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## MARYLAND HEALTH CARE COMMISSION

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### MEMORANDUM

**TO:** Commissioners, Maryland Health Care Commission  
  
Holy Cross Hospital of Silver Spring  
Clarksburg Community Hospital  
Montgomery County Department of Health and Human Services  
Shady Grove Adventist Hospital  
Shady Grove Adventist Emergency Center at Germantown

**FROM:** Marilyn Moon, Ph.D. *MM/pep*  
Chair/Reviewer

**RE:** Recommended Supplemental Decision in the Matter of  
Proposed New Hospitals in Montgomery County  
Holy Cross Hospital of Silver Spring, Docket No. 08-15-2286

**DATE:** May 15, 2012

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Enclosed is my Recommended Supplemental Decision regarding my review on remand from the Circuit Court for Baltimore City. The remand was ordered by the Court to give the Adventist Entities (former applicant Clarksburg Community Hospital, interested party Shady Grove Adventist Hospital, and interested party Shady Grove Emergency Center at Germantown) an opportunity to comment on certain data that was not included in the record of the review of the applications to establish new hospitals in upper Montgomery County. That review resulted in a 180-page Commission decision, dated January 20, 2011 (the "Decision") that approved the application of Holy Cross Hospital of Silver Spring ("Holy Cross Hospital") for a Certificate of Need to establish a 93-bed general acute care hospital in Germantown ("HCH-G") and denied the application of Clarksburg Community Hospital ("CCH") to establish an 86-bed general acute care hospital in Clarksburg.

I have carefully considered the comments filed by the Adventist Entities, the response of Holy Cross Hospital, and have again looked at bed need, as well as HCH-G's expected service area and market penetration. I recommend that the Commission

**APPROVE** the application of **Holy Cross Hospital of Silver Spring** for a Certificate of Need to establish a 93-bed general acute care hospital in Germantown, with the conditions that are standard for a project involving shell space. The proposed hospital will contain 60 general medical/surgical beds, a 15-bed intensive care unit, 12 obstetric beds, six acute psychiatric beds, five operating rooms, and an emergency department with 14 treatment spaces.<sup>1</sup>

I recommend that Holy Cross Hospital of Silver Spring be awarded a Certificate of Need because I again conclude that its proposal for a new general acute care hospital in Germantown will supply upper Montgomery County with hospital bed capacity that the current and growing population of this region needs and that the new hospital will improve access to hospital services at a reasonable cost. Holy Cross and its parent, Trinity Health, are financially well positioned to implement this project.

While the 2011 Decision contained miscalculations of MSGA bed need for HCH-G's expected service area, these miscalculations do not warrant any alteration in the Commission's conclusions with respect to the need for or the viability of the new hospital, as argued by the Adventist Entities. The 2011 Decision indicated that the proposed hospital could fill its beds and be feasible if it captured 10 percent of the MSGA demand generated in its expected service area. However, the Decision indicated that a 10%-20% market penetration range was achievable. My Recommended Supplemental Decision makes it clear that a market share of 10% was not put forward as a ceiling in the 2011 Decision and supports the 2011 Decision's use of a 10-20% market share range as constituting the critical range for market share in an analysis of this proposed hospital's expected service area demand levels as they relate to proposed bed capacity. I have analyzed the corrected need forecast for HCH-G's proposed MSGA beds using a 15% market share assumption, which is demonstrably reasonable and achievable based on the market shares achieved by Maryland hospitals in their comparable service areas. I find that HCH-G is likely to capture this share of the market and note that Holy Cross's campus in Silver Spring already captures slightly less than 7% of the MSGA market share in the proposed Germantown hospital's expected service area.

Holy Cross Hospital of Silver Spring has a strong record in providing quality care, access to care for the indigent, broad community benefits, and efficient and effective management of its hospital operations. I recommend that the Commission re-issue a Certificate of Need for the proposed Holy Cross Hospital in Germantown.

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<sup>1</sup> Holy Cross Hospital has notified the Commission that further refinement of its physical plant design has resulted in an Emergency Department with 14 (rather than 12) treatment spaces, but with no additional square footage. This is not a significant change in physical plant design that requires Commission approval.

**REVIEW SCHEDULE AND FURTHER PROCEEDINGS**

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on May 31, 2012, beginning at 11:00 a.m., at 4160 Patterson Avenue. The Commission will issue a final decision based on the record of the proceeding.

As provided under COMAR 10.24.01.09B, a party may submit written exceptions to the enclosed Recommended Supplemental Decision and Order. Exceptions should be filed by email no later than noon on Wednesday, May 23, 2012. Copies of exceptions will be distributed electronically to the Commissioners; thus, paper copies may be filed the following day. Written exceptions and argument must identify specifically those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. A party must submit 30 copies of their written exceptions and responses to exceptions. Responses to exceptions should be filed no later than 5:00 p.m. on Monday, May 28.

Oral argument during the exceptions hearing before the Commission is limited to 15 minutes per applicant and 10 minutes per interested party, unless extended by the Vice Chair or the Vice-Chair's designated presiding officer. I will not be chairing the meeting when this Recommended Supplemental Decision is considered by the Commission. The schedule for the submission of exceptions and responses is as follows:

Submission of exceptions	Wednesday, May 23, 2012 No later than noon
Submission of responses	Monday, May 28, 2012 No later than 5:00 pm
Exceptions hearing	May 31, 2012 11:00 a.m.

**IN THE MATTER OF**

**PROPOSED NEW HOSPITALS**

**IN MONTGOMERY COUNTY**

**Holy Cross Hospital of Silver Spring  
Docket No. 08-15-2286**

**Clarksburg Community Hospital  
Docket No. 09-15-2294**

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**BEFORE THE**

**MARYLAND HEALTH**

**CARE COMMISSION**

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**Recommended Supplemental Decision**

**May 31, 2012**

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## I. INTRODUCTION

This matter is back before the Commission upon remand from the Circuit Court for Baltimore City. The review came before the Commission as a review of two applications to establish new hospitals in upper Montgomery County, Maryland. On January 20, 2011, the Commission granted a Certificate of Need to Holy Cross Hospital of Silver Spring to establish a new hospital, Holy Cross Hospital-Germantown (“HCH-G”), in Germantown, Maryland. On the same day, the Commission denied the application of Clarksburg Community Hospital, Inc., a corporation formed by Adventist HealthCare, Inc., that sought to establish a new hospital to be known as Clarksburg Community Hospital (“CCH”) in Clarksburg, Maryland. The Commission found that the CCH project was inconsistent with six applicable State Health Plan standards and two Certificate of Need (“CON”) review criteria. The Commission analysis of the two applications is contained in a 180-page decision dated January 20, 2011 (the “Decision”).

The “Adventist Entities”, consisting of CCH, interested party Shady Grove Adventist Hospital, and interested party Shady Grove Adventist Emergency Center at Germantown, appealed the Commission’s grant of a CON for HCH-G on three grounds; they did not allege that the CCH application should have been approved. By a February 21, 2012 Memorandum and Order (“Mem. Opinion”), W. Michel Pierson, Judge of the Circuit Court for Baltimore City, sustained the Commission on two<sup>1</sup> out of the three issues raised by the Adventist Entities, but remanded the matter to the Commission to give the Adventist Entities an opportunity “to comment on the information employed in the Decision” that was not contained in the record. (Mem. Opinion at 8).

On remand, the Adventist Entities had the opportunity to file comments specific to the use of “extra-record” data in the Decision. Specifically, at issue on remand, were “several sources of data that are the subject of [the Adventist Entities’] argument ... population data from Spatial Insights, Inc.; historical population data, current population estimates and projected population for 2014 prepared by Applied Geographic Solutions, Inc; and the ‘D.C. Discharge databases/Data Set.’” (Mem. Opinion at 2). The Adventist Entities have had access to the above-referenced data since January of 2011.

This remand is limited in scope to the use of specific data in the Decision. On May 4, 2012, the Adventist Entities filed comments on the data. On May 9, 2012, HCH-G filed a response to those comments.

### **Reviewer’s Recommendation**

I recommend that the Commission re-issue a Certificate of Need, approving the application, Docket No. 08-15-2286, of Holy Cross Hospital of Silver Spring to establish a new

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<sup>1</sup> The Circuit Court found that the Commission had properly considered input from the Health Services Cost Review Commission, rejecting the Adventist Entities’ argument that statutory language requiring coordination with HSCRC “vest[s] HSCRC with veto power over the Commission decisions.” (Mem. Opinion at 8). The Court noted that the second issue raised by the Adventist Entities was an “illusory issue” because the Commission had not permitted the “shifting” of beds from Holy Cross Hospital in Silver Spring to the proposed new hospital and, thus, that the Commission had not violated the bed need standard in the Acute Care Chapter of the State Health Plan. (Mem. Opinion at 7).

93-bed general acute care hospital in Germantown, with the same standard conditions as in the 2011 Certificate of Need. Although the Adventist Entities have correctly pointed out calculation errors in the Commission's January 20, 2011 decision, Holy Cross Hospital-Germantown has satisfied all State Health Plan Standards and Certificate of Need review criteria and should be re-issued a Certificate of Need.

## II. REVIEW AND ANALYSIS OF ADVENTIST ENTITIES' COMMENTS

The Adventist Entities found errors in the projection of bed need in the Decision. The applicable State Health Plan standard, shown below, requires that a proposal to increase capacity of either MSGA beds or pediatric beds must be justified in one of four ways. The fourth approach outlined in (c)(iv) of the standard permits a service area analysis modeled on the jurisdictional bed need projection methodology. Analysis at the service area-level was used by the applicants in the review, was used in the Decision, and is used in this Recommended Supplement to the Decision.

### **10.24.10.04B(2) Identification of Bed Need and Addition of Beds**

*Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.*

- (a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.*
- (b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.*
- (c) Additional MSGA or pediatric beds may be developed or put into operation only if:
  - (i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or*
  - (ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or*
  - (iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or*
  - (iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.**

The Adventist Entities correctly pointed out two errors that occurred in the analysis of service area bed need in the Decision. The first was in the projected range of use rates of MSGA beds by the adult population aged 15 to 64 in the expected service area of HCH-G in the forecast

year of 2018. The range used for this rate, usually referenced as the “non-Medicare MSGA discharge rate” occurred because the wrong use rate for the base year of 2008 was inadvertently inserted in the bed demand forecast calculations. The overstated base year use rate affected the range of use rates employed in projecting demand in the target year, ten years after the base year.

The Decision used a range of projected 2018 use rates for the HCH-G expected service area, unadjusted, of 64.3 to 71.2 discharges per thousand population aged 15 to 64. The correct range of projected 2018 use rates for this age group in the HCH-G expected service area, which should have been used in the Decision, prior to any adjustment, was 46.6 to 52.3 discharges per thousand population.<sup>2</sup> Thus, for the entire adult population aged 15 and older, this translates into the Decision’s overstated use rate range for MSGA beds of 92.0 to 106.2 discharges per thousand; the correct range would be 77.4 to 90.5 discharges per thousand.

In their comments, the Adventist Entities calculated the (apparently unadjusted) range of projected 2018 use rates for the 15-64 age group to be 45.8 to 50.8. They use this range of 45.8 to 50.8 in their 2018 projection of bed demand for HCH-G’s expected service area. As noted in the table below, I have recalculated the range for this age group and find that the correct unadjusted 2018 range is 46.6 to 52.3; as one can see, this rate is relatively close to that calculated by the Adventist Entities. The differences are not large enough to be significant. I arrived at the unadjusted rate by trending the 2008 use rate to 2018 based on the average annual rate of change over the immediately preceding five-year period (2003-2008) and the immediately preceding ten-year period (1998-2008).

The Decision replicated the State Health Plan methodology, as much as possible, in developing the applicants’ service area forecasts “with the exception that Montgomery County experience serves as the basis for adjustment” rather than the state as a whole. Decision at 40. I followed this method because I conclude that it is the best method to use in a jurisdiction with multiple existing acute care general hospitals with overlapping service areas.

The following table summarizes the MSGA discharge rate for the 15-64 age group used in the 2011 decision and the corrected discharge rates, unadjusted, and the final corrected discharge rate range, adjusted for county-wide proportional change in discharges, which serves as the range used in the service area bed demand forecast.

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<sup>2</sup> The overall statewide MSGA discharge rate for the population aged 15-64 in 2008 (Maryland and DC hospital discharges only) was 70.8 discharges per thousand population. Montgomery County and subregions of the County, such as the HCH-G expected service area have a much lower use rate for this age group, which is probably why this error was not readily apparent.

**MSGA Discharge Rate Range  
Population Aged 15-64**

	<b>Minimum MSGA Discharge Rate</b>	<b>Maximum MSGA Discharge Rate</b>
<b>2011 Decision (adjusted)</b>	<b>64.3</b>	<b>71.2</b>
<b>Corrected Rates (unadjusted)</b>	<b>46.6</b>	<b>52.3</b>
<b>Corrected Rates (adjusted)</b>	<b>45.3</b>	<b>56.4</b>

The second error in the Decision involves the projection of the average length of stay (“ALOS”) used in MSGA bed need projection. The Decision’s missteps in adapting the SHP methodology to adjust ALOS resulted in an inappropriately high range of ALOS for both the Medicare and non-Medicare patient population. I find that the Decision should have used a 2018 projected range for the 65 and older population (the “Medicare” population) in HCH-G’s expected service of 3.99 to 4.15 days; for the 15 to 64 year old population, the projected 2018 range should have been 3.27 to 3.42 days. For the entire adult population, this equates to a 2018 range of 3.63 to 3.80 days (instead of the range of 4.60 to 4.74 days that was used in the Decision), as shown in the following table.

**MSGA Average Length of Stay Range  
All Adults**

	<b>Minimum</b>	<b>Maximum</b>
<b>2011 Decision (adjusted)</b>	<b>4.60</b>	<b>4.74</b>
<b>Corrected ALOS (adjusted)</b>	<b>3.63</b>	<b>3.80</b>

The Decision identified a projected 2018 range of MSGA average daily census (“ADC”) generated by the population of HCH-G’s expected service area (“ESA”) of 358 to 447 patients. When I alter the demand projection to reflect the correct discharge rate and ALOS values, the projected 2018 range for the expected service area’s MSGA ADC is 230 to 314 patients. This is a 2018 MSGA ADC projection for an expected service area (“ESA”) that is an “85% service area,” i.e., a geographic area expected to generate 85% of the demand for MSGA patient days at the proposed Germantown hospital. Thus, in order to project the full level of MSGA bed demand in 2018 available to the prospective hospital, the projected ADC is adjusted accordingly. I note that HCH-G and CCH each used an 85% service area in their analyses of their projected ESA in their respective applications. (Decision at 38).

The following table compares the correct projected MSGA ADC for HCH-G’s expected service area with the projection used in the Decision, as outlined above. The table also makes the same comparison for HCH-G’s MSGA ADC at two levels of market capture (or market share), ten percent and fifteen percent.

**Projected 2018 MSGA Average Daily Census Generated from HCH-G Expected Service Area  
Population and**

**Projected 2018 MSGA Average Daily Census at HCH-G at Two Levels of Market Capture**

	Projected MSGA ADC HCH-G Expected Service Area		Projected ADC Adjusted for "85%" Service Area		Projected HCH-G ADC at 10% Market Share Capture		Projected HCH-G ADC at 15% Market Share Capture	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
<b>2011 Decision</b>	358	447	421	526	42	53	63	79
<b>Corrected Projection</b>	230	314	271	370	27	37	41	56

The following table identifies the projected MSGA bed need at HCH-G, both in the Decision and as corrected, for the same range of market capture, utilizing the target average annual occupancy rates of the State Health Plan, which are scaled to average daily census. Two target occupancy rates come into play here. For an MSGA ADC of 1-49 patients, the State Health Plan target occupancy rate is 70 percent. (COMAR 10.24.10.05(d)(4)). For MSGA ADC of 50 to 99 patients, the State Health Plan target occupancy rate is 75 percent. (*Id.*). The numbers shown for the 10% market share capture in the Decision are different from those shown in Table 31 of the Decision (a minimum of 53 and a maximum of 66) because, for all the bed need values shown in that table, a conservative target occupancy rate of 80% was used<sup>3</sup> rather than the 70 to 75% targets actually applicable to the projected ADC.

**Projected Bed Need at HCH-G at Two Levels of Market Capture and the State Health Plan Target  
Occupancy Rate**

	Projected HCHG Bed Need at 10% Market Share Capture and SHP Target Occupancy Rate		Projected HCHG Bed Need at 15% Market Share Capture and SHP Target Occupancy Rate	
	Minimum	Maximum	Minimum	Maximum
<b>2011 Decision</b>	60	71	84	105
<b>Corrected Projection</b>	39	53	59	75

It will be noted that, when a market capture share assumption of fifteen percent is applied to HCH-G's expected service area, the range of corrected bed need projected for HCH-G, 59 to 75 beds, is almost identical to the overstated bed need projection in the Decision at the ten percent market capture rate for this 75-MSGA bed hospital (60-71).

It is true that my Recommended Decision and the Decision identified utilization projections at the proposed hospital level at a market share rate of ten percent in comparing the two hospitals' applications. A market share capture assumption of ten percent is a very conservative benchmark. This is illustrated by the fact that nearly seven percent of MSGA patients in HCH-G's ESA traveled to Holy Cross Hospital in Silver Spring for their hospital care in 2008. (See Appendix 2). Statewide, the 47 general acute care hospitals in Maryland operating in 2008, on average, had a market share of 28.8% in their "85%" service areas. Because the hospitals that are the only hospitals in their jurisdictions tend to have the largest market shares in their service areas, I examined the 32 hospitals that operated in multi-hospital jurisdictions in

<sup>3</sup> The State Health Plan uses an 80% target occupancy rate for hospitals with an ADC greater than 100 patients.

2008, to get a better sense of what a reasonable benchmark would be for HCH-G. Excluding the extreme outlier of James Lawrence Kernan Hospital in Baltimore City (this specialty rehabilitation hospital had a market share of only 0.2% in its 85% service area in 2008 and only 11 acute care beds), the remaining 31 general hospitals in multi-hospital markets had an average market share of 17.8% in their 85% service areas in 2008. Maryland's two academic medical centers and other large hospitals with tertiary services, such as cardiac surgery, tend to have large and diffuse service areas in which they command the lowest levels of market share. I note that, after eliminating these hospitals from consideration to get a better "peer group" for HCH-G, the remaining 23 community hospitals in Maryland without cardiac surgery services that are located in multi-hospital jurisdictions, commanded an average 21.1% market share in their 85% service areas in 2008.

Additionally, as noted in the Decision, of the women who participate in the Montgomery County Maternity Partnership at Holy Cross Hospital in Silver Spring, 75% come from HCH-G's ESA.<sup>4</sup> (Decision at 46, 101, 170). Because many of these women depend on public transportation to travel past closer available hospitals to go to Holy Cross Hospital's Silver Spring campus, it is reasonable to assume that more Maternity Partnership patients in HCH-G's ESA may access Holy Cross services if such services are more convenient.

The Adventist Entities conduct their analysis using only a ten percent market share for HCH-G. This assumption serves as the constant in their analyses, and forms the basis for their belief that "the CON Decision's 2018 MSGA bed need projections do not support a finding of need for the 75 MSGA and ICU beds proposed for the Holy Cross Germantown project." (Comments at 12).

Despite the miscalculations in the Decision's MSGA bed need projection that were noted by the Adventist Entities, the corrected bed need projection still supports a finding of need for the complement of 75 MSGA beds proposed for the HCH-G project. The Adventist Entities' conclusion solely focuses on the bed demand that HCH-G would be projected to achieve in 2018 if it captured only ten percent of the projected demand for MSGA beds in its expected service in that year. This focus has been selected because of the following findings and conclusions made in the Decision (at 42):

With respect to the new hospitals' proposed ESAs, this analysis reflects the much larger service area population expected for the HCH-G project when compared with the CCH ESA and the ability of the proposed 75 MSGA beds at HCH-G to be highly occupied with a market penetration of MSGA patients originating in the service area of 10% while the CCH project would need to achieve market penetration in excess of 20% in its expected service area to fill its proposed 70 beds at similar levels. ... [M]arket share observed to be achieved by Montgomery County hospitals in "90%" service areas ranged from 7 to 21

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<sup>4</sup> This information played an important part in the Commission's finding that that "HCH-G has a greater potential for positive impact on 'demographic access to services' because of the substantial number of residents from the HCH-G ESA that currently travel to [Silver Spring] for services, especially the participants in the Montgomery County Maternity Partnership, and the more diverse population of the unique zip code areas of the HCH-Germantown ESA...." (Decision at 180-181).

percent, but only one of the five, SGAH, achieved a market share above 10% in a service area representing this level of importance for a hospital. This strongly suggests that the proposed HCH-G project would be likely to achieve efficient utilization of its proposed MSGA beds by penetrating its expected service area at a level that existing hospital experience indicates is realistic.

...

The Commission further concludes that, considering MSGA bed need at the hospital service area and new hospital expected service area level, and incorporating the State Health Plan bed need forecasting methodology steps and Montgomery County trends in MSGA bed use, rather than the overall State experience, as a basis for establishing target discharge rate and ALOS values: (1) a redistribution of MSGA bed capacity from the southeastern area of the County, dominated by HCH-SS and Washington Adventist Hospital to the north and central regions of the County, dominated by Shady Grove Adventist Hospital and Suburban Hospital, is consistent with service area patterns and trends; (2) the HCH-G project has a service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed over the coming decade; and (3) the service area of the CCH project is such that it is possible but not likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed for its project over the coming decade.

I believe that, as noted at the end of the first paragraph of the preceding excerpt, the key conclusion regarding market capture in the Decision was “that the proposed HCH-G project would be likely to achieve efficient utilization of its proposed MSGA beds by penetrating its expected service area at a level that existing hospital experience indicates is realistic.” This is still true. I note that the Decision found that the 75 MSGA beds at HCH-G would be “highly occupied” with a market penetration level of ten percent, in contrast to the market penetration needed by CCH. I explicitly find that, as indicated in the first sentence of the excerpt, 10 to 20 percent constitutes a critical range of market share for consideration in an analysis of expected service area demand levels of this type and their relevance to proposed bed capacity.

The Decision did not conclude that either CCH or HCH-G would have to achieve a high level of bed occupancy in 2018 at a ten percent level of market share in order for a proposed hospital to be found to be needed. Rather, the Commission found that HCH-G would experience a level of demand in its expected service area that would warrant the availability of 53 to 66 MSGA beds operating at an annual average occupancy rate of 80% if it were successful in capturing 10 percent of the demand for MSGA beds in its expected service area; this is equivalent to 59 to 75 beds at the more appropriate 70% to 75% occupancy rate target identified in the State Health Plan, as shown in the preceding table. The Decision also found that the proposed Clarksburg Community Hospital project would only need 23 to 28 beds operating at an annual average occupancy rate of 80% (26 to 32 beds at the more appropriate 70% occupancy rate target) if it were successful in achieving the same level of market share in its expected service area. Thus, an important conclusion from the Decision with respect to HCH-G was simply that the proposed hospital would have “a service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully

support the MSGA beds proposed over the coming decade.” (Decision at 42). This conclusion remains true for HCH-G.

I want to point out that the Decision’s overstatement of the 2018 demand for MSGA beds applied not only to the HCH-G expected service area, but to all of the other hospital service areas examined, including the proposed Clarksburg Community Hospital. However, as shown in the preceding tables, correcting for this overstatement indicates that HCH-G would still achieve approximately the same level of bed use in 2018 by capturing a 15 percent share of the MSGA demand in its expected service area, i.e., a level of market share that is approximately eight percentage points higher than its parent hospital, located in Silver Spring, has already achieved in the Germantown market. (See Appendix 2). And, as previously noted, the 23 non-cardiac surgery hospitals operating in multi-hospital jurisdictions in 2008 achieved an average MSGA market share of 21.1 percent in their 85% MSGA service areas.

As previously noted, the State Health Plan permits a determination of bed need to be made at the service area level, and requires that such an analysis hew to the approach outlined in the Plan’s methodology for forecasting bed need at the jurisdictional level. The consideration of market share implications for filling proposed hospital beds at given levels of forecasted demand in a service area is an obvious and conventional analytic approach. The Decision’s use of a 10 to 20 percent market share as the critical range emerged from the context of the following information on MSGA market share levels achieved by existing hospitals in Montgomery County, as shown in Table 25 of the Decision. (Decision at 38).

**2008 MSGA Market Share of Discharges – “90% MSGA Service Areas”  
Montgomery County Hospitals**

<b>Hospital</b>	<b>Number of Zip Code Areas in the Service Area</b>	<b>Market Share of MSGA Discharges* Originating in the Service Area</b>
<b>Washington Adventist</b>	89	6.2%
<b>HCH-SS</b>	68	8.7%
<b>Suburban</b>	67	9.5%
<b>Montgomery General</b>	48	10.2%
<b>Shady Grove Adventist</b>	37	20.7%
<b>Average</b>	62	11.1%

The Commission noted that the “90%” service areas used in the Decision were not directly comparable to the “85%” expected service areas used by CCH and HCH-G in their applications. (Decision at 38). For a more directly comparable perspective, the following table shows the 85% service areas and market share for existing Montgomery County hospitals.

**2008 MSGA Market Share of Discharges – “85% MSGA Service Areas”  
Montgomery County Hospitals<sup>5</sup>**

<b>Hospital</b>	<b>Number of Zip Code Areas in the Service Area</b>	<b>Market Share of MSGA Discharges* Originating in the Service Area</b>
<b>Washington Adventist</b>	62	7.5%
<b>HCH-SS</b>	51	10.3%
<b>Suburban</b>	37	15.3%
<b>Montgomery General</b>	25	15.9%
<b>Shady Grove Adventist</b>	22	28.5%
<b>Average</b>	39	15.5%

For the five Montgomery County hospitals in 2008, MSGA market share in each hospital’s 85% service area ranged from 7.5% to 28.5%, with an average of 15.5% and a median of 15.3%. The Montgomery County hospital that is closest in size and range of services to HCH-G is Montgomery General Hospital (“MGH”; now known as MedStar Montgomery Medical Center). MGH currently has 120 licensed MSGA beds; the number of licensed MSGA beds for the other Montgomery County hospitals currently ranges from 203 (Suburban Hospital) to 295 (HCH-SS).

The range of market shares reflects the nature of the individual hospitals and the level of competition in their service areas. As shown in the above table, MGH’s market share in 2008 in its 85% service area was 15.9%. Washington Adventist Hospital (“WAH”) and HCH-SS have large, diffuse service areas (as illustrated by the larger number of zip code areas in their 85% service areas) and lower average overall market shares in these service areas because they compete against each other as well as Prince George’s County and District of Columbia hospitals. Specialized service offerings, such as cardiac surgery at WAH and special relationships, such as the relationship between HCH-SS and Kaiser Permanente also contribute to larger and less concentrated service areas with lower overall market share. SGAH has limited competition; and, therefore, its 85% service area has the smallest number of zip code areas and the highest level of MSGA market share. The limited competition in the area as well as HCH-G’s relationship with HCH-SS should make it easier for HCH-G to achieve the volume needed to support its proposed 75 MSGA beds.

The Adventist Entities incorrectly elevated the Decision’s finding with respect to the level of use that HCH-G could achieve at a quite conservative market share level of 10 percent to the status of a threshold standard for approval.<sup>6</sup> The Decision does not support their position. I have used a corrected bed need projection and a reasonable market share in considering the

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<sup>5</sup>Holy Cross Hospital of Silver Spring, in its response to the Adventist Entities comments, also includes an examination of MSGA market share for Montgomery County hospitals at the “85% service area level”. However, that examination started with a definition of the 85% service area based on all acute care discharges, with the exception of neonates. My examination in this footnoted table defines the 85% service area as the zip code areas from which 85% of MSGA discharges alone are derived.

<sup>6</sup>Interestingly, in the Montgomery County new hospital review, the bed demand projections of Clarksburg Community Hospital implied an ability for that hospital to achieve much higher levels of MSGA market share in its expected service area. (Decision at 34).

comments filed by the Adventist Entities and the record in this review. I find that HCH-G's 75 MSGA beds are likely to be well-utilized within a few years after the completion of the project.

**(13) Financial Feasibility**

*A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.*

*(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.*

*(b) Each applicant must document that:*

*(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;*

*(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;*

*(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and*

*(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.*

The Adventist Entities "piggy-back" on their analysis of bed need, exclusively focusing on the bed need for HCH-G at the ten percent market share level, to develop a totally derivative analysis of financial performance for HCH-G. The Adventist Entities' analysis concludes, not unexpectedly, that, at lower projected utilization levels, HCH-G will generate less revenue and that bottom-line performance cannot be maintained because hospitals cannot reduce their variable expenses on a dollar for dollar basis when revenue targets are not met. They do not undertake any analysis of the financial feasibility of the HCH-G project that is based on HCH-G capturing more than ten percent of the total MSGA demand in its expected service area.

As previously noted in this Recommended Supplemental Decision, the incorrect bed need calculation used in the Decision does not change the Commission's findings and conclusions with respect to the need for the HCH-G project. There is sufficient bed need in HCH-G's expected service area for this new hospital to support a revenue base that will result in the profitable operation of the hospital. I find that, using the corrected bed need, the proposed HCH-G hospital is financially feasible.

## **B. Need**

### ***COMAR 10.24.01.08G(3)(b) Need.***

***The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.***

The only need issue addressed by the Adventist Entities in their comments is the MSGA bed need projection. As discussed above, the MSGA bed need standard of COMAR 10.24.10, is satisfied by the HCH-G project. In considering this review criterion, the Commission found that HCH-G also demonstrated a need for the obstetric and acute psychiatric bed capacity proposed for the new hospital and the surgical facilities proposed. That has not changed. I find that need for the new hospital in Germantown has been established.

## **D. Viability of the Proposal**

### ***COMAR 10.24.01.08G(3)(d) Viability of the Proposal.***

***The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.***

In considering this review criterion, the Commission found that both the HCH-G project and the Clarksburg Community Hospital project would be well accepted by the medical community and general population in their respective service areas. (Decision at 149-165). The Commission found that the sponsor of the HCH-G project had adequately demonstrated, with a high degree of certainty, that resources are available for its project planning and for the execution of its plans, which included both HCH-G and the expansion and renovation of the existing Holy Cross Hospital in Silver Spring. The plans of Holy Cross Hospital of Silver Spring and its parent, Trinity Health, were found to have substantially lower risk than those of the Adventist Entities based on the former organizations' superior creditworthiness, liquidity, capital structure, and profitability. Nothing in the comments of the Adventist Entities addresses or alters these findings.

The Commission also found in its Decision that, from the perspective of market feasibility, HCH-G had demonstrated that it can achieve utilization levels consistent with its projections. Cognizant that no forecast can be established with perfect confidence, the Decision also found that the HCH-G project "is backed by resources, in the form of Holy Cross Hospital of Silver Spring and Trinity Health, that can weather difficulties." (Decision at 163). The Adventist Entities have argued in their comments that the HCH-G project is not viable because it cannot demonstrate that it can achieve its projected use levels, which are consistent with a viable level of financial performance. As previously noted, the sole focus of the Adventist Entities is on projected service area demand at the lowest level of market share considered in the Decision. I find that HCH-G continues to be a viable project.

### III. SUMMARY

In January, 2011, the Commission issued a Certificate of Need authorizing Holy Cross Hospital of Silver Spring to establish a 93-bed acute care general hospital in Germantown. Appendix 3 summarizes the basis for the Commission's decision, detailing its review of the applicable State Health Plan standards and Certificate of Need general review criteria.

I have fully considered the comments provided by the Adventist Entities based on their review of the extra-record data that was in the Decision. The Adventist Entities have correctly identified two errors that occurred in the Decision's analysis of bed need, at the proposed hospital expected service area level. They assert that the Commission would not have granted a CON for HCH-G if the errors in the analysis of service area bed need had not occurred, positing that the Commission would have found that the project was not needed and not financially feasible.

I have considered the Decision's miscalculation of the bed need projection for the expected service area of the Germantown hospital, and applied a reasonable and achievable market share for the hospital. I conclude, as I did in my 2010 Recommended Decision, that the hospital is needed and is financially feasible. The market share that the Germantown hospital would need to achieve in its expected service area by 2018, the target year used in the bed need analysis, to attain the same levels of bed occupancy found in the Decision, while five percentage points higher than the level used in the Decision, is within the range of market penetration that can be attained by this new hospital, as demonstrated by Maryland general acute care hospital experience. It is important to note that, in 2008, Holy Cross Hospital of Silver Spring, the sponsor of the Germantown hospital project, captured 6.7% of the MSGA market share generated in the expected service area of the Germantown hospital. The Decision found that the project would need to capture only ten percent of the projected range of MSGA market demand in 2018 to occupy its proposed MSGA bed capacity of 75 beds at a level that would comply with the State Health Plan's bed need standard. Based on my review of the corrected bed need projection, this same level of bed use will be attained in 2018 if the new hospital captures 15 percent of the range of projected MSGA market demand. In 2008, three of the five existing Montgomery County hospitals captured 15 percent or more of the MSGA market in their respective "85% MSGA service areas," directly comparable, in terms of accounting for MSGA discharges, to the expected service area of HCH-G. I note that the 23 Maryland hospitals most comparable to HCH-G (non-cardiac surgery community hospitals operating in multi-hospital jurisdictions) achieved an average MSGA market share of 21.1 percent in their 85% MSGA service areas in 2008.

Because the Adventist Entities' assessment of financial feasibility is based upon an unrealistic assumption that a ten percent market share is the highest level of market penetration that HCH-G can achieve and that this represents a static condition, their conclusions with respect to financial feasibility lack a firm foundation. The Holy Cross Hospital in Germantown has demonstrated financial feasibility.

I conclude that the proposed new hospital in Germantown is needed. I believe that residents of upper Montgomery County, including patients who currently travel to Holy Cross

Hospital in Silver Spring for their medical care, will benefit from having this new hospital in Germantown. As I noted in 2011, Holy Cross Hospital is well-positioned, financially, to build the Germantown hospital; the Germantown hospital is well-positioned, geographically and demographically, to make the hospital succeed

For these reasons, I recommend that the Commission approve the Certificate of Need application, Docket No. 08-15-2286, of Holy Cross Hospital of Silver Spring to establish a new 93-bed general acute care hospital in Germantown, with the standard conditions for a project that contains shell space.

IN THE MATTER OF	*	BEFORE THE
	*	
PROPOSED NEW HOSPITALS	*	MARYLAND HEALTH
	*	
IN MONTGOMERY COUNTY	*	CARE COMMISSION
	*	
Holy Cross Hospital of Silver Spring	*	
Docket No. 08-15-2286	*	
	*	

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**FINAL ORDER**

Based on the analysis and findings in the Commission’s Final Decision, it is this 31<sup>st</sup> day of May, 2012,

**ORDERED**, by a majority of the Maryland Health Care Commission, that the application of Holy Cross Hospital of Silver Spring for a Certificate of Need to establish a 93-bed acute care general hospital at Observation Drive and Middlebrook Road, on the Germantown campus of Montgomery College, in Montgomery County, containing 75 MSGA beds, 12 obstetric beds, 6 acute psychiatric beds, five operating rooms, and 14 emergency department treatment bays,<sup>1</sup> at a total project cost of \$201,983,857, consisting of a total current capital cost of \$169,191,969, including capitalized interest, an inflation allowance of \$1,409,242, financing and other cash requirements of \$6,382,646, and working capital of \$25,000,000, is **APPROVED** subject to the following conditions:

1. Holy Cross Hospital-Germantown will not finish the shell space without giving notice to the Commission and obtaining all required Commission approvals.
2. Holy Cross Hospital-Germantown will not obtain or request an adjustment in rates by the Health Services Cost Review Commission (“HSCRC”) that includes depreciation or interest costs associated with construction of the proposed shell space until and unless Holy Cross Hospital of Germantown has filed a CON application involving the finishing of the shell space, has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.
3. The HSCRC, in calculating an initial rate or any future rates for Holy Cross Hospital of Germantown and its peer group, shall exclude the capital costs

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<sup>1</sup> Holy Cross Hospital has notified the Commission that further refinement of its physical plant design has resulted in an Emergency Department with 14 (rather than 12) treatment spaces, but with no additional square footage. This is not a significant change in physical plant design that requires Commission approval.

associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation (i.e., the rate should only account for depreciation going forward through the remaining useful life of the space). Allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.

**MARYLAND HEALTH CARE COMMISSION**

## Appendix 1

## **Record of the Review on Remand**

On February 21, 2012, W. Michel Pierson, Judge of the Circuit Court for Baltimore City, sustained the Commission on two of three issues raised by petitioners Clarksburg Community Hospital, Inc. and Adventist Healthcare, Inc., d/b/a Shady Grove Adventist Hospital (collectively, the “Adventist Entities”) and remanded the matter to the Commission to give the Adventist Entities an opportunity “to comment on the information employed in the Decision.” (R-1)

On March 2, 2012, Marilyn Moon, Ph.D., the reviewer in this matter, notified counsel of record Diane Festino Schmitt and Jack Tranter that the project was remanded back to MHCC and requested that Adventist file comments regarding the use of “extra-record” data in the Decision. (R-2)

On behalf of the Adventist Entities, Diane Festino Schmitt, by letter to Dr. Moon on March 7, 2012, requested that she withhold issuing a schedule/process for the remand until after the appeal period passed and formally make all extra-record data a part of the administrative record in this matter (R-3)

On March 9, 2012, Jack Tranter, counsel to Holy Cross Hospital—Germantown (“Holy Cross”) notified Dr. Moon that it did not object to the Commission providing to the Adventist Entities the three data bases in question in this matter; and argued that the Adventist Entities have no standing to appeal this matter. (R-4)

On March 27, 2012, Diane Festino Schmitt notified Suellen Wideman, AAG, counsel for MHCC in this matter, that the Adventist Entities would not pursue an appeal to the Court of Special Appeals at that time and requested the extra-record data in the format in which the Reviewer reviewed it. (R-5)

On March 28, 2012, Ms. Wideman notified the parties by email correspondence that the Adventist Entities had all of the extra-record data since January of 2011 and that Dr. Moon would respond to the parties’ requests by letter. (R-6)

On behalf of Holy Cross, Mr. Tranter replied to the Adventist Entities’ request for additional time to file comments by letter to Dr. Moon on March 28, 2012. (R-7)

On March 29, 2012, Ms. Wideman requested that counsel for the parties consider and discuss the date for filing comments on the extra-record data. (R-8)

On March 29, 2012, Ms. Wideman re-sent to the Adventist Entities thirteen original emails and attached data provided by Paul Parker, the Commission’s Director of Hospital Services, in January of 2011 (R-9) and provided a copy of the correspondence and data originally

sent to the Adventist Entities on January 28, 2011 and January 31, 2011 to Ms. Schmitt on March 30, 2012. (R-10)

Holy Cross agreed to an extension of time for filing comments, with conditions, on March 30, 2012. (R-11)

Ms. Wideman wrote to counsel for the parties on April 3, 2012, providing a list of the zip code areas comprising the defined MSGA service areas in this matter. (R-12)

The Adventist Entities requested clarification of zip code area data by email correspondence on April 5, 2012. (R-13) Also on April 5, 2012, Holy Cross requested that this matter be considered by the Commission on April 19, 2012 as the Adventist Entities did not file comments by the deadline of April 2, 2012. (R-14) Ms. Wideman provided additional clarification of the zip code data to the parties herein on April 5, 2012. (R-15)

On April 11, 2012, the Adventist Entities argued against the Holy Cross request for the MHCC to consider this matter on April 19, 2012 and proposed that the Adventist Entities file its comments by May 7, 2012. (R-16)

Ms. Wideman proposed revised filing deadlines for comments and the Recommended Supplement to the Decision in this matter on April 16, 2012 (R-17) in response to Holy Cross' letter of that same date setting forth the unnecessary cost estimates for every month of delay to completion of site work at its location. (R-18) The Adventist Entities agreed to work with Holy Cross to establish the filing dates for comments and responses on April 18, 2012 (R-19)

Holy Cross filed a Motion Seeking Issuance of an Interlocutory Non-Final Determination Authorizing Holy Cross Hospital to Continue Construction of a New Hospital In Germantown on April 18, 2012. (R-20)

Ms. Wideman provided preliminary notice to counsel for the parties on April 20, 2012 via email correspondence regarding the possibility of scheduling a hearing in this matter during the last week of April. (R-21) Ms. Wideman requested additional clarification of the Adventist Entities schedule for filing comments and responses on April 24, 2012. (R-22)

On April 24, 2012, the Adventist Entities filed its Opposition to HCH's Motion Seeking Issuance of an Interlocutory Non-Final Determination. (R-23) On that same date, the Commission's Vice-Chair, provided notice to the parties that he would chair a hearing on April 25, 2012, giving each party ten minutes to present oral argument on the Motion Seeking Issuance of an Interlocutory Non-Final Determination Authorizing Holy Cross Hospital to Continue Construction of a New Hospital in Germantown filed by Holy Cross on April 18, 2012. (R-24)

On April 25, 2012, the Commission received documentation that Judge W. Michel Pierson denied the Motion to Revise Judgment (Pleading No. 22), along with the opposition, on April 16, 2012. (R-25)

The transcript of the motions hearing held on April 25, 2012 In the Matter of Proposed New Hospitals in Montgomery County, Holy Cross Hospital Silver Spring, Docket No. 08-15-2289; Clarksburg Community Hospital, Docket Number 09-15-2294 was received by the Commission on May 3, 2012. (R-26)

On May 4, 2012, the Adventist Entities filed Adventist's Comments on Additional Evidence Entered Into The Record. (R-27) and on May 7, 2012, the Adventist Entities filed original signature pages for Richard J. Coughlan and David S. Cohen's Affidavits A and B to its Comments. (R-28)

On May 10, 2012, Holy Cross filed its Response to Comments Filed By the Adventist Entities. (R-29)

On May 11, 2012, Dr.Moon notified the parties via email letter dated April 11, 2012 that she did not desire additional filings, evidence, or oral argument in this matter, that she expected to issue a Recommended Supplemental Decision on or about May 16, 2012; a party taking exceptions would have seven days to file them with the Commission and a party filing responses to exceptions would have five dates to file its reponse; and that oral argument on the exceptions will be heard on May 31, 2012. (R-30) On May 14, 2012, another email was sent to the parties from Dr.Moon revising the date of document R-30 to May 11, 2012. (R-31)

## Appendix 2

**2008 MSGA MARKET SHARE DISCHARGES to  
Germantown Expected Service Area (ESA) Zip Codes**

ESA Zip Codes	2008 MSGA MARKET SHARE						TOTAL	Total Discharges MD & DC Hospitals
	FREDERICK	HOLY CROSS	MGH	SGAH	SUBURBAN	WAH		
20837	3.7%	2.3%	2.5%	59.7%	9.3%	2.8%	80.28%	355
20838	22.2%	0.0%	0.0%	50.0%	11.1%	0.0%	83.33%	18
20839	0.0%	0.0%	0.0%	55.2%	6.9%	17.2%	79.31%	29
20841	2.3%	6.0%	1.0%	60.3%	9.1%	3.1%	81.82%	385
20842	24.6%	1.5%	0.7%	50.7%	5.2%	6.0%	88.81%	134
20850	0.3%	4.8%	3.0%	55.4%	18.9%	3.0%	85.48%	2858
20851	0.3%	14.2%	5.1%	32.4%	30.0%	4.2%	86.18%	731
20853	0.1%	17.8%	31.2%	16.3%	14.2%	3.7%	83.33%	2021
20855	0.4%	4.7%	16.8%	46.5%	10.6%	2.7%	81.73%	810
20871	8.0%	7.1%	5.6%	51.3%	7.8%	3.2%	82.97%	411
20872	9.1%	2.9%	21.4%	38.1%	4.7%	3.5%	79.61%	770
20874	0.5%	5.4%	3.1%	63.4%	9.1%	3.4%	84.97%	2628
20876	0.7%	6.2%	3.9%	61.1%	8.8%	4.3%	84.88%	1005
20877	0.3%	5.5%	3.7%	63.6%	11.3%	2.8%	87.31%	2198
20878	0.4%	4.1%	1.8%	58.2%	12.6%	3.4%	80.43%	2586
20879	0.3%	6.1%	8.2%	56.6%	12.0%	1.9%	85.18%	1255
20882	1.1%	4.0%	31.7%	36.5%	6.6%	2.9%	82.65%	732
20886	0.3%	7.8%	6.1%	58.4%	9.6%	3.1%	85.35%	1597
<b>Total for Above</b>								
<b>Zip Codes</b>	234	1385	1772	10661	2536	664	17252	20523
<b>Percent of Total</b>	1.1%	6.7%	8.6%	51.9%	12.4%	3.2%	84.1%	

Source: HSCRC (Maryland) Hospital and DC Hospital Discharge Data Bases, CY 2008

## Appendix 3

## Summary of Analysis and Findings – 2011 Commission Decision

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
<b>I. THE STATE HEALTH PLAN COMAR 10.24.01.08G(3)(a)</b>			
<b>State Health Plan: Acute Care Hospital Services-General Standards COMAR 10.24.10.04A-</b>			
(1) Information Regarding Changes	15	Meets Standard	Meets Standard
(2) Charity Care Policy	17	Meets Standard	Meets Standard
(3) Quality of Care	21	Meets Standard	Meets Standard
<b>Project Review Standards</b>			
(1) Geographic Accessibility	26	Meets Standard	Meets Standard
(2) Identification of Bed Need and Addition of Beds	35	Does Not Meet Standard	Meets Standard
(3) Minimum Average Daily Census for Establishment of a Pediatric Unit	43	Not Applicable	Not Applicable
(4) Adverse Impact	43	Not Applicable	Not Applicable
(5) Cost-Effectiveness	50	Does Not Meet Standard	Meets Standard
(6) Burden of Proof Regarding Need	52	Does Not Meet Standard	Meets Standard
(7) Construction Cost of Hospital Space	58	Meets Standard	Meets Standard
(8) Construction Cost of Non-Hospital Space	63	Not Applicable	Not Applicable
(9) Inpatient Nursing Unit Space	64	Meets Standard	Meets Standard
(10) Rate Reduction Agreement	64	Not Applicable	Not Applicable
(11) Efficiency	66	Does Not Meet Standard	Meets Standard
(12) Patient Safety	67	Meets Standard	Meets Standard
(13) Financial Feasibility	73	Does Not Meet Standard	Meets Standard
(14) Emergency Department Treatment Capacity and Space	80	Meets Standard	Meets Standard
(15) Emergency Department Expansion	83	Not Applicable	Not Applicable
(16) Shell Space	84	Not Applicable	Meets Standard
<b>State Health Plan: Acute Hospital Inpatient Obstetric Services-Review Standards COMAR 10.24.12.04</b>			
(1) Need	95	Meets Standard	Meets Standard
(2) The Maryland Perinatal System Standards	97	Meets Standard	Meets Standard

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
(3) Charity Care Policy	99	Meets Standard	Meets Standard
(4) Medicaid Access	101	Meets Standard	Meets Standard
(5) Staffing	103	Meets Standard	Meets Standard
(6) Physical Plant Design and New Technology	104	Meets Standard	Meets Standard
(7) Nursery	105	Meets Standard	Meets Standard
(8) Community Benefit Plan	108	Does Not Meet Standard	Meets Standard
(9) Source of Patients	109	Meets Standard	Meets Standard
(10) Non-Metropolitan Jurisdictions	109	<i>Not Applicable</i>	<i>Not Applicable</i>
(11) Designated Bed Capacity	109	<i>Not Applicable</i>	<i>Not Applicable</i>
(12) Minimum Volume	111	Meets Standard	Meets Standard
(13) Impact on the Health Care System	112	Meets Standard	Meets Standard
(14) Financial Feasibility	112	See COMAR 10.24.10 and Viability Review Criterion	See COMAR 10.24.10 and Viability Review Criterion
(15) Outreach Program	113	Meets Standard	Meets Standard
<b>State Health Plan: Overview, Psychiatric Services, and EMS-Standards for Psychiatric Services COMAR 10.24.07 Availability</b>			
(AP1a) Bed Need	113		See COMAR 10.24.01.08G
(AP1b) Delicensing Requirements	114		<i>Not Applicable</i>
(AP1c) State Hospital Conversion Bed Need	114		<i>Not Applicable</i>
(AP1d) Preference	114		<i>Not Applicable</i>
(AP2a) Procedures for Psychiatric Emergency Inpatient Treatment	114		Meets Standard
(AP2b) Emergency Facilities	115		Meets Standard
(AP2c) Emergency Holding Beds	115		Meets Standard
(AP3a) Array of Services	115		Meets Standard
(AP3b) Required Services for Child & Adolescent Psychiatric Services	116		<i>Not Applicable</i>
(AP3c) Psychiatric Consultation Services	116		Meets Standard
(AP4a) Separate CONs for Each Age Group	116		Meets Standard
(AP4b) Physical Separation and Distinct Programs for Each Age Group	116		Meets Standard

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
<b>Accessibility</b>			
(AP5) Required Services	116		Meets Standard
(AP6) Quality Assurances	117		Meets Standard
(AP7) Denial of Admission Based on Legal Status	117		Meets Standard
(AP8) Uncompensated Care	117		Meets Standard
(AP9) Admission of Acute Child Psychiatric Patients to General Pediatric Beds	118		<i>Not Applicable</i>
<b>Accessibility-Variant LHPA Standard Cost</b>			
(AP10) Occupancy	118		<i>Not Applicable</i>
(AP11) Age-Adjusted Average Total Cost	118		<i>Not Applicable</i>
<b>Quality</b>			
(AP12a) Clinical Supervision	119		Meets Standard
(AP12b) Staffing	119		Meets Standard
(AP12c) Staffing of Child and/or Adolescent Acute Psychiatric Units	119		<i>Not Applicable</i>
<b>Continuity</b>			
(AP13) Discharge Planning and Referrals	119		Meets Standard
<b>Acceptability</b>			
(AP14) Letters of Acknowledgement	120		Meets Standard
<b>II. COMAR 10.24.01.08G(3)(b) NEED</b>	124, 130	CCH has not adequately justified need for MSGA beds and ED treatment capacity. Its case for OB bed capacity is weaker than that of HCH-G. CCH has adequately justified need for surgical facilities.	HCH-G has adequately justified need for MSGA, OB, and acute psychiatric beds, surgical facilities, and ED treatment space.
<b>III. COMAR 10.24.01.08G(3)(c) AVAILABILITY OF MORE COST EFFECTIVE ALTERNATIVES</b>	146	CCH has not made the case that it is a more cost effective alternative to expanding Shady Grove Adventist Hospital or to establishing HCH-G.	HCH-G will be more cost effective than CCH at meeting the needs for additional beds in its upcounty extended service area; HCH-G will provide improved accessibility in terms of travel time for more residents than the Clarksburg location; when considering resources in the County as a whole, HCH-G is the most cost-effective alternative.

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
<p><b>IV. COMAR 10.24.01.08G(3)(d) VIABILITY OF THE PROPOSAL</b></p>	<p>154</p>	<p>Although it is less than certain, CCH/WAH may be able to obtain resources needed to undertake both the development of CCH and the replacement of WAH, if approved; however, ability to sustain CCH has not been shown due to problems with market feasibility.</p>	<p>Project Financially Viable</p>
<p><b>V. COMAR 10.24.01.08G(3)(e) COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED</b></p>	<p>164</p>	<p>Hospital in compliance</p>	<p>Hospital in compliance although historic track record not as strong as AHC</p>
<p><b>VI. COMAR 10.24.01.08G(3)(f) IMPACT ON EXISTING PROVIDERS</b></p>	<p>168</p>	<p>No undue negative impact.</p>	<p>No undue negative impact. The HCH-G project has a greater potential for positive impact on demographic access to services.</p>