciated. Should you have any questions concerning this matter, please contact me at (301) 644-5208 or kimberly.miskell@fcps.org.

Sincerely,

Kim Miskell

Kim Miskell
Assistant Purchasing Manager

KM/kl

cc: Jenifer Waters, Health Service Specialist
Bid File

Cigna Healthcare
1640 Dallas Pkwy
Plano, TX 75093



Telephone: 800.244.6224
www.cignahealthcare.com

SINGLE CASE AGREEMENT

05/06/2025

Attn: Mohamed Matope
Quality One Care Health Inc
9221 Colesville Rd
Silver Spring, MD 20902
Tax ID: **900715209**
NPI: **1528351285**

RE: [REDACTED]
MEMBER ID#: [REDACTED]
AUTHORIZATION #: [REDACTED]
DATES OF SERVICE: 05/01/2025 – 12/31/2025

Dear **Quality One Care Health Inc,**

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 [REDACTED]. As result, you are a Cigna participating provider with respect to such health care services provided to [REDACTED] 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: Hours	Billed Charge (per hour)	Total Billed Charge(s)	Allowed Amount (per hour)	Total Allowed Amount
S9123	960	\$80.00	\$76,800.00	\$68.00	\$65,280.00
S9124	combined	\$80.00		\$68.00	
Totals:			\$76,800.00		\$65,280.00

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

Quality One Care Health Inc
9221 Colesville Rd
Silver Spring, MD 20902

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

SIGNATURE *Mohamed Matope*

PRINT NAME MOHAMED MATOPE

PRINT TITLE DIRECTOR

05/07/2025
Date

05/06/2025
Date

"Cigna Healthcare" is a registered service mark and the "Tree of Life" logo is a service mark of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

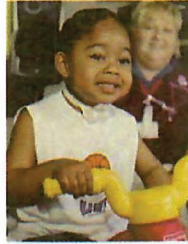
*Your insurer or claim administrator has arranged with Cigna Health Management, Inc. and Cigna Behavioral Health, Inc. (if applicable) to provide utilization review and/or case management services.

Letters of Support

HIGH QUALITY CARE, INC

"Bringing Quality Care To you"

217 Main Street, Suite 201, Laurel, MD 20707 Ph 301-617-9315 Cell 301-617-9319



December 20, 2025

Maryland Health Care Commission
ATTN: Certificate of Need Review

RE: Letter of Support / Referral Partnership for Quality One Care Home Health, Inc. Proposed Home Health Agency (HHA) Service Area (Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties)

To Whom It May Concern:

On behalf of High Quality Care, Inc., I am writing to express strong support for Quality One Care Home Health, Inc. ("Quality One Care" or "QOC") in connection with its Certificate of Need application to establish and operate a Medicare-certified Home Health Agency (HHA) serving Anne Arundel, Montgomery, Prince George's, Calvert, Charles, and St. Mary's Counties in Maryland.

I have had the opportunity to work closely with Quality One Care for over ten (10) years through professional collaboration and subcontracted service arrangements. Throughout this time, QOC has consistently demonstrated excellence in clinical practice, documentation standards, and patient-centered service delivery. QOC has earned a strong reputation for recruiting highly skilled nursing staff and maintaining a dependable operational structure that supports continuity of care.

High Quality Care regularly encounters individuals and families who require skilled home health services. Upon approval and launch of QOC's proposed HHA, we anticipate coordinating and referring appropriate patients to QOC for home health services, including skilled nursing, therapy services, and care coordination as clinically indicated. We are confident QOC will provide safe, timely, and compliant care that supports improved outcomes and reduced avoidable hospital utilization.

Based on our long-standing working relationship, we believe Quality One Care has the qualifications, staffing capacity, and operational readiness to successfully operate a Medicare-certified home health agency and to serve as a trusted partner in the continuum of care.

Please feel free to contact me if additional information would be helpful.

Sincerely,

Dr Joy Davis

www.highqualitycareinc.com

3602 BALIN CT.
ANNANDALE, VA 22003
TEL (703)479-8716/301-523-6233
FAX (800)878-9505
INFO@NUDIMENSIONSLLC.COM
WWW.NUDIMENSIONSLLC.COM



NUDIMENSIONS

Excellent Care Begins and Ends Here

December 18th, 2025

To Whom it may concern

Nu Dimensions LLC is writing to confirm our professional relationship with Quality One Care Home Health, Inc. (“Quality One Care” or “QOC”) and to express support for QOC’s Certificate of Need application to establish and operate a Medicare-certified Home Health Agency (HHA) serving Anne Arundel, Montgomery, Prince George’s, Calvert, Charles, and St. Mary’s Counties.

For several years, Nu Dimensions has worked with QOC to support clinical services and care coordination for individuals in our group home settings. QOC has provided consistent clinical support, reliable nursing services, strong documentation practices, and quality oversight.

Upon approval of QOC’s proposed HHA, Nu Dimensions anticipates coordinating and referring appropriate patients to QOC for skilled home health services as clinically indicated.

Please contact me if additional information would be helpful.

Sincerely,

Martin Tamukong

CEO





Achieve with us.

Dec 18, 2025

To Whom It May Concern:

As a healthcare facility with many patients and varying degrees of complex care situations, we have had to work with other healthcare agencies in the area in order to us to fulfill our goals in providing excellent health care services to the community and our patients. One of such agencies is Quality One Care.

Our partnership with Quality One Care started in 2018 and they have been a very valuable partner to us not only in the home health care services but also as a consultant on some of our cases. Since our partnership, we have come to appreciate their high level of initiative, strong work ethics and proven leadership in their services as well as expertise in home care management. The level of caregiver experience, healthcare assessment skills and competency in the code of conduct that their staff brings to the table is refreshing when compared to other agencies we have partnered with in the past. Their administrative staff is well versed, professional and well trained when it comes to handling difficult situations that sometimes arise in the field. Their expertise and experience in risk-management and their dedication to provide quality services to our clients has been one of the reasons why we put at the top of our partners in the region. We appreciate a partner that can not only do their duties, but also understands our goals as a company and aims to help us achieve those goals.

Quality One Care has been an exceptional partner and we frequently recommend their services and expertise to our clients and patients.

Sincerely,

A handwritten signature in black ink that reads 'Ericka W. Strach-Oyedot'.

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Largo, Maryland 20774

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**Maryland Department of Planning:
Population Totals**

Historical and Projected Total Population for Maryland's Jurisdictions (November 2025)

Geography	Census 2000	Census 2010	Census 2020	2025	2030	2035	2040	2045	2050	2055
MARYLAND	5,296,486	5,773,552	6,177,224	6,300,610	6,492,470	6,687,460	6,863,910	7,029,400	7,191,870	7,341,680
BALTIMORE REGION	2,512,431	2,662,691	2,794,636	2,825,000	2,883,890	2,945,760	2,998,760	3,047,530	3,101,210	3,148,940
Anne Arundel County	489,656	537,656	588,261	609,690	633,740	651,390	664,350	677,220	691,090	698,250
Baltimore County	754,292	805,029	854,535	854,120	862,590	880,110	894,340	905,430	919,450	933,690
Carroll County	150,897	167,134	172,891	177,900	180,660	183,120	185,520	187,830	189,960	192,110
Harford County	218,590	244,826	260,924	268,060	275,760	283,640	291,390	299,010	306,510	314,200
Howard County	247,842	287,085	332,317	345,700	359,830	375,680	389,140	399,980	410,070	420,420
Baltimore City	651,154	620,961	585,708	569,530	571,310	571,820	574,020	578,060	584,130	590,270
WASHINGTON SUBURBAN REGION	1,870,133	2,068,582	2,300,979	2,361,200	2,447,030	2,534,090	2,616,990	2,693,350	2,763,320	2,828,170
Frederick County	195,277	233,385	271,717	305,170	329,280	343,210	357,730	372,870	386,720	400,090
Montgomery County	873,341	971,777	1,062,061	1,085,700	1,123,150	1,154,470	1,183,590	1,209,480	1,232,870	1,253,580
Prince George's County	801,515	863,420	967,201	970,330	994,600	1,036,410	1,075,670	1,111,000	1,143,730	1,174,500
SOUTHERN MARYLAND REGION	281,320	340,439	373,177	387,660	406,970	426,220	444,960	463,760	482,110	500,140
Calvert County	74,563	88,737	92,783	95,010	96,840	98,160	99,570	100,460	100,910	101,140
Charles County	120,546	146,551	166,617	175,920	186,270	196,750	207,290	218,080	228,870	239,600
St. Mary's County	86,211	105,151	113,777	116,730	123,860	131,310	138,100	145,220	152,330	159,400
WESTERN MARYLAND REGION	236,699	252,614	251,617	253,510	261,600	269,920	277,340	284,990	292,370	299,430
Allegany County	74,930	75,087	68,106	67,160	67,510	67,860	68,170	68,470	68,770	69,070
Garrett County	29,846	30,097	28,806	28,400	28,660	28,910	29,150	29,380	29,540	29,620
Washington County	131,923	147,430	154,705	157,950	165,430	173,150	180,020	187,140	194,060	200,740
UPPER EASTERN SHORE REGION	209,295	239,951	243,616	252,980	263,190	273,400	282,110	290,200	297,960	305,270
Caroline County	29,772	33,066	33,293	34,230	35,240	36,290	37,160	38,040	38,840	39,560
Cecil County	85,951	101,108	103,725	106,740	112,730	119,920	126,210	132,350	138,440	144,450
Kent County	19,197	20,197	19,198	19,580	20,060	20,490	20,920	21,350	21,740	22,080
Queen Anne's County	40,563	47,798	49,874	54,210	56,500	57,600	58,290	58,510	58,660	58,670
Talbot County	33,812	37,782	37,526	38,220	38,660	39,100	39,530	39,950	40,280	40,510
LOWER EASTERN SHORE REGION	186,608	209,275	213,199	220,260	229,790	238,070	243,750	249,570	254,900	259,730
Dorchester County	30,674	32,618	32,531	33,200	33,840	34,430	34,850	35,290	35,640	35,910
Somerset County	24,747	26,470	24,620	25,190	25,720	26,070	26,260	26,440	26,550	26,590
Wicomico County	84,644	98,733	103,588	106,960	113,120	117,960	121,870	125,930	129,800	133,460
Worcester County	46,543	51,454	52,460	54,910	57,110	59,610	60,770	61,910	62,910	63,770

Projected numbers are rounded to the nearest 10.

Projections for the Baltimore Region incorporate data from the Baltimore Metropolitan Council's Cooperative Forecasting Group.

Projections for the Washington Suburban Region incorporate data from the Metropolitan Washington Council of Governments' Cooperative Forecasting and Data Subcommittee.

Prepared by the Maryland Department of Planning, State Data and Analysis Center, November 2025.

Historical and Projected Change in Total Population for Maryland's Jurisdictions (November 2025)

Geography	2000-2010	2010-2020	2020-2025	2025-2030	2030-2035	2035-2040	2040-2045	2045-2050	2050-2055
MARYLAND	477,066	403,672	123,386	191,860	194,990	176,450	165,490	162,470	149,810
BALTIMORE REGION	150,260	131,945	30,364	58,890	61,870	53,000	48,770	53,680	47,730
Anne Arundel County	48,000	50,605	21,429	24,050	17,650	12,960	12,870	13,870	7,160
Baltimore County	50,737	49,506	-415	8,470	17,520	14,230	11,090	14,020	14,240
Carroll County	16,237	5,757	5,009	2,760	2,460	2,400	2,310	2,130	2,150
Harford County	26,236	16,098	7,136	7,700	7,880	7,750	7,620	7,500	7,690
Howard County	39,243	45,232	13,383	14,130	15,850	13,460	10,840	10,090	10,350
Baltimore City	-30,193	-35,253	-16,178	1,780	510	2,200	4,040	6,070	6,140
WASHINGTON SUBURBAN REGION	198,449	232,397	60,221	85,830	87,060	82,900	76,360	69,970	64,850
Frederick County	38,108	38,332	33,453	24,110	13,930	14,520	15,140	13,850	13,370
Montgomery County	98,436	90,284	23,639	37,450	31,320	29,120	25,890	23,390	20,710
Prince George's County	61,905	103,781	3,129	24,270	41,810	39,260	35,330	32,730	30,770
SOUTHERN MARYLAND REGION	59,119	32,738	14,483	19,310	19,250	18,740	18,800	18,350	18,030
Calvert County	14,174	4,046	2,227	1,830	1,320	1,410	890	450	230
Charles County	26,005	20,066	9,303	10,350	10,480	10,540	10,790	10,790	10,730
St. Mary's County	18,940	8,626	2,953	7,130	7,450	6,790	7,120	7,110	7,070
WESTERN MARYLAND REGION	15,915	-997	1,893	8,090	8,320	7,420	7,650	7,380	7,060
Allegany County	157	-6,981	-946	350	350	310	300	300	300
Garrett County	251	-1,291	-406	260	250	240	230	160	80
Washington County	15,507	7,275	3,245	7,480	7,720	6,870	7,120	6,920	6,680
UPPER EASTERN SHORE REGION	30,656	3,665	9,364	10,210	10,210	8,710	8,090	7,760	7,310
Caroline County	3,294	227	937	1,010	1,050	870	880	800	720
Cecil County	15,157	2,617	3,015	5,990	7,190	6,290	6,140	6,090	6,010
Kent County	1,000	-999	382	480	430	430	430	390	340
Queen Anne's County	7,235	2,076	4,336	2,290	1,100	690	220	150	10
Talbot County	3,970	-256	694	440	440	430	420	330	230
LOWER EASTERN SHORE REGION	22,667	3,924	7,061	9,530	8,280	5,680	5,820	5,330	4,830
Dorchester County	1,944	-87	669	640	590	420	440	350	270
Somerset County	1,723	-1,850	570	530	350	190	180	110	40
Wicomico County	14,089	4,855	3,372	6,160	4,840	3,910	4,060	3,870	3,660
Worcester County	4,911	1,006	2,450	2,200	2,500	1,160	1,140	1,000	860

Projected numbers are rounded to the nearest 10.

Projections for the Baltimore Region incorporate data from the Baltimore Metropolitan Council's Cooperative Forecasting Group.

Projections for the Washington Suburban Region incorporate data from the Metropolitan Washington Council of Governments' Cooperative Forecasting and Data Subcommittee. Prepared by the Maryland Department of Planning, State Data and Analysis Center, November 2025.

Historical and Projected Total Population for Maryland's Jurisdictions - Annualized Growth Rates (November 2025)

Geography	2000-2010	2010-2020	2020-2025	2025-2030	2030-2035	2035-2040	2040-2045	2045-2050	2050-2055
MARYLAND	0.9%	0.7%	0.4%	0.6%	0.6%	0.5%	0.5%	0.5%	0.4%
BALTIMORE REGION	0.6%	0.5%	0.2%	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%
Anne Arundel County	0.9%	0.9%	0.7%	0.8%	0.6%	0.4%	0.4%	0.4%	0.2%
Baltimore County	0.7%	0.6%	0.0%	0.2%	0.4%	0.3%	0.2%	0.3%	0.3%
Carroll County	1.0%	0.3%	0.6%	0.3%	0.3%	0.3%	0.2%	0.2%	0.2%
Harford County	1.1%	0.6%	0.5%	0.6%	0.6%	0.5%	0.5%	0.5%	0.5%
Howard County	1.5%	1.5%	0.8%	0.8%	0.9%	0.7%	0.6%	0.5%	0.5%
Baltimore City	-0.5%	-0.6%	-0.6%	0.1%	0.0%	0.1%	0.1%	0.2%	0.2%
WASHINGTON SUBURBAN REGION	1.0%	1.1%	0.5%	0.7%	0.7%	0.6%	0.6%	0.5%	0.5%
Frederick County	1.8%	1.5%	2.3%	1.5%	0.8%	0.8%	0.8%	0.7%	0.7%
Montgomery County	1.1%	0.9%	0.4%	0.7%	0.6%	0.5%	0.4%	0.4%	0.3%
Prince George's County	0.7%	1.1%	0.1%	0.5%	0.8%	0.7%	0.6%	0.6%	0.5%
SOUTHERN MARYLAND REGION	1.9%	0.9%	0.8%	1.0%	0.9%	0.9%	0.8%	0.8%	0.7%
Calvert County	1.8%	0.4%	0.5%	0.4%	0.3%	0.3%	0.2%	0.1%	0.0%
Charles County	2.0%	1.3%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	0.9%
St. Mary's County	2.0%	0.8%	0.5%	1.2%	1.2%	1.0%	1.0%	1.0%	0.9%
WESTERN MARYLAND REGION	0.7%	0.0%	0.2%	0.6%	0.6%	0.5%	0.5%	0.5%	0.5%
Allegany County	0.0%	-1.0%	-0.3%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
Garrett County	0.1%	-0.4%	-0.3%	0.2%	0.2%	0.2%	0.2%	0.1%	0.1%
Washington County	1.1%	0.5%	0.4%	0.9%	0.9%	0.8%	0.8%	0.7%	0.7%
UPPER EASTERN SHORE REGION	1.4%	0.2%	0.8%	0.8%	0.8%	0.6%	0.6%	0.5%	0.5%
Caroline County	1.1%	0.1%	0.6%	0.6%	0.6%	0.5%	0.5%	0.4%	0.4%
Cecil County	1.6%	0.3%	0.6%	1.1%	1.2%	1.0%	1.0%	0.9%	0.9%
Kent County	0.5%	-0.5%	0.4%	0.5%	0.4%	0.4%	0.4%	0.4%	0.3%
Queen Anne's County	1.7%	0.4%	1.7%	0.8%	0.4%	0.2%	0.1%	0.1%	0.0%
Talbot County	1.1%	-0.1%	0.4%	0.2%	0.2%	0.2%	0.2%	0.2%	0.1%
LOWER EASTERN SHORE REGION	1.2%	0.2%	0.7%	0.9%	0.7%	0.5%	0.5%	0.4%	0.4%
Dorchester County	0.6%	0.0%	0.4%	0.4%	0.3%	0.2%	0.3%	0.2%	0.2%
Somerset County	0.7%	-0.7%	0.5%	0.4%	0.3%	0.1%	0.1%	0.1%	0.0%
Wicomico County	1.6%	0.5%	0.6%	1.1%	0.8%	0.7%	0.7%	0.6%	0.6%
Worcester County	1.0%	0.2%	0.9%	0.8%	0.9%	0.4%	0.4%	0.3%	0.3%

Projections for the Baltimore Region incorporate data from the Baltimore Metropolitan Council's Cooperative Forecasting Group. Projections for the Washington Suburban Region incorporate data from the Metropolitan Washington Council of Governments' Cooperative Forecasting and Data Subcommittee. Prepared by the Maryland Department of Planning, State Data and Analysis Center, November 2025.

Historical and Projected Total Population Aged 16+ (November 2025)

Geography	2000 Census	2010 Census	2020 Census*	2025	2030	2035	2040	2045	2050	2055
MARYLAND	4,085,942	4,584,109	4,972,951	5,145,520	5,351,930	5,516,480	5,641,480	5,763,340	5,897,540	6,029,100
BALTIMORE REGION	1,945,666	2,124,750	2,255,368	2,310,880	2,381,670	2,434,930	2,470,040	2,502,370	2,545,400	2,587,900
Anne Arundel County	379,394	426,743	470,585	493,450	516,930	530,870	539,430	548,280	559,680	566,520
Baltimore County	595,770	650,037	690,780	698,820	711,180	724,630	733,210	739,460	749,660	761,130
Carroll County	113,461	131,346	139,919	147,280	151,910	155,840	157,870	159,480	161,190	163,230
Harford County	164,126	191,798	209,414	220,230	230,260	238,050	242,880	247,730	253,670	260,750
Howard County	185,381	221,949	261,193	278,420	294,970	308,400	317,460	324,970	334,280	345,150
Baltimore City	507,534	502,877	483,477	472,680	476,420	477,140	479,190	482,450	486,920	491,120
WASHINGTON SUBURBAN REGION	1,430,914	1,629,735	1,842,450	1,919,230	2,007,110	2,078,440	2,140,060	2,200,000	2,259,330	2,315,880
Frederick County	147,144	181,492	215,287	248,650	272,730	284,070	294,070	306,500	319,730	332,770
Montgomery County	675,119	765,578	848,430	880,300	918,260	943,230	962,770	981,940	1,001,560	1,019,740
Prince George's County	608,651	682,665	778,733	790,280	816,120	851,140	883,220	911,560	938,040	963,370
SOUTHERN MARYLAND REGION	209,173	262,050	294,936	312,170	332,280	349,910	364,640	379,310	394,060	409,170
Calvert County	54,988	68,683	73,785	77,220	80,290	82,450	83,550	84,230	84,700	85,140
Charles County	89,512	112,688	131,695	141,540	151,510	160,300	168,520	176,870	185,300	193,910
St. Mary's County	64,673	80,679	89,456	93,410	100,480	107,160	112,570	118,210	124,060	130,120
WESTERN MARYLAND REGION	189,157	205,292	206,690	210,070	217,390	223,320	227,490	232,670	238,510	244,330
Allegany County	61,607	63,288	57,402	56,870	57,410	57,850	58,030	58,230	58,490	58,850
Garrett County	23,299	24,412	23,952	23,810	24,170	24,450	24,480	24,540	24,630	24,700
Washington County	104,251	117,592	125,336	129,390	135,810	141,020	144,980	149,900	155,390	160,780
UPPER EASTERN SHORE REGION	161,725	190,814	198,181	209,720	220,650	230,510	236,570	242,150	248,700	255,720
Caroline County	22,743	25,707	26,323	27,510	28,820	29,860	30,340	30,790	31,390	32,060
Cecil County	64,715	78,888	83,228	87,390	93,200	99,120	103,130	107,210	112,030	117,260
Kent County	15,657	17,081	16,548	17,060	17,530	17,970	18,420	18,840	19,220	19,570
Queen Anne's County	31,417	37,812	40,514	45,290	48,120	50,020	50,770	51,120	51,700	52,330
Talbot County	27,193	31,326	31,568	32,470	32,980	33,540	33,910	34,190	34,360	34,500
LOWER EASTERN SHORE REGION	149,307	171,468	175,326	183,450	192,830	199,370	202,680	206,840	211,540	216,100
Dorchester County	24,351	26,403	26,491	27,440	28,160	28,690	28,960	29,270	29,550	29,790
Somerset County	20,646	22,570	20,860	21,490	22,000	22,110	22,050	22,190	22,370	22,470
Wicomico County	66,207	79,221	83,535	87,750	93,610	97,430	99,520	102,160	105,370	108,750
Worcester County	38,103	43,274	44,440	46,770	49,060	51,140	52,150	53,220	54,250	55,090

Projected numbers are rounded to the nearest 10.

*2020 Modified Age & Race Census File

Prepared by the Maryland Department of Planning, State Data and Analysis Center, November 2025.