STATE OF MARYLAND

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MEMORANDUM

TO: Commissioners

Dimensions Health Corporation
Mt. Washington Pediatric Hospital, Inc.
Anne Arundel Medical Center
Doctors Community Hospital
Prince George's County Health Department

FROM: Robert E. Moffit, Ph.D.
Commissioner/Reviewer

RE: Recommended Decision
Application for Certificate of Need
Dimensions Health Corporation
d/b/a Prince George's Hospital Center and
Mt. Washington Pediatric Hospital, Inc
Docket No. 13-16-2351

DATE: September 30, 2016

Enclosed is my Recommended Decision in my review of a Certificate of Need ("CON") application by Dimensions Health Corporation ("Dimensions"), d/b/a Prince George's Hospital Center ("PGHC") and Mt. Washington Pediatric Hospital, Inc. ("MWPH"). The application seeks CON approval to relocate PGHC and the MWPH unit at PGHC to a replacement general hospital to be known as Prince George's Regional Medical Center ("PGRMC"), at a site in Largo (Prince George's County), Maryland. Having conducted site visits at the existing hospital and the proposed site, and having considered the entire record in this review, I recommend that the Commission **APPROVE** the application, as modified by the applicants on August 31, 2016, and award a Certificate of Need for the replacement hospital. I find that the proposed project is consistent with Certificate of Need review criteria and applicable standards in the State Health Plan for Facilities and Services ("State Health Plan")

As an introductory observation, I note that a fundamental purpose of Maryland's Certificate of Need law is to restrain excess capacity, including the excess construction of hospitals and other regulated health care facilities. This statutory goal is based on an economic theory that health care markets are unique in that supply induces demand, and excess supply thus drives excessive health care costs. The law, therefore, is designed to restrain excessive supply, allow for coordinated

health planning to meet the needs of State residents, and thus to control or reduce Maryland's overall health care and medical costs. The Commission is to enforce the law and apply the regulatory standards to achieve this goal.

Interested Parties.

The interested parties in this review are Anne Arundel Medical Center, Doctors Community Hospital, and the Prince George's County Health Department.

Background.

The Certificate of Need ("CON") application that was docketed in this review was a replacement application filed by the applicants on January 16, 2015. It was then broadly understood that the University of Maryland Medical System Corporation ("UMMS") would undertake the management of the new hospital. The 2015 application, however, did not provide any clarity on that transition, and, specifically, did not contain crucial details concerning the hospital's future management and governance structure.

In their 2015 application, the applicants proposed an estimated total project cost of $651, 223,000. The proposed funding would be based on three major pillars: $206.7 million in debt; $208 million in funding from Prince George's County; and $208 million in funding from the State of Maryland. The Commission had never previously considered an application for a project with this amount of capital funding from Maryland taxpayers, nor such a large proportion of public funding as a component of total capital funding. Preceding the applicants' 2015 CON application, Maryland and/or Prince George's County taxpayers had been subsidizing Prince George's Hospital Center for more than a decade.

Based on my review of the 2015 replacement application, the extensive comments filed by interested parties, my site visit to the existing hospital and the proposed replacement hospital site, my review of a study of several professional profiles and analyses of prevailing health problems and care deficits in Prince George's County,[1] I concluded that there was a clear and compelling need for a replacement hospital, and that its proposed location in Largowas an excellent choice. That convenient location, astride main arteries and the Metro line, could attract a potentially strong patient base for the new hospital. This stronger patient base would not only include the residents of the County, but could also secure patient enrollment from surrounding areas, including the District of Columbia. I also determined that the most serious need in the County was the provision of a robust primary and ambulatory care network to serve the pressing needs of the people in the County and to improve the health status of those who were suffering from chronic illnesses.

Maryland law provides the Commission with broad authority to issue a Certificate of Need for the establishment, relocation, or expansion of hospitals and other health care facilities. Pursuant to law, the Commission's procedural regulations, COMAR 10.24.01, and various chapters of the State Health Plan set forth the criteria and standards for CON review. These requirements cover a range of areas, including adverse impact on geographically contiguous institutions; the cost effectiveness of the project; its compatibility with State rate setting; and its efficiency and viability.

[1] Detailed at the project status conference held on May 17, 2016 and in resulting documents. Docket Item ("DI") #92.

I reviewed the applicants' January 2015 submission to determine its compliance with over 50 regulatory standards, and found that the project was compliant with the vast majority of these requirements. However, the most significant problem was the financial feasibility of this historically large capital project, which I determined would jeopardize the proposed replacement hospital's financial future. I concluded, therefore, that the cost of the proposed project, as presented and based on a comparison of other regional hospitals, was unwarranted because of excessive space and service capacity. For this reason, I advised the parties that a project status conference was needed in this review, at which I would discuss areas of the project's non-compliance with regulatory requirements and recommend changes that would enable me to recommend that the Commission approve the project.

Project Status Conference.

At the May 17, 2016 project status conference, I made it clear to the parties that my recommendations did not entail substantive changes in the replacement hospital's service lines, but primarily involved reductions in cost and size. I explained that the project seemed out of proportion to the need, as well as my assessment of volume and discharge patterns and the Commission's bed need projections. I found that the project's relatively high cost, when compared with similar hospital projects, required a reconsideration of its size and scope.

I also concluded that the overall investment was too heavily weighted to hospital facilities and that more resources should be invested in primary care development. The strengthening of primary and ambulatory care in Prince George's County will not only meet the most crucial needs of its residents - who suffer disproportionately from chronic disease and health care disparities - but is also vital to the long-term viability of the new hospital through increased referrals from physicians and other medical professionals working in the hospital's service area. New and robust primary and ambulatory care networks, I determined, were essential to the overall long-term success of this major project.

The Proposed Project, as Modified on August 31, 2016.

In the modification to their application filed on August 31, 2016, the applicants complied with my specific recommendations concerning the cost and size of the project. The applicants thus reduced the total project costs from $639,055,000 (excluding the County's $12.3 million land donation) to $543,000,000; reduced the total construction costs from $284,744,090 to $225,000,000; and reduced the total square footage of the project by approximately 130,000 square feet.[2]

The applicants also complied with my recommendations to reduce finished operating rooms and treatment bays. In the category of medical/surgical/gynecological/addictions ("MSGA") beds, they reduced total beds from 216 to 205, a slight variation from my recommendation of 202. This was based on the applicants' updated review of their specific bed needs, including pediatric bed needs, which I found to be reasonable.

[2] Modification in Response to May 17, 2016 Project Status Conference, for Certificate of Need for Prince George's Regional Medical Center as a Replacement and relocation of Prince George's Hospital Center, from Co-Applicants Dimensions Health Corporation and Mt. Washington Pediatric Hospital (August 31, 2016) (DI #92)

Operational Efficiencies.

At the project status conference, I also requested that the applicants detail the measures that they would undertake to improve operational efficiency and reduce the staffing hours and cost per unit of services. I asked the applicants to quantify the financial impact of these operational efficiencies to the best of their ability. The applicants have complied with my request, and in their modification have outlined a detailed set of measures designed to increase operational efficiencies.[3] These include improvements in revenue collections through reductions in claim denials and net bad debt write-offs, implementation of pay-for-performance measures that will reward the hospital under the State's payment model, reductions in the length of hospital stays, reductions in staffing and labor costs, savings resulting from the replacement hospital's design and equipment efficiencies, and reductions in drug costs. In their September 21, 2016 memorandum to me, senior officials of the Health Services Cost Review Commission ("HSCRC") assessed the applicants' modified application, stating,

> In summary, we believe that the performance improvements identified by PGHC in their CON modification are achievable. *Furthermore, we believe that PGHC will exceed the savings estimated from performance improvements, which will have a positive impact on the projected income statements."* [4]

The Development of Ambulatory Care.

At the project status conference, I noted that the provision of a strong and robust primary and ambulatory care network is essential to the improvement of the health status of the residents of Prince George's County and crucial to the long-term financial success of the project, and I asked the applicants to provide a detailed account of how they were going to accomplish this objective.

The applicants have complied with my request, and have specified, in exhaustive detail, how they plan to expand and improve primary and ambulatory care.[5] Their proposed program includes a continuation of their cooperation with the Prince George's Health Department, an agency that has already undertaken an admirable and consequential effort to improve primary care for Prince George's County residents. It also includes building on the progress of the Health Enterprise Zone serving Capitol Heights, developing an aggressive population health program , conducting a community needs assessment, building and maintaining a strong primary and ambulatory care network (including "Family Health and Wellness Centers"), aggressively recruiting primary care and specialty medical professionals, and launching a targeted program to identify and monitor high utilizers of emergency care (and assigning physicians to those persons), as well as a broader use of telehealth to maintain communication and to secure care for these and other patients.

[3] August 31, 2016 Modifications (DI #92, pp. 17-30) (emphasis added).
[4] Donna Kinzer, Executive Director, and Gerard J. Schmith, Deputy Director, HSCRC, Memorandum to Robert E. Moffit, PhD, concerning "Modification of Application for Certificate of Need to Relocate Prince George's Hospital Center" (DI #97, p. 5) (hereafter cited as "HSCRC Memo on Modification").
[5] August 31, 2016 Modifications (DI #92, pp. 31-52).

Governance and Management.

It is common knowledge that the Prince George's Hospital Center has long endured serious financial and managerial problems. These problems have been well documented in various reports and have been publicized in the media. PGHC leadership's repeated attempts to resolve these problems over the years have fallen short of their expectations. From year to year, the financial shortfalls have been accompanied by continuous infusions of taxpayer subsidies from State and County officials.

The long-term financial viability of this project is dependent on appropriate management. Strong and effective management will help to secure the efficient delivery of high quality and cost effective care, establish the institution on a firm and permanent financial footing, and finally bring to an end the dependence of the institution on an expensive diet of taxpayer subsidies. Indeed, the applicants themselves, in presenting this project to the Commission, have declared their desire to be free of this historic and unhappy dependence.

At the project status conference, I requested that the applicants provide an account of the proposed management and governance of the new hospital. With the enactment of the Prince George's County Regional Medical Center Act of 2016,[6] the Maryland General Assembly provided additional funding for the new hospital, but conditioned those monies on the University of Maryland Medical System Corporation becoming the sole corporate member of Dimensions Health System and assuming responsibility for the project.

The applicants have complied with my request, and outlined their plans for the managerial transition from Dimensions to UMMS. Under an August 30, 2016 Memorandum of Understanding provided with the application modifications, UMMS will become the sole corporate member and assume governance of Dimensions shortly after the Commission's approval of the CON for the replacement and relocation of the hospital. Dimensions will remain the sponsor of the project and subject to oversight by UMMS. Over the period 2016 to 2018, Dimensions will be governed by an interim local board, but subject to the UMMS Board of Directors. In 2019, a 21-member permanent Board will govern Dimensions, but be subject to the ultimate authority of UMMS and its President and CEO.

Project Funding and Competitiveness.

In their application modifications, the applicants estimate a project cost of $555,350,000, including Prince George's County's $12.3 million donation of land. Of the total, $416 million is attributable to State and County grants. Unlike virtually every other CON application that the Commission considers, the funding of this project is largely a major public enterprise. In their assessment of the funding, HSCRC staff determined that the project's funding sources, including the large State and County grants and the authorized bond proceeds and interest income, "appear appropriate," but noted that the applicants will still need to resort to short-term borrowing for the hospital's early operations.[7]

Over the next few years the hospital's rates may still not be competitive. In an October 23, 2015 response to my initial inquiry on the 2015 application, HSCRC staff said that PGHC was

[6] Senate Bill 324 (Chapter 13 of 2016 Laws of Maryland).
[7] HSCRC Memo on Modifications (DI #97, p. 1).

more than 14 percent *above* the "average adjusted charges" of its peer group hospitals, and 10 percent above "adjusted" statewide hospital charges. HSCRC staff states that the hospital would need to achieve "significant productivity improvements" to improve its charge performance.[8] In their September 21, 2016 response to my inquiries, HSCRC staff notes that a review of current performance shows that PGHC per capita charges are still 12 percent higher than its peer hospitals. The HSCRC notes, of course, that its analysis incorporates the fact that PGHC serves a disproportionately larger share of high cost patients through its trauma center, as well as indigent patients, who contribute to its higher rates: "By 2023, PGHC's projected charges per case," writes the HSCRC, "would be approximately 20 percent higher than the peer group of hospitals after taking into account the redistributed system revenue and projected future volume changes at PGHC."[9] The HSCRC staff further said that, in the future, the hospital's rate structure would thus be subject to HSCRC prescribed efficiency measures. [10]

Commissioners know, of course, that health care rate projections, just like health care cost projections, are subject to numerous uncertainties, such as the payer mix, the ability to retain the hospital's traditional patient base, attract new patients and increase volume through primary and ambulatory care outreach, cost effective applications of technology, an improved reputation for delivering quality care. Competitive rates can also be achieved, as noted, by increasing hospital productivity and securing impressive savings, through economic efficiencies in care delivery, such as those that the applicants have already outlined in extended detail. I also believe the UMMS will provide the strong managerial leadership necessary to achieve these economic efficiencies and thus improve the hospital's competitive position.

Conclusion.

As I stated at the May 17, 2016 project status conference, the people of Prince George's County need and deserve a strong revitalized health care system, and a modern hospital is a "crucial variable in that equation." I also noted that, for the Commission, this decision takes on a special gravity because of the very large investment in this project that is being undertaken by Maryland taxpayers. For that reason, I issued recommendations that would reduce the overall size and cost of the project, bring it into line with comparable projects, and lay the groundwork for a strong, permanent financial basis for the new regional medical center. I also emphasized that the project's success would be reinforced by a strong and robust network of primary and ambulatory care services.

With these changes, the Commission, if it approves the application to establish the proposed new Prince George's Regional Medical Center, can help the people of Prince George's County secure the goals that the applicants have outlined in their recent modifications to their application, but at a lower cost than in the 2015 application. Concerning the recent modifications that they made, subsequent to the project status conference, the applicants stated that,

> *Dimensions and UMMS are confident that the Reviewer's recommendations compromise neither their ability to serve the health care needs of Prince George's County nor the transformational quality of the proposed project.*[11]

[8] HSCRC Memo on Modifications (DI #97, p. 2).
[9] HSCRC Memo on Modifications (DI #97, p. 4).
[10] Ibid.
[11] August 31, 2016 Modifications (DI #92, p. 3)(emphasis added).

Review Schedule and Further Proceedings.

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on October 20, 2016, beginning at 1:00 p.m. at 4160 Patterson Avenue in Baltimore. The Commission will issue a final decision based on the record of the proceeding.

As provided under COMAR 10.24.01.09B, the applicant and interested parties may submit written exceptions to the enclosed Recommended Decision. As noted below, exceptions must be filed no later than 5:00 p.m. on Friday, October 7, 2016. Written exceptions must specifically identify those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. Responses to exceptions must be filed no later than 5:00 p.m. on Wednesday, October 12, 2016. Copies of exceptions and responses must be sent by email to the MHCC and all parties by these deadlines. The applicant and interested parties must also file 30 copies of written exceptions and responses to exceptions by noon of the business day following the deadline.

Oral argument during the exceptions hearing before the Commission will be limited to 10 minutes per interested party and 15 minutes for the applicant, unless extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and responses is as follows:

Submission of exceptions	October 7, 2016 No later than 5:00 p.m.
Submission of responses	October 12, 2016 No later than 5:00 p.m.
Exceptions hearing	October 20, 2016 1:00 p.m.

IN THE MATTER OF	*	**BEFORE THE**
	*	
DIMENSIONS HEALTH CORPORATION d/b/a PRINCE GEORGE'S HOSPITAL CENTER and MT. WASHINGTON PEDIATRIC HOSPITAL, INC.	* * * * * *	**MARYLAND HEALTH CARE COMMISSION**
	*	
Docket No.: 13-16-2351	*	
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Reviewer's Recommended Decision

October 20, 2016

(Released September 30, 2016)

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I. INTRODUCTION

A. The Applicants

The applicants are Dimensions Health Corporation ("Dimensions") d/b/a Prince George's Hospital Center ("PGHC") and Mt. Washington Pediatric Hospital, Inc. ("MWPH"), which will be a tenant of the proposed replacement hospital. They are co-applicants in a project that would replace and relocate Prince George's Hospital Center and MWPH.

PGHC is currently owned and operated by Dimensions, which was formed in 1982. Dimensions operates three campuses containing licensed health care facilities:

- Prince George's Hospital Center, a 233-bed general hospital in Cheverly that also houses a 15-bed special hospital-pediatric, Mt. Washington Pediatric Hospital, through a lease arrangement;

- Laurel Regional Hospital, a 63-bed general hospital in Laurel with a special hospital-chronic unit licensed for 46 beds; and

- The Bowie Health Campus, which contains: the Bowie Health Center, a freestanding medical facility that provides emergency service on a 24/7 basis; Dimensions Surgery Center, an ambulatory surgical facility; and Larkin Chase Care and Rehabilitation Center, a comprehensive care facility, or nursing home.

PGHC was founded in 1944. The general hospital, which dates from 1951, provides inpatient medical/surgical, gynecology, and addictions ("MSGA") services, pediatric services, obstetric ("OB") services, and acute psychiatric services.

PGHC is one of four Level II regional trauma centers in Maryland and also functions as a referral center for perinatal services (neonatal intensive care and high-risk maternity care), having a Level III designation by the Maryland Institute for Emergency Medical Services Systems ("MIEMSS"). It operates a cardiac surgery program and hosts a residency program for internal medicine. As previously noted, it hosts a special hospital for pediatric care by leasing space to MWPH, a non-Dimensions entity.

Over the last six years PGHC has experienced an annual average of 11,775 discharges and an overall average daily census of 162.3 patients, distributed as shown in Table I-1 below.

Table I-1: PGHC Acute Care Discharges and Average Daily Census, CY 2010-2015

Discharges	2010	2011	2012	2013	2014	2015
MSGA	9,133	8,069	7,218	6,951	7,855	8,431
OB	2,809	2,427	2,360	2,273	2,394	2,338
Psychiatric	1,348	1,421	1,363	1,321	1,395	1,387
Pediatric	48	45	23	23	3	2
Total	**13,348**	**11,962**	**10,964**	**10,568**	**11,647**	**12,158**
Average Daily Census	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
MSGA	131.1	118.2	115.6	111.7	126.0	126.8
OB	22.3	19.5	17.8	16.2	17.5	16.1
Psychiatric	21.6	21.6	20.2	20.4	24.4	25.2
Pediatric	0.4	0.3	0.1	0.1	0.0	0.0
Total	**175.4**	**159.6**	**154.4**	**148.7**	**168.2**	**168.5**

Source: HSCRC Discharge Database

MWPH is co-owned by Johns Hopkins Medical System and the University of Maryland Medical System Corporation ("UMMS"). It offers rehabilitation and other special hospital services for pediatric patients on two campuses, a main campus in the Mt. Washington neighborhood of Baltimore and a satellite facility at PGHC. Its specialty pediatric services include: physical and occupational therapy; speech and language pathology; psychology; neurology; developmental evaluation psychiatry; and chronic illness programs.

Table I-2: MWPH Discharges and Average Daily Census (All Special Hospital - Pediatric), 2010-2015 (Both Campuses)

	CY2010	CY2011	CY2012	CY2013	CY2014	FY2015
Discharges	699	610	719	802	695	813
Average Daily Census	58.5	48.4	57.0	60.9	49.7	64.8

Source: HSCRC Discharge Database

B. The Project

The proposed project seeks to relocate and replace Prince George's Hospital Center and the Prince George's satellite of Mt. Washington Pediatric Hospital with a new hospital to be known as Prince George's Regional Medical Center ("PGRMC"). The replacement hospital would be constructed in Largo, about five miles to the southeast of the existing Cheverly campus. The site is located adjacent to the Capital Beltway (I-495) and is in close proximity to the Largo Town Center Metro Station. The proposed project, as modified by the applicant on August 31, 2015 involves construction of a hospital building of 595,695 square feet ("SF") with nine levels containing hospital facilities and services and three top levels providing a helicopter port and security room, and two elevator machine rooms. A separate, prefabricated 27,000 SF structure would house a central utility plant.

The relocated hospital would provide all of the facilities and services currently provided by PGHC. The following table compares hospital service capacities in the applicants' January 2015 replacement application, which was docketed for review, with those modifications to the project that were submitted on August 31, 2016, in response to recommendations for changes in the size and cost of the project and capacity that I made at a May 17, 2016 project status conference.

Table I-3 Bed and Selected Service Capacities: PGHC and Two Plans for PGRMC

	Existing PGHC	Project Plan in January 2015 Application	Project Plan in August 31, 2016 Modification
Physical Bed Capacity / (FY 2017 Licensed Bed Capacity)			
General Medical/Surgical	170	133	122
Intensive Care	34	32	32
Total MSGA	204(169)	165	154
Obstetric (Postpartum)	42(34)	22	22
Pediatric	12(2)	1	1
Acute Psychiatric	38(28)	28	28
MWPH – Special Hospital-Pediatric	15	15	15
TOTAL BED CAPACITY - General and Special Hospital	**311(248)**	**231**	**220**
Other Service Capacities			
Dedicated Observation Beds	---	20	20
Operating Rooms	10	9	8
Emergency Department Treatment Spaces	40	52	45

Source: Docket Item (DI) #92, 8/31/16 Dimensions' Modifications to application, and Interim Update: Licensed Acute Care Hospital Beds Fiscal Year 2017 (published August 2016).
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_AcuteCare_Interim_Update_Hospital_Beds_FY17.pdf

Applicants' Rationale for the Project

The current hospital's physical plant is old. The majority of the building, including the space used for most of the inpatient units, is 48 to 65 years old. Only two major building components have been added since 1968 -- the ambulatory care facility, which includes the emergency department and the parking garage, and dates from 1976 -- and the Pavilion, which was built in 1995.

The applicants characterize PGHC as "not designed for modern, patient-centered/family-oriented medicine." The inadequacy of space is a running theme throughout the applicants' detailed description of departmental deficiencies, including some "critical area" space. They state that the age and configuration of the buildings on the campus make modernization of the existing campus undesirable.

Beyond practical limitations, the applicants cite research which they state supports a relocation and replacement of the hospital in order to meet a need to establish "an academically-affiliated regional medical center for the County to improve actual and perceived quality of care." (DI #30, p. 15)

Project Cost and Financing

The estimated total project cost is $555,350,000, including the estimated value of the land ($12,350,000) donated by Prince George's County on which the replacement hospital will be located. The estimated construction cost is $225 million and total estimated project cost, exclusive of the land value, is $543 million.

Table I-4: Project Costs and Sources of Funds

Uses of Funds		
	January 2015 Replacement Application	**August 2016 Modifications to Application**
Land (Value of Donated Land)	$ 12,350,000	$ 12,350,000
New Construction		
Building	$284,744,090	$225,000,000
Fixed Equipment	-	35,967,350
Site Preparation / Infrastructure	17,133,951	23,833,950
Architect/Engineering Fees & Permits	27,106,653	25,265,631
Subtotal	**$328,984,694**	**$310,066,931**
Other Capital Costs		
Contingencies	$ 30,000,000	$ 27,544,547
Other*	20,079,220	19,329,220
Movable Equipment	158,916,566	118,724,773
Capitalized Construction Interest	39,762,000	22,900,000
Subtotal	**$248,757,786**	**$188,498,540**
Total Current Capital Costs	**$577,742,480**	**$498,565,471**
Inflation	25,824,520	17,173,011
Total Capital Costs	**$615,917,000**	**$528,088,482**
Financing Cost and Other Cash Requirements		
Loan Replacement Fees	$ 4,131,000	$ 2,500,000
Bond Discount	-	-
Legal Fees	1,000,000	927,115
Non-Legal Consultant Fees	900,000	834,403
Liquidation of Existing Debt	-	0
Debt Service Reserve Fund	14,775,000	8,500,000
Other (RPAI, Gold's Gym)	14,500,000	14,500,000
Subtotal	35,306,000	27,261,518
Total Project Cost and Uses of Funds	**$651,223,000**	**$555,350,000**
Sources of Funds		
	January 2015 Replacement Application	**August 2016 Modifications to Application**
Authorized Bonds	$206,760,000	$117,809,717
Interest Income from bonds proceeds	16,113,000	9,190,283
State Grant or Appropriations	208,000,000	208,000,000
Local Grant or Appropriations	208,000,000	208,000,000
Donated Land	12,350,000	12,350,000
Total Sources of Funds	**$651,223,000**	**$555,350,000**

*Includes UMMS PM, Builder's Risk, Commissioning/Testing, Warehousing, Testing, Traffic Study, Davis Langdon, CM Pricing, Scheduling, Helipad, Survey, Risk Assessment, Code, review, ICRA, MET Testing, Curtainwall Testing, Legal, Office Consolidation, Enabling, Equipment Planning, IT Design, Offsite Improvements, IT Design, Original site leave behind costs.
Source: (DI#30, Exh. 1, Table E & DI #92, Exh. 62, Table E).

As shown in the project budget estimate, this project relies heavily on a grant of $416 million, split evenly between the State and Prince George's County governments, accounting for approximately 77% of the total expenditure outlay required. The balance of the project funding needed will be borrowed, through the sale of bonds (22%) and interest generated from the bond

proceeds (2%). Dimensions has no equity it can bring to the project. Dimensions plans to obtain a bridge loan to finance this project until all the government appropriations are received.

If this project is approved, 2016 legislation requires that UMMS become the sole corporate member of Dimensions and assume responsibility for the governance of Dimensions. (DI #92, p.55) While the Dimensions entity may remain as the licensed operator of the replacement hospital and the other Dimensions Health System components, Dimensions will be wholly owned by UMMS.[1]

C. Recommended Decision

I recommend that the Maryland Health Care Commission approve this project based on its finding that: the proposed project complies with the applicable State Health Plan standards; and that the need for the project, its costs and effectiveness, and its viability have been demonstrated. I conclude that the project's impact will be primarily positive and that its potential impact on existing providers does not warrant denial of the project. I also believe the project's impact on the health care delivery system in Prince George's County, reflecting the leadership and resources available through the University of Maryland Medical System and paired with a robust primary and ambulatory care network, has the potential to be revolutionary. I summarize my key findings below.

Need and Capacity

My review determined that modernization of PGHC was needed and relocation to the Largo site was an excellent choice. However, the applicants' volume projections were over stated and the hospital replacement planned was bigger and more costly than it needed to be. Thus the feasibility and viability of the project, as originally presented, were, at best, highly questionable, as confirmed by HSCRC in its review of the project in the fall of 2015. Because of these concerns, I convened a Project Status Conference and outlined changes I found to be needed in the project plan. With some secondary exceptions, the applicants responded positively to my requirements and recommendations, reducing the size of the replacement hospital and its estimated cost, and incorporating most of my recommendations on reduced service capacity. I believe that the new project plan is much more appropriate to the needs of the project sponsors and the population of Prince George's County.

[1]In its August 31, 2016 modifications to the application, the applicants attached an August 30, 2016 Memorandum of Understanding between the UMMS and Dimensions. The applicants state that UMMS affiliation with Dimensions will be similar to other UMMS affiliations, in which UMMS or a subsidiary of UMMS is the sole member of the local affiliate entity or hospital. In such situations, there is a local board of directors and local leadership, including a president/CEO who manages the local hospital. The local board and leadership are subject to the oversight of the UMMS board of directors. (8/31/16 modifications, DI #92, pp.54-55 and Exh. 72)

Costs and Effectiveness

I find that Dimensions adequately demonstrated that the proposed relocation and replacement of PGHC is a cost effective approach to the needed modernization of this general hospital and the new site is excellent in terms of access.

The project plan as originally presented, was too costly and too big, jeopardizing its financial feasibility. I am satisfied that the new project plan is a more cost effective means of meeting the hospital's modernization needs and the likely demand for medical services. Nonetheless, UMMS leadership must still work on making the replacement hospital more price competitive than the existing PGHC. Based on proposed operational efficiencies, as well as the most recent and projected financial performance, I am optimistic that progress can be made on this important goal.

Efficiency

Replacing the current outdated facility with a modern facility will improve adjacencies and work flow. Single rooms will allow for more efficient use of the hospital's bed capacity. Dimensions provided estimates of staffing efficiencies that are driven by the new facility's design, as well as a variety of operational performance improvements that could be pursued regardless of whether there is a new facility. HSCRC has stated that the performance improvements identified by Dimensions are achievable, and perhaps, understated.

Financial Feasibility and Viability

This project is largely supported by County and State funding commitments and land donation. This public funding plan will limit the applicants' need to borrow for project implementation. A high level of public support for the project has been documented.

Dimensions is planning system changes, in addition to this hospital relocation, that will allow it to support the higher capital cost basis of the replacement hospital without extraordinary increases in the system's global revenue, i.e., more of the systems revenue will be allocated to PGHC. While this redistribution promises to improve the hospital's position, I continue to have concerns with the likely high price position of the replacement hospital, a concern echoed by HSCRC, and a problem that plagues the existing PGHC. Nonetheless, I am encouraged by the impressive measures that are being pursued to develop an infrastructure of improved primary care in the county and I am optimistic that, under strong UMMS leadership, efforts to improve operational efficiency and reduce costs may surpass expectations. The project creates opportunities for success that are not possible with the current hospital.

Impact on Other Providers and the Health Care System

I find that the project is highly likely to have a very positive impact on the safety and quality of hospital care and is an important piece of the effort to improve the health care delivery system in Prince George's County.

My analysis shows that the project is likely to have an impact on the volume of care provided at three Maryland hospitals and at MedStar Washington Hospital Center in D.C. However the likely level of impacts is not large enough to warrant denial or reconsideration of the planned approach to modernizing PGHC.

II. PROCEDURAL HISTORY

A. Record of the Review

The procedural history for this project is included as Appendix 1.

B. Interested Parties in the Review

Doctor's Community Hospital ("DCH"), Anne Arundel Medical Center ("AAMC"), and the Prince George's County Health Department are interested parties in this review.

DCH acknowledges the need for a replacement hospital but has disagreements with several aspects of the current application. DCH stated that the assumptions regarding the "recapture" of Prince George's County market share are overstated and that impact of the project on DCH is understated. DCH questioned the number of MSGA beds and claimed that bed need exceeded MHCC projections. DCH believes that the financial projections appear flawed and questioned the cost effectiveness of this project and whether HSCRC would approve the revenue increase related to the project's increased capital costs, which exceed $21 million.

AAMC describes the applicants' wish to modernize their facilities as "a laudable goal" that it does not oppose, but encourages the Commission to fully evaluate the viability of the project's components. (DI #44, p.1) AAMC questions the cardiac surgery component of the project, concluding that the applicant failed to address all applicable standards in the Cardiac Surgery Chapter of the State Health Plan. AAMC also contends that the application neither claims nor demonstrates that PGRMC will meet the minimum volume requirements for cardiac surgery programs by 2022, and also questions the validity of the volume projections, which rely on an assumption of a substantial increase in market share. (DI #44, p. 4) More broadly, AAMC questions whether Marylanders would be better served by establishment of a new PGRMC rather than by investments in "the health care delivery system of Prince George's County," and states that the first priority is a need to invest in "ambulatory care, especially primary care" in the County.

The Prince George's County Health Department expressed its support for the project, stating that the new hospital will benefit the County by helping to recruit needed doctors to the area, support the expansion of the cardiac program, and provide Prince George's County residents with a local, state-of-the-art acute care hospital for needed care.

C. Local Government Review and Comment

As noted above, the Prince George's County Health Department is an interested party in this review and provided comments supporting the replacement hospital project. Local government elected officials are among those who provided letters of support.

D. Community Support

The Maryland Health Care Commission received many written expressions of support for the project from various individuals and organizations. I have summarized the filings, attempting to adjust for duplications, categorizing correspondents in order to provide useful information on the nature and character of the expressions of support.

Forty-two (42) letters were filed that supported the construction of the new PGRMC and appear to be individually-prepared communications. Of these, 16 were from physicians or other health care practitioners; seven were from small businesses and organizations within Prince George's County; five were from persons with no particular self-identified organizational connection; and 14 were from elected officials. Four of these were members of the Maryland delegation to the U.S. House of Representatives, and two were members of the Maryland Senate (separate letters). Letters also came from the Mayors of Capitol Heights, Greenbelt, and New Carrollton. Letters also came from: Martin O'Malley, who was Governor at the time the initial application was filed; the Prince George's County Executive; the Chair of the Prince George's County Council; the Commissioners of Charles County; the Prince George's County Fire Chief; Reverend Duane Kay; and William Kirwan, now Chancellor Emeritus of the University System of Maryland. (DI# 3).

III. BACKGROUND

A. Population Change, Race, and Income

Population Projections

Prince George's County is the second most populous county in the State of Maryland with an estimated population of 909,530 (2015, U.S. Census Bureau) and, at approximately 485 square miles, the second most densely populated jurisdiction in the State. It is situated in the heart of the Baltimore/Washington corridor and borders Washington D.C. The proposed site of the hospital in Largo is about 37 miles south of the City of Baltimore and 19 miles east of the District of Columbia.

Prince George's County's population was projected to grow at a rate of 4.3% during the five-year period between 2010 and 2015, slightly faster than the projected State growth rate of 4.1%. However, the projected future rate of growth is somewhat lower than that of the State. Prince George's County's population is projected to increase by 7.6% between 2010 and 2025 compared to an 11.4% projected population growth for Maryland.

Table III-1. Projected Population Change, 2010 to 2040
Prince George's County and Maryland

Year	Population		Growth Rates at 5 year intervals	
	Prince George's	Maryland	Prince George's	Maryland
2010	863,420	5,773,552	--	--
2015	900,350	6,010,150	4.3%	4.1%
2020	914,500	6,224,550	1.6%	3.6%
2025	929,650	6,429,750	1.7%	3.3%
2030	944,550	6,612,200	1.6%	2.8%
2035	957,650	6,762,300	1.4%	2.3%
2040	967,850	6,889,700	1.1%	1.9%
Change 2010-2040	104,430	1,116,148	12.1%	19.3%

Source: Maryland Department of Planning, 2014 Total Population Projections by Age, Sex and Race (revised Jan. 2015), https://data.maryland.gov/Planning/Maryland-Historical-and-Projected-Population-by-Ju/nnwx-dpqi

The County's age distribution is somewhat younger than that of the State. In 2010, 64.5% of Prince George's County residents were 44 or younger, compared to 60% in the State and 9.4% of residents were 65+ compared to 12.3% statewide. More detailed demographic information is available in Appendix 2.

Table III-2. Age Distribution of Prince George's County Population, 2010 – 2040

Year	Jurisdiction	0-14	15-44	45-64	65-74	75+
2010	Prince George's	19.6%	44.9%	26.1%	5.8%	3.6%
	Maryland	19.2%	40.8%	27.7%	6.7%	5.6%
2020	Prince George's	19.6%	44.9%	26.1%	5.8%	3.6%
	Maryland	18.0%	40.0%	26.2%	9.4%	6.4%
2030	Prince George's	18.1%	43.5%	25.0%	8.5%	5.1%
	Maryland	17.9%	39.3%	23.1%	10.8%	8.8%
2040	Prince George's	16.6%	41.8%	23.6%	8.7%	9.3%
	Maryland	17.4%	38.4%	23.8%	9.3%	11.2%

Source: Maryland Department of Planning, 2014 Total Population Projections by Age, Sex and Race (Revised January 2015)

Racial Composition

Prince George's County is the most racially diverse county in the State. It is a "minority majority" county. African Americans racially account for 64.5% of the County's population. About 19% of the remaining population is White, Other (9.1%), or Asian (4.1%). By comparison,

Maryland's population is predominately White (58%), with African Americans comprising about 29%, of the population, followed by Asian (6%) and Other (4%).[2]

Table III-3. Population by Race* Prince George's County, Southern Maryland and Maryland, 2011

Jurisdiction	White	Black or African American	Asian	Other**	Two or more Races
Prince George's	**19.2%**	**64.5%**	**4.1%**	**9.1%**	**3.2%**
Maryland	**58.2%**	**29.4%**	**5.5%**	**4.0%**	**2.9%**

* All racial categories, with the exception of "two or more," reported as "alone."
**Other includes American Indian, Alaskan Native, Native Hawaiian, other Pacific Islander, and other races.
Source: 2010 U.S. Census of Population

Economic Status

Prince George's County households had an estimated median income of $71,904[3] in 2014, about 2.6% below the State median. The U.S. Census Bureau estimates that, in 2014, Prince George's County had a slightly smaller percentage of residents living in poverty (10.3%), than Maryland overall (10.4%), based on the federal Department of Health and Human Services Poverty Guidelines. Table III-4 below shows the estimated poverty rates for various segments of the population in Prince George's County and in Maryland, in 2013.

Table III-4. Proportion (%) of Total Residents Living in Poverty, 2013*

Proportion Living in Poverty	Prince George's	Maryland
Total Residents	9.4%	9.8%
Over age 18	12.2%	12.9%
Ages 5-17	11.1%	11.6%
Under age 5	13.7%	15.3%

*Based on Federal Poverty Guidelines. American Community Survey. Estimates based on a sample of household over a five year period.
http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

The U.S. Census Bureau provides a variety of estimates based on community surveys. Often these results are compiled and reported for a time period (rather than for a single year) to reduce sampling error. Economic indicators drawn from this source and shown in Table III-5 below provide a snapshot of the region's economic well-being, and do not indicate major shifts since the 2010 census.

[2] Source: 2014 U.S. Census Population: http://quickfacts.census.gov/qfd/states/24/24033.html
[3] Source: U.S. Census Bureau, Small Area Income and Poverty Estimates, December 2015

Table III-5. Indicators of Economic Well-Being*

	Prince George's	Maryland
Persons below poverty level, 2010-2014	10.3%	10.1%
Homeownership rate, 2010-2014	62.3%	67.1%
Median value of owner-occupied housing units, 2010-2014	$258,800	$287,500
Per capita money income, past 12 months (2014 dollars), 2010-2014	$32,637	$36,670
Median Household Income, 2010-2014	$73,856	$74,149

*From US Census Bureau State & County Quickfacts, which reports data collected by the US Census Bureau for timeframes between each 10-year census. http://quickfacts.census.gov/qfd/index.html

B. Prince George's County General Acute Care Hospitals

Prince George's County has five general acute care hospitals.[4] Licensed acute care bed capacity, which is established in Maryland each year based on a retrospective look at average daily patient census, has been broadly declining throughout the State in recent years. Between FY 2010 and FY 2017, Prince George's County's five hospitals saw a decline in licensed acute care bed complements of 15.2%. During that same period, the number of licensed acute care beds statewide declined by 9.9%. (see Table III-7)

Table III-6. Prince George's County Licensed Acute Care Beds by Hospital and Service: Maryland, 2016

General Hospitals	Licensed Acute Care Beds - FY 2017					Reported Physical Acute Care Bed Capacity
	MSGA	Obstetric	Pediatric	Psychiatric	Total	
Doctors Community Hospital Lanham	190	0	0	0	190	218
Fort Washington Medical Center Fort Washington	32	0	0	0	32	37
Laurel Regional Hospital Laurel	45	0	0	18	63	171
MedStar Southern Maryland Hospital Center Clinton	133	30	4	25	192	339
Prince George's Hospital Center Cheverly	169	34	2	28	233	311
Total	**569**	**64**	**6**	**71**	**710**	**1,076**

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services FY 2017.

[4] In July 2015, Laurel Regional Hospital announced that it plans to phase out its inpatient general hospital operations within three years.

Table III-7. Change in Acute Care Bed Inventories, Prince George's County General Acute Care Hospitals FY2010-FY2017

	Licensed Beds FY 2010	Licensed Beds FY 2017	Change FY 2010-2017	Reported Physical Bed Capacity
Doctors Community	190	190	No change	218
Fort Washington	43	32	-25.6%	37
Laurel Regional	95	63	-33.7%	171
MedStar Southern Maryland	246	192	-22.0%	339
Prince George's	254	233	-8.3%	311
Total Prince George's	828	710	-14.3%	1,076

Source: MHCC, Annual Report on Selected Maryland Acute Care and Special Hospital Services FY 2017.

C. Hospital Utilization Trends

The tables below profile hospital inpatient demand in Prince George's County and Maryland from CY 2009 to CY 2015, as reported in HSCRC Discharge Data Base, and selected outpatient service statistics from the HSCRC Financial Data Base for a four-year period (CY 2011 to CY 2015)**.** The HSCRC Financial Data Base is not audited, but is a "snapshot" of hospital volume by rate center (it also includes information on revenues, not shown here) on a monthly basis. The data in this Data Base in subject to change and hospitals are encouraged to revise the data to reflect the most current information.

Inpatient Care

Some important facts and trends regarding the provision of inpatient care in the county for the six-year period reviewed include:

Acute care inpatient discharges are falling…

- Total acute care discharges declined by 22.9% in Prince George's County hospitals. (declined by 20.7% statewide)

- The average daily census ("ADC") in Prince George's County hospitals declined by 10.4%, from 567 to 509. Statewide, the decline was 11.1% during this period.

- This decline in inpatient activity followed a ten-year period (1998-2008) in which average daily census rose by 6.7% in Prince George's County. Statewide ADC increased 24.6% during this period.

…and Length of inpatient stay is increasing

- In 2015, MSGA average length of stay ("ALOS") was 4.8 days in Prince George's County general hospitals and 4.8 days across Maryland. The increases since 2009 were 10.6% in Prince George's County hospital and 11.4% statewide.

- This reversal of a long term decline in MSGA ALOS began slowly in 2006 and accelerated in 2011.

- Total acute care ALOS increased 10.4% in Prince George's County hospitals and 11.1% statewide.

Taking a longer view, I note that demand for acute care hospital beds in Maryland has resumed a downward trend that had been interrupted by growth between 1998 and 2008, following approximately 20 years of decline.[5]

Outpatient Care

Outpatient activity at the hospitals in Prince George's County – and statewide – declined over the four year period of CY 2011 to CY 2015. A look at specific service lines shows:

- Emergency Department visit volume dropped by 3% at PGHC. All Prince George's County hospitals combined saw a 7% drop and, statewide, ED visits were down 2%.

- Same day surgery visits to hospitals declined by 25% in Prince George's County and 2% statewide. However, PGHC reports an increase of 37% in same day surgeries over the period.

- Total outpatient visits[6] declined only one percent statewide. Prince Georges County hospitals saw a much larger drop (9%) over the four-year period and PGHC reported an 8% decline in total outpatient visits.

Table III-11 at the end of this section shows outpatient visit volumes over time.

[5] Note that Tables III-8 through III-10 at the end of this section summarize use of general acute care hospital beds in Prince George's County from 2009-2015. Appendix 3 provides similar detail for the four acute care service lines: MSGA; obstetric; pediatric; and psychiatric.

[6] Defined as the aggregate of ED visits, same day surgery visits, outpatient psychiatric visits, and clinic visits.

Table III-8: Total Acute Care Discharges Prince George's County Hospitals, CY 2009 – 2015

ACUTE CARE DISCHARGES							
Hospital	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Doctors Community	12,137	13,060	12,574	11,149	10,618	8,851	9,118
Fort Washington	3,037	3,008	2,284	2,059	2,293	2,169	2,255
Laurel Regional	5,943	5,592	5,179	5,206	5,456	4,345	4,422
Prince George's	13,709	13,345	11,965	10,970	10,570	11,648	12,158
MedStar Southern Maryland	16,929	16,816	16,505	15,524	13,478	12,867	11,938
Total	51,755	51,921	48,507	44,908	42,415	39,880	39,891
All Maryland Hospitals	689,986	665,491	639,947	614,073	588,621	564,615	547,469

Source: HSCRC Discharge Database.

Table III-9: Total Acute Care Discharge Days, Prince George's County Hospitals, CY 2009 – 2015

ACUTE CARE DISCHARGE DAYS							
Hospital	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Doctors Community	48,875	55,503	54,354	51,791	49,302	42,438	47,014
Fort Washington	10,981	10,888	8,824	7,785	8,569	8,257	8,605
Laurel Regional	23,331	21,655	20,349	20,247	19,682	16,354	16,619
Prince George's	62,351	64,036	58,238	56,283	54,201	61,276	61,377
MedStar Southern Maryland	61,571	60,654	63,626	61,229	55,139	54,001	51,996
Total	207,109	212,736	205,391	197,335	186,893	182,326	185,611
All Maryland Hospitals	2,801,793	2,719,637	2,711,421	2,634,736	2,558,532	2,526,305	2,490,067

Source: HSCRC Discharge Database.

Table III-10: Total Acute Care Average Length of Stay
Prince George's County General Hospitals, CY 2009 – 2015

ACUTE CARE AVERAGE LENGTH OF STAY							
Hospital	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Doctors Community	4.03	4.22	4.32	4.65	4.64	4.79	5.16
Fort Washington	3.62	3.62	3.86	3.78	3.74	3.81	3.82
Laurel Regional	3.93	3.87	3.93	3.89	3.61	3.76	3.76
Prince George's	4.55	4.80	4.87	5.13	5.13	5.26	5.05
MedStar Southern Maryland	3.64	3.61	3.85	3.94	4.09	4.20	4.36
Total	4.00	4.10	4.23	4.39	4.41	4.57	4.65
All Maryland Hospitals	4.06	4.09	4.24	4.29	4.35	4.47	4.55

Source: HSCRC Discharge Database

Table III-11: Outpatient Visits: Prince George's County General Hospitals, Calendar Year 2011 – 2015

Hospital	Visit Type	2011	2012	2013	2014	2015	% Change 2011-2015
Prince George's Hospital Center	Total ED Visits	51,312	53,126	50,993	49,857	49,691	-3%
	Same Day Surgery	1,548	1,710	2,000	2,412	2,128	+37%
	Psych. Day & Night	5,147	4,432	2,786	2,317	1,791	-65%
	Clinic Visits	739	1,297	1,307	185	226	-69%
	Total OP visits	58,746	60,565	57,086	54,771	53,836	-8%
Doctors Community Hospital	Total ED Visits	57,116	52,398	50,616	53,698	57,753	+1%
	Same Day Surgery	7,679	6,687	5,593	5,546	4,959	-35%
	Psych. Day & Night	--	--	--	--	--	--
	Clinic Visits	10,428	11,496	12,772	12,766	11,638	+12%
	Total OP visits	75,223	70,581	68,981	72,010	74,350	-1%
Laurel Regional Hospital	Total ED Visits	35,268	36,041	35,133	33,053	31,181	-12%
	Same Day Surgery	3,632	3,255	3,066	3,260	2,417	-33%
	Psych. Day & Night	10,334	13,256	12,135	7,542	5,745	-44%
	Clinic Visits	3,280	2,798	2,945	2,667	2,161	-34%
	Total OP visits	52,514	55,350	53,279	46,522	41,504	-21%
Ft. Washington Medical Center	Total ED Visits	44,749	46,366	43,826	43,974	42,712	-5%
	Same Day Surgery	915	844	814	579	787	-14%
	Psych. Day & Night	--	--	--	--	--	--
	Clinic Visits	--	--	--	--	--	--
	Total OP visits	45,664	47,210	44,640	44,553	43,499	-5%
MedStar Southern Maryland	Total ED Visits	64,813	70,660	63,625	58,046	54,664	-16%
	Same Day Surgery	5,547	5,763	5,134	4,882	4,144	-25%
	Psych. Day & Night	1,578	1,220	1,015	1,565	1,638	+4%
	Clinic Visits	8,300	5,692	8,653	11,151	9,699	+17%
	Total OP visits	80,238	83,335	78,427	75,644	70,145	-13%
	Totals						
All Prince George's County Hospitals	Total ED Visits	253,258	258,591	244,193	238,628	236,001	-7%
	Same Day Surgery	19,321	18,259	16,607	16,679	14,435	-25%
	Psych. Day & Night	17,059	18,908	15,936	11,424	9,174	-46%
	Clinic Visits	22,747	21,283	25,677	26,769	23,724	+4%
	Total OP visits	312,385	317,041	302,413	293,500	283,334	-9%
All MD Hospitals	Total ED Visits	2,558,667	2,724,944	2,579,444	2,513,731	2,499,709	-2%
	Same Day Surgery	329,332	327,856	315,621	311,122	322,008	-2%
	Psych. Day & Night	120,618	128,110	121,559	111,585	115,173	-5%
	Clinic Visits	2,215,973	2,244,442	2,218,292	2,235,083	2,210,418	0%
	Total OP visits	5,224,590	5,425,352	5,234,916	5,171,521	5,147,308	-1%

Source: HSCRC Financial Data Base

IV. REVIEW AND ANALYSIS

A. The State Health Plan

COMAR 10.24.01.08G(3)(a) State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan chapters that need to be considered in the review of this project are: COMAR 10.24.10, Acute Care Hospital Services; COMAR 10.24.11, General Surgical Services; COMAR 10.24.12, Acute Hospital Inpatient Obstetric Services; COMAR 10.24.17, Specialized Health Care Services - Cardiac Surgery and Percutaneous Coronary Intervention Services; and COMAR 10.24.07, Psychiatric Services.

COMAR 10.24.10 - State Health Plan for Facilities and Services: Acute Care Hospital Services

COMAR 10.24.10.04A — General Standards.

(1) <u>Information Regarding Charges.</u> ***Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:***

- ***(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;***
- ***(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and***
- ***(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.***

<u>Applicants' Response</u>

The applicants responded that Prince George's Hospital Center makes information regarding charges readily available to the public via its website. They provided a web link to the current charge information,[7] as well as a copy of the most recent estimated averages charges for common procedures in FY16. The applicants provided a copy of Policy No. 210-03: Public Information Regarding Charges, which outlines how PGHC complies with individual requests, maintains the public information regarding charges website, and describes staff training regarding these charge-related inquiries. (DI #30, Exh. 17; DI #92, Exh. 70)

[7]http://www.dimensionshealth.org/wp-content/uploads/2016/07/New-PGHC-Est-Avg-Chrgs-Common-Procedures-FY16.pdf

Reviewer's Analysis and Findings

This standard is intended to ensure that information regarding the average cost for common inpatient and outpatient procedures is readily available to the public and that policies are in place and employees are trained to address charge-related inquiries. The policy must include requirements to post a current list of charges for common inpatient and outpatient services, procedures for responding to requests and inquiries, and requirements for staff training.

I find that the applicant is in compliance with this standard.

(2) Charity Care Policy ***Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.***

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicants' Response

The applicant stated that PGHC provides care to all patients, regardless of their ability to pay. As a member of Dimensions Healthcare System, PGHC adheres to DHS Policy No. 210-01: Financial Assistance Program, which outlines charity care provisions for patients whose financial situation may be a barrier to receiving healthcare treatment/services. Per Part D. Notification of Eligibility Determination, Probable Eligibility Determination: "Dimensions will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both". (DI#30, Exh. #19) In compliance with the required Notice of Charity Care Policy, the applicant also provided copies of the Charity Care notices displayed in PGHC's Emergency Department, admissions area, and hallways near the cashier, as well as a copy of the annual notice printed in local periodicals. (DI# 30, Ex. 20-21)

PGHC reported that in the Health Services Cost Review Commission's Community Benefit Report, it was ranked third among 46 Maryland hospitals on its level of charity care

provision with charity care amounting to 10.39% of total operating expenses in FY 2013, compared to the statewide average of 6.3%.[8]

Reviewer's Analysis and Findings

I find that the applicant meets this standard.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicants' Response

Prince George's Hospital Center is in good standing with the Maryland Department of Health and Mental Hygiene's Office of Health Care Quality, which licenses hospitals, and with the Joint Commission for Hospital Accreditation.

In accordance with subsection (b) of this standard, the applicants provided a summary of Prince George's Hospital Center's quality measures that, between October 2012 and September 2013, fell within the bottom quartile on MHCC's Quality Data Website. At that time, PGHC scored below average on 21 of the 23 applicable measures in the Maryland Hospital Performance Evaluation Guide (June 28, 2013 posting).[9] The applicants noted that although the Hospital Performance Evaluation Guide has been revised to emphasize a different approach,[10] PGHC has

[8] I note that a review of the latest data shows that, in FY 2014, PGHC ranked sixth of 52 Maryland hospitals, with charity care at 7.3% of total operating expenses, while the statewide average was 3.4%. http://www.hscrc.maryland.gov/documents/HSCRC_Initiatives/CommunityBenefits/cbr-fy14/FY14-MD-Hospital-Community-Benefits-Report.pdf.

[9] This posting was the last set of performance metrics that MHCC posted in its Hospital Performance Evaluation Guide before transitioning to a new format for reporting hospital quality.

[10] MHCC recently expanded its reporting of performance measures on an updated Maryland Health Care Quality Reports website, where hospital performance is reported by each measure. In its quality reports, MHCC now focuses on two priority areas: (1) patient experience, as reported by the Centers for Medicare and Medicaid Services ("CMS") in its Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") survey; and (2) healthcare associated infections, as tracked by CDC's National Healthcare Safety Network ("NHSN").

taken steps to improve the quality of care at the hospital, including hiring the Senior Director of Clinical Quality & Patient Safety from UMMS and implementing performance improvement action plans for all of the deficient metrics. As of the end of 2014, PGHC had met or surpassed the Maryland and national goals for 10 of the 21 quality measures on which it had previously scored below average. PGHC noted that seven of the 11 remaining quality measures were no longer measurable due to a lack of data and two measures still ranked above 90% (about 4% below the goal). The applicants also noted that ongoing improvements are anticipated with the interventions and investments made by Dimensions to improve the quality and safety of patient care. (DI #30, pp.47-48 and Exh. 23)

Reviewer's Analysis and Findings

The applicants addressed PGHC's ranking in the MHCC's most recent Hospital Performance Evaluation Guide, and also provided PGHC's Performance Improvement Action Plan that has quarterly actions towards improving the hospital's metrics that fell in the lower performance percentile. I note that subsection (b) of this standards is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals reported performance on that measure as reported in the most recent Maryland guide, which has been reengineered with a different focus, and no longer compiles percentile standings. I understand that Commission staff will recommend needed changes to the Acute Care Hospital Services Chapter when that chapter is updated.

I find that the applicant has met this standard.

COMAR 10.24.10.04B-Project Review Standards

(1) Geographic Accessibility

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

Applicants' Response

The applicants stated that the proposed Largo site for PGRMC will be marginally more accessible, in terms of travel time, for its projected service area population than PGHC's Cheverly location for its current service area population. The proposed site would feature an average drive time for its service area population of 18.3 minutes, compared to an average drive time of 19.2 minutes for the current Cheverly site.[11] (DI #30, pp.49, 51) This calculation was replicated for the projected respective service area populations in the year 2022 (developed from population data provided by Claritas[12]). These projections showed that, under normal driving conditions, 86.9% of

[11] The applicants state that these averages were calculated using drive times from each zip code to each hospital at moderate driving conditions that were provided by Spatial Insights.

[12] The 2022 population projections were developed by the applicant using a compound average growth rate from 2013 and 2018 population provided by Claritas (now owned by Nielsen).

the population in the current hospital service area would live within 30 minutes of the Cheverly facility. Projections for the new site in Largo show that 87.7% of the service area population would live within 30 minutes.

In addition, the applicant analyzed the aggregate drive times for the respective service area populations of both of these locations. That analysis shows that the Largo site reduces the aggregate drive time for the service area population considerably by18.2%. See table below.

Table IV-1: Applicants: Service Area Travel Time Analysis Comparing Prince George's Hospital Center at Cheverly and PGRMC at Largo

	Cheverly	Largo
% of population > 30 minutes travel time	13.1%	12.3
% of population < 30 minutes travel time	86.9%	87.7%
Service area population's aggregate drive time (minutes)	21,830,016	17,852,781

Source: DI #10, p.49.

The applicants' analysis noted that the population of six zip code areas in the defined service area for the new hospital will be more than 30 minutes from the proposed site. Three of those zip code areas are located on the southern border of Prince George's County, two are in Charles County, and one is in St. Mary's County. All of these zip code areas are within 30 minutes of other hospitals that have both MSGA and pediatric inpatient services, as shown in the table below.

Table IV-2: Applicants: Drive Times from Select Zip Codes to Proposed PGRMC in Largo and Closest Hospital with MSGA and Pediatric Inpatient Beds

Zip Code Area	County	Drive Time to PGRMC (minutes)	Drive Time to Closest Maryland Hospital with MSGA & Pediatric Beds	Closest Hospital
20602	Charles	34	13	UM Charles Regional
20603	Charles	38	24	UM Charles Regional
20607	Prince George's	35	21	MedStar Southern Maryland
20608	Prince George's	44	18	Calvert Memorial
20613	Prince George's	31	13	MedStar Southern Maryland
20653	St. Mary's	89	26	MedStar St. Mary's

Source: January 2015 Replacement Application (DI #30, CON Application, p.52).

The applicants concluded that, with the exception of these six zip code areas, the service area population of the proposed Largo site has optimal driving access as defined by this standard. ((DI # 30, p. 51)

Interested Party Comments

No interested party comments were submitted regarding the applicants' response to this standard.

Reviewer's Analysis and Findings

This standard requires my evaluation of whether the proposed replacement hospital is

located to optimize accessibility to pediatric and general medical/surgical and critical care for its likely service area population. An optimally accessible location is defined as one in which 90 percent of the likely service area population is within 30 minutes' drive time, under normal conditions.

In my analysis of the applicants' compliance with this standard, I started with the premise that, because this relocation project is aimed at improving the health care delivery system for all of Prince George's County, I would consider all zip code areas in the County to define the service area, rather than identify a set of zip code areas that are likely to be in the 85% service area. My analysis revealed that all Prince George's County zip code areas are within a 30 minute drive time of at least one hospital that has both licensed MSGA beds and licensed pediatric beds.[13] The relocation to the Largo site will not change this. Further, I found that the relocation will improve accessibility for the County's residents, as detailed below.

- 27 of the 35 zip codes totally or primarily within Prince George's County and accounting for 78% of the County's population are within a 30-minute drive time of PGHC at its current location. This proximity will be enhanced by relocation to Largo because 29 zip code areas projected to account for 84% of the County's population in 2024 are within 30 minutes' drive time of the Largo site.

- Of the zip code areas that are currently more than 30 minutes from PGHC in Cheverly, three are within 30 minutes of the proposed new location.

- Three of the five zip code areas that have a drive time greater than 30 minutes to both the Cheverly location and the Largo location, all are closer to the Largo location.

- There is one zip code area, 20707, Laurel, that is under 30 minutes' travel time from Cheverly but over 30 minutes' travel time to Largo, but the difference is only three minutes (29 minutes vs. 32 minutes).

I also wanted to understand the impact of the relocation on accessibility for the residents of the zip code areas in PGHC's current primary service area.[14] (See Table IV-3 below). For this reason, I analyzed the nine zip code areas that make up PGHC's primary service area for MSGA patients during 2014.[15] That analysis also took into account the proximity rank, i.e., a ranking of hospitals in terms of travel time.

The data for this analysis appears in Table IV-3. Of the nine zip code areas in PGHC's primary MSGA service area, five would be closer to the proposed location, and two would be fewer than five minutes further from that location. The two other zip code areas would be more

[13] Drive time analysis is based on drive times run by Spatial Insights using Freeway 2013 software at travel speeds in heavy traffic for each of the six road categories

[14] Those zip codes that contributed the first 60% of the hospital's 2014 MSGA discharges.

[15] The latest year for which MHCC had complete discharge data for both Maryland and District of Columbia hospitals.

than 10 minutes further from the new location than they are from the current location: one (20019) is a D.C. zip code area for which PGHC is not currently the closest hospital; and the other, 20710, is within 10 to 12 minutes of four other hospitals, one in Maryland and three in the District of Columbia.

Table IV-3: Travel Time from PGHC's 2014 Primary Service Area Zip Code Areas to Its Existing Cheverly Location and to the Proposed Location in Largo

Zip Code	County/DC	Travel Time to the Current Location (minutes)	Proximity Rank including DC Hospitals	Travel Time to the Proposed Largo Location (minutes)	Proximity Rank including DC Hospitals	Change Differential in Travel Time (minutes)
20785	Prince George's	5.7	1	6.5	1	0.8
20743	Prince George's	10.1	1	8.0	1	-2.1
20019	District of Columbia	14.6	2	26.6	4	12
20774	Prince George's	19.0	2	6.9	1	-12.1
20784	Prince George's	4.6	1	9.0	1	4.4
20747	Prince George's	17.4	2	10.1	1	-7.3
20706	Prince George's	12.2	2	9.7	2	-2.5
20710	Prince George's	2.1	1	12.8	5	10.7
20721	Prince George's	18.1	2	8.1	1	-10.0

In summary, all Prince George' County zip code areas are currently within 30 minutes of a hospital that offers MSGA and pediatric services. The proposed relocation would not change that. Moreover, the proposed relocation would increase the percentage of the County's population that would be within 30 minutes of Dimensions' primary Prince George's hospital. I note also that the proposed location is very accessible to Metro.

For these reasons, I find that the proposed relocation site has been selected to optimize travel time for the residents of Prince George's County and that the proposed project meets this standard.

(2) <u>Identification of Bed Need and Addition of Beds</u>

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.

Applicants' Response

In its 2015 replacement application, the applicants submitted detailed bed need projections to support the need for its original proposal for 165 MSGA beds and one pediatric bed. They also submitted detailed projections to justify the need for the proposed 22 obstetric beds and the 28 psychiatric beds using similar methodologies to the methodology used for the MSGA beds. In their August 31, 2016 modification, the applicants reduced the proposed MSGA bed complement to 154 beds, but left unchanged the proposed obstetric, pediatric, and psychiatric beds complements.

Interested Party Comments

Anne Arundel Medical Center

Anne Arundel Medical Center did not submit comments under this standard.

Doctors Community Hospital

Doctors Community Hospital commented on the application based on PGHC's licensed beds for FY 2015, stating that the applicants had not justified what, at the time, was a complement of MSGA beds that exceeded its licensed capacity.[16]

Reviewer's Analysis and Findings

This standard provides that only additional MSGA and pediatric beds identified as needed and/or currently licensed shall be developed at an acute care general hospital and contains tests that apply to proposed additional beds.

At the time the 2015 replacement application was submitted, Prince George's Hospital Center was licensed for 215 beds, including 141 MSGA beds and eight pediatric beds. Licensure

[16] As I note in the analysis below, PGHC's allotment of licensed beds has increased, and the applicants' recent modifications have lowered the number of MSGA beds proposed. A summary of DCH's comments is not useful here, as the updated licensed bed capacity and reduced project proposal combine to make the comments moot.

increased to 237 beds as of July 1, 2015, and then decreased slightly to 233 beds effective July 1, 2016.[17] It is left up to PGHC to allocate total licensed beds among its approved inpatient services, and PGHC allocated its FY 2017 license for 233 beds as follows: 169 MSGA, 34 OB, 28 psychiatric, and two pediatric beds.

I have also considered the need for the number of beds proposed in the context of the Need criterion which requires consideration of the bed need analysis in the State Health Plan. As shown below, the latest Acute Care Hospital Services Chapter's bed need analysis for MSGA and pediatric beds resulted in a projected MSGA bed need for 2022 ranging from 82 fewer to 94 additional beds for Prince George's County.

Table IV-4: Projected MSGA and Pediatric Bed Need -- 2022

	2022 Gross Bed Need		FY 2017 Licensed & Approved Beds	2022 Ned Bed Need	
	Minimum	Maximum		Minimum	Maximum
MSGA	487	663	569	-82	+94
Pediatric	2	2	6	-4	-4

Source: Maryland Register, Volume 41, Issue 5, March 7, 2014; MHCC, Annual Report on Selected General and Special Hospital Services, Fiscal Year 2017

I will address the need for the proposed MSGA, obstetric, and psychiatric bed capacity, later in this Recommended Decision, under the Need criterion.[18] That is also where I will address the comments on the need for the proposed beds made by Doctors Community Hospital.

On August 31, 2016, the applicants submitted modifications to the application, which now contains a total of 205 beds including 154 MSGA beds and one pediatric bed. The proposal to construct a replacement hospital with 154 MSGA beds and one pediatric bed does not represent an increase in beds within this standard.

I find that the applicants have satisfied this standard.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

[17] Maryland's dynamic licensing law that calculates future licensed acute care beds effective July 1 of each year based on each hospital's average daily census for the 12 month period ending March 31st multiplied by 140% (an occupancy rate of 71.4%).

[18] See discussion regarding COMAR 10.24.01.08G(3)(b) at Section IV-B of this Recommended Decision, *infra*, p. 86.

Applicants' Response

The applicants responded that this standard does not apply because the application does not propose the establishment of a pediatric unit.

In response to MHCC staff's completeness question that characterized the proposed one bed pediatric unit as "inconsistent with the intent of this standard," the applicants maintained that part of Dimensions' mission is to provide basic pediatric services to families within PGHC's service area, stating that, "[d]espite the declining pediatric census, families expect to have basic pediatric services at their community hospitals, with specialized services being offered at larger hospital centers." The applicants also stated that 11 of the 33 hospitals in Maryland that have licensed pediatric beds are licensed for four or fewer beds, including five that have allocated only one or two licensed beds to pediatric services, as PGHC does.

The applicants' plan for the project places the licensed pediatric bed within a "hybrid ED and inpatient/clinical decision unit" (i.e., an observation unit) that "includes four treatment/ observation/short-stay rooms and one inpatient bed." The applicants stated in its January 2015 replacement application that such a hybrid approach is efficient, allowing for pediatric emergency room staff to also cover the pediatric bed. It notes that a discrete, separate inpatient unit of one bed would be costlier to staff. (DI #30, pp.86-88)

In response to my request, made at the May 17, 2016 project status conference, that the applicants justify the continuing need to retain a single licensed pediatric bed for the admission of pediatric patients "rather than simply operating the proposed pediatric space as an observation unit without a licensed bed," the applicants reiterated much of what was said in the January 2015 modified application. They also provided data estimating that there were approximately 3,198 pediatric inpatient discharges, resulting in approximately 15,267 patient days for the projected PGRMC pediatric service area during FY 2015, and that, at an 85% target occupancy rate, this would equate to a need for 49.2 pediatric beds for the service area. The applicants state that the only licensed pediatric beds within its primary service area are at PGHC, with two, and MedStar Southern Maryland Hospital Center, with four beds. The applicants state that "these pediatric patients are predominantly being served by out-of-service area hospitals."[19]

Reviewer's Analysis and Findings

The applicants are correct that this standard is not applicable. In completeness review, however, staff asked the applicant to explain more fully Dimensions' view of the continuing need for a licensed pediatric bed despite an extremely low census. The response reiterated much of what was said in the January 2015 modified application and cited data (both summarized above) showing that most pediatric admissions from Prince George's County are handled by a D.C. hospital specializing in pediatric care. This pattern of concentration of pediatric inpatient care at a small number of hospitals has occurred throughout Maryland and will not be affected by this project. The replacement hospital will have no measurable impact on any existing providers of

[19]Children's National Medical Center, a pediatric hospital in Washington, D.C., has the highest market share of pediatric patients in the region. It is located 13 miles from the replacement hospital site in Largo. (DI #92, p.9)

pediatric hospital services, because of the very small number of hospitalizations forecast in the application. PGHC did not hospitalize any patients under the age of 15 in FY 2015 and is projecting that only five patients, one admission per year, will be admitted at PGHC over the next five years.

The application eliminates a conventional inpatient unit for pediatric services at the replacement hospital, which is a logical response that has been implemented by other hospitals in Maryland (although none had the extraordinarily low level of inpatient activity exhibited by PGHC). The applicants project that, in PGRMC's third year of operation, about two pediatric patients will be admitted per month. In their modified application, however, the applicants have satisfactorily addressed PGRMC's desire to maintain a single-bed pediatric service.[20]

I find that this standard is not applicable in this review.

(4) Adverse Impact

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

Applicants' Response

In response to this standard, the applicants provided a statement of assumptions regarding its financial projections that stated that Dimensions had removed any capital-related rate increase. (DI#92, p.56) In the August 2016 modifications to the application, Dimensions states that it has been working with the HSCRC to "develop a funding option" to help support the construction of PGRMC, noting that it is seeking to design its Global Bucket Revenue ("GBR") agreement with HSCRC to allow for the redistribution of revenues within its system Dimensions estimates that $30 million of its GBR will be available for reallocation to PGRMC's GBR from other Dimensions' facilities to help fund the PGRMC project when it is completed. (DI #92, p. 56; DI #96)

[20] The Commission's policy on how hospitals should manage further contraction of inpatient pediatric service should be addressed in updates the Acute Care Hospital Services Chapter of the SHP.

Reviewer's Analysis and Findings

Technically, this standard would be inapplicable because the applicant is not seeking the addition of new systems revenue as a source of project funds. Discussion of this and other related aspects of the proposal will be addressed under the financial feasibility standard later in this section of the Recommended Decision.

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Applicants' Response

The applicants stated that the project does not propose to eliminate any services, noting that none of the proposed changes in this project will have an impact on access to care for indigent and/or uninsured patients as the hospital will continue to care for patients regardless of their ability to pay. (DI #30, p.86)

Reviewer's Analysis and Findings

As I discussed at length in the Geographic Accessibility section, I believe that the relocation of the facility will not hinder – and may improve – access to the hospital's services.

I find that this standard is met.

(5) Cost-Effectiveness

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

- ***(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;***
- ***(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and***
- ***(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.***

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without

undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

Applicants' Response

The applicants stated that paragraph (b) of the standard does not apply and responded to paragraph (c) by noting that the location is in a Priority Funding Area. In addressing paragraph (a), the applicants stated that Dimensions and the Prince George's County government identified six objectives for the proposed regional medical center and for selecting its optimal location, and that these objectives were informed by the MOU and a study by the University of Maryland School of Public Health. They also developed six options that were measured against the objectives. The objectives and options are listed below. (DI#30, p.90)

Applicants Project Objectives

1. Maintain PGHC's role as a regional medical center;
2. Address public perceptions of PGHC;
3. Improve the hospital's ability to recruit physicians to serve its service area population;
4. Maintain or improve access for its service area population on a site with: centralized location within Prince George's County with access to I-495; walkable Metro access; proximity to bus routes; pedestrian access;
5. Enable collaboration with the University of Maryland School of Medicine and UMMS; and
6. Site and cost considerations including: adequate size; site acquisition and development costs, engineering and traffic considerations; timing of site availability; and future expansion and development potential.

Applicants' Project Options

1. Replace the entire facility on its current campus;
2. Make major additions/renovations on the existing site;
3. Relocate the hospital to the Woodmore Town Center site;
4. Relocate the hospital to the Landover Mall site;
5. Relocate the hospital to the Boulevard at the Capital Centre (Powell Property); and
6. Relocate the hospital to the Boulevard at the Capital Centre (Schwartz Property).

The applicants dismissed use of the present site (options 1 and 2), due "to the significant disruption, estimated higher cost, poor access, extended time frame, and inability to address all of the program and adjacency requirements properly…." HOK, an engineering firm that was a consultant for the project, recommended the replacement and relocation of the hospital to a new site. (DI #30, p. 102) The following excerpt from HOK's Summary of Site and Architecture Key Findings explained this decision:

> The age and configuration of the existing facility are below current standards, and the quality of the patient experience in the current facility is compromised by these factors …. The engineering systems are in need of significant upgrades or replacement, which render continued use or expansion of the existing facility questionable relative to the benefits of providing new engineering systems in a new facility, where both could concurrently offer the latest in medical space planning, patient care, and patient/visitor/staff amenities… [C]onversion of some existing space to outpatient care … may be appropriate on a case-by-case basis, but the age and condition of the facility suggest that for outpatient care, a new appropriately sized and planned facility on the site would be more appropriate….
> The benefits of new idealized planning of acute care space would be compromised by the quality and organization of the existing building spaces.
>
> The existing site is currently constrained to the point that new construction for acute care services would be functionally and physically compromised by the existing building shape and organization, and by the shape of the available open space on the existing site.[21]

Information about the remaining site options[22] is summarized in the following Table IV-5.

.

[21] HOK, *Prince George's Hospital Facility Assessment Report* (DI #32, Exh. 31).
[22] The applicants' assessment of the on-site and relocation alternatives is found in Appendix 4.

Table IV-5: Applicants Overview of Possible Relocation Sites Considered

Site	Description
Option 3: Woodmore Town Center site	This site is a grouping of proximate properties located on the east side of the Capital Beltway. A variety of owners control the property including Petrie-Ross, the Roman Catholic Archdiocese of Washington DC, and Prince George's County. During the review process, different property configurations were reviewed to identify the most likely combination for a successful hospital campus. Road access to the site is primarily located at the Route 202 and McCormick/St. Joseph's Drive intersection. Campus Way could be used as secondary ingress/egress. The final configuration of the site is surrounded by a new retail center… An existing Roman Catholic Church is located at the intersection of St Joseph's and Route 202. The proposal would include relocating the church in order to better consolidate the land bay for the hospital campus. Finally, existing and proposed (under construction) residential subdivisions complete the property adjacency descriptions. **Site Improvement Costs: $75,495,000**
Option 4: Landover Mall site	Home to the Landover Mall before its demolition in 2006…Located at the southwest side of the intersection of the Capital Beltway (I-95/495) and MD Route 202… Road access to the site is primarily from the Route 202 exit of I-95/495. The original offer was for 16 acres, but the review process determined that a larger site was required. The owner has suggested that additional acreage is available. **Site Improvement Costs: $31,425,000**
Option 5: Boulevard at the Capital Centre (Powell Property	A 16-17 acre portion of a 70 acre parcel, which is currently occupied by a significant amount of retail square footage referred to as the Boulevard at the Capital Centre, and an adjacent undeveloped property of 8.5 acres located on the east side of the Capital Beltway between the Arena Drive and Central Avenue Exits. In order to develop the property as a hospital campus, the existing buildings would need to be demolished. Road access to the site is located along Arena Drive and a combination of Lottsford Road/Harry S Truman Drive, and the site is adjacent to an existing Metrorail Station facility. **Site Improvement Costs: $24,500,000**
Option 6: Boulevard at the Capital Centre (Schwartz Property)	This 16 acre site is adjacent to the Capital Centre on the west side of the Capital Beltway (I-95/495) zoned M-A-C (Major Activity Center). It is comprised of two land bays separated by a public road that leads to the Largo Metrorail Station (Blue Line). Road access to the site is located along Lottsford Road via either Arena Drive or Harry S. Truman Drive. Currently the site is undeveloped. The owner demonstrated a significant amount of entitlement approvals had already been obtained for the site. These approvals would require revisions to accommodate the regional medical center. The site also provides a significant amount of road frontage along a public right-of-way. Pedestrian access from the surrounding area is well developed and includes a pedestrian bridge from the Largo Metro site to the Capital Centre site. **Site Improvement Costs: $24,275,000**

The site chosen (option 5) was one of the Capital Centre sites ("the Powell Property Parcel"). The site is a 16-17 acre portion of a 70-acre parcel, which is currently occupied by a significant amount of retail square footage at the Capital Centre, and an adjacent undeveloped 8.5 acre parcel located on the east side of the Capital Beltway between the Arena Drive and Central

Avenue exits. In order to develop the property as a hospital campus, the existing buildings would need to be demolished. The site is adjacent to an existing Metrorail Station.

Because of the size and cost of the proposed project, staff asked the applicant a completeness question querying why the relocated hospital needs to be an "academically-affiliated tertiary care center" with such a specialized scope of services instead of a modern, full-service and academically-affiliated community hospital. The applicants' response was that, based on "feedback from medical professionals and other stakeholders within Prince George's County, there is significant value in building a strong academic-affiliated specialty services medical center rather than a smaller community hospital…." The applicants spoke to the importance of local access to services, stating:

1. Most residents prefer to receive health care services from physicians and hospital facilities near their homes. Lack of transportation to specialty care services outside of Prince George's County is a barrier for underserved residents in receiving timely care, which ultimately leads to increased hospital readmissions and excessive ER utilization.

2. Local access to specialized services improves access for populations with limited means or those who do not wish to travel to the District of Columbia.

3. Local access to specialty services means local access to specialty physicians, improving chances of patients participating in follow-up care.

4. Local access for certain specialized services allows for participation in the care delivery process by patients' local primary care physicians.

5. Referring physicians continue to be part of care delivery for their patients if patients are treated locally. Local physicians and their patients have access to the latest therapies via an academically affiliated hospital.

6. Patients with limited resources may not seek initial care or follow-up care if they have to travel to D.C. or Baltimore. Transition and coordination of care is hindered, delayed, or may not occur when patients have to travel to D.C. or Baltimore for care.

7. Local access to specialty services allows patients to be closer to support mechanisms, such as families and social services entities.

8. In-County central location of specialty services creates a local practice home for specialists/sub-specialists who are in demand by County residents. This advances the goals of Patient Centered Medical Homes by creating care teams that include local academically affiliated specialty services. This can also enhance trust between the community and academia when an academic hospital is located within the community, which in turn allows for increased community-based participatory research, helping to address local health care and disparities issues.

In addition, the applicants stated that an academically-affiliated specialty care medical center would: enhance the ability to attract and retain physicians; promote a learning culture and best practice adoption; and promote research and access to clinical trials. In response to the project status conference, the applicants made changes to the project, reducing building space and some service capacities. An "Ambulatory Care Center" component was eliminated.[23]

Interested Party Comments

Anne Arundel Medical Center

AAMC did not comment on this standard.

Doctors Community Hospital

Doctors Community Hospital commented that PGHC is a high-cost hospital, stating that, among Maryland general hospitals with global budgets, in FY-2014, PGHC had the sixth highest case mix-adjusted charge per case. DCH noted that the application proposed a 7% charge increase upon implementation of the CON, which would exacerbate the cost issue.

DCH submitted comments under COMAR 10.24.01.08G(3)(c), the Availability of More Cost-Effective Alternatives criterion, which is closely related to this standard, claiming that the applicant did not "address common sense cost saving alternatives," such as re-use of some portion of the existing PGHC campus; shifting some services to Laurel; use of some of the excess capacity of MSGA beds at other Prince George's County Hospitals, including DCH; or development of a non-rate regulated ambulatory care center. DCH cited the Kaiser-Permanente outpatient facility in Largo as an example, and wrote that "[a] large, non-hospital, community based center modeled after the Kaiser Permanente facility – combining urgent cases, 24/7 radiology, pharmacy and lab services – is the future. This project is based on the past." (DI #46, pp.21-22)

DCH did not comment on the August 2016 redesign of the project.

Applicants' Response to Comments

The applicants responded to DCH's comments regarding price competitiveness, stating that "nothing in Standard .05B(5) requires Dimensions to demonstrate its price competitiveness relative to other hospitals," but also noted that its cost competitiveness had improved due to volume shifts, stating:

[23]In their modifications to the application, the applicants stated that "Dimensions is reassessing its ambulatory care plan in light of these changes and will develop a plan that will consider and address what type of ambulatory care services Dimensions may offer on its PGRMC campus in the future.… Dimensions may construct a medical office building that could house non-rate regulated ambulatory services. If Dimensions proceeds with such a project, it would likely seek a determination of non-coverage of CON review."

> An analysis of PGHC's price competitiveness in FY 2014, based on HSCRC nonconfidential abstract data, presented a price variance of 23.2% for non-trauma cases above a peer group of local competitors that includes: Washington Adventist Hospital, Holy Cross Hospital, Doctors Community Hospital, Southern Maryland Hospital Center, and Anne Arundel Medical Center. As volumes have increased at PGHC during the first six months of FY 2015, this price variance has declined to 14.5% for non-trauma cases.
> (DI #50, p.17)

In response to DCH's claims that Dimensions had not considered "common sense alternatives," the applicants stated that several of the alternatives DCH suggested had been considered, pointing out that they had evaluated renovating the existing PGHC structure or using the site to construct a replacement hospital. It was noted that Dimensions had evaluated "enhancing efficiencies between PGHC and LRH" on an ongoing basis, citing its 2011 relocation of the inpatient chronic care unit from PGHC to LRH. The applicants also noted that, in planning the replacement hospital, Dimensions had considered (and rejected) relocating certain services, such as consolidating the behavioral health units at the two hospitals. (DI #50, p.15)

Reviewer's Analysis and Findings

I find that the applicants have identified the project's objectives and assembled and analyzed alternative approaches to meeting those objectives, in conformance with this standard. As previously noted, I found the January 2015 project plan to be too large and too costly. I am satisfied that the modifications made by the applicant have reduced the cost of this project without affecting its effectiveness in meeting the project objectives.

I find that the application complies with this standard.

(6) Burden of Proof Regarding Need

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Applicants' Response

Under this standard, the applicants referred to their response to the Need criterion, COMAR 10.24.01.08G(3)(b).[24]

[24] See discussions at Section IV-A of this Recommended Decision regarding COMAR 10.24.01.04B(2), *supra*, p. 22 and at Section IV-B of this Recommended Decision regarding COMAR 10.24.01.08G(3)(b), *infra*, p. 86.

Interested Party Comments

Anne Arundel Medical Center

Anne Arundel Medical Center did not comment on the applicants' response to this standard.

Doctors Community Hospital

Doctors Community Hospital stated that the applicants had not demonstrated the need for additional MSGA beds. DCH stated that, even with the aging of the population and overall population growth, Maryland hospitals are likely to experience a substantial decline in their inpatient case load by FY 2022 compared to 2013. DCH further expressed the opinion that Dimensions' projection of recapturing patients that are currently well served by existing facilities does not constitute need for increasing MSGA beds. (DI #46, pp. 10-11)

Applicants' Response to Comments

The applicants did not specifically respond to DCH's comments under this standard. However, the applicants did respond to these comments under the bed need standard in the Acute Care Hospital Services Chapter and under the Need criterion.[25]

Reviewer's Analysis and Findings

This standard specifically requires an applicant to demonstrate the need for a service not covered by Regulation .05 of this chapter or another chapter of the State Health Plan. I find that the applicants are not proposing any new services and that the need for the capacities for the key services are covered in one of the State Health Plan chapters and/or that I have covered them under the Need criterion.[26]

As to DCH's specific comments regarding additional MSGA beds, I found under COMAR 10.24.10.04B(2), that Dimensions is not proposing to add MSGA beds.[27] As to the issue of increased volume at PGRMC as a result of recapturing patients, I have found that it is reasonable to expect some market recapture as a result of the construction of a new facility and other changes including changes in the management of the facility as discussed under the Need criterion.[28] I find that the applicants have successfully demonstrated the need to modernize the PGHC facilities and the need for the services and capacities proposed by Dimensions and MWPH, as modified in their August 31, 2016 filing. I have concluded that this level of needed modernization is most cost-effectively achieved through relocation and replacement.

[25]See summary of the applicants' response, and my analysis and findings under COMAR 10.24.01.08G(3)(b), *infra*, p. 86.
[26] Ibid
[27] See summary of the applicants' response, and my analysis and findings under COMAR 10.24.10.04B(2), *supra*, p. 22.
[28]See my analysis and findings under COMAR 10.24.01.08G(3)(b), *supra*, p. 86.

I did, however, believe that the level of demand projected for the replacement hospital was overstated and held a project status conference on May 17, 2016 seeking a modest reduction in some of the service capacities as well as the overall size of the project. The applicants responded with a modified application that satisfactorily met those specifications.

My findings with respect to the applicants' demonstration of need for this project can be found in my review of the applicable review standards of the State Health Plan. These include: COMAR 10.24.10.04B(2),[29] Identification of Bed Need and Addition of Beds; COMAR 10.24.10.04B(5),[30] Cost-Effectiveness; COMAR 10.24.10.04B(14),[31] Emergency Department Treatment Capacity and Space; COMAR 10.24.10.04B(15),[32] Emergency Department Expansion; COMAR 10.24.11.05B(2),[33] General Surgical Services; COMAR 10.24.12.04(1),[34] Obstetric Services; and COMAR 10.24.07(AP1a),[35] Psychiatric Services. I have also addressed need issues in this project review in my evaluation of the general criteria at COMAR 10.24.01.08G(3)(b)[36] and (c).[37]

(7) Construction Cost of Hospital Space

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Introduction: the Marshall Valuation Service

This standard requires a comparison of the project's estimated construction cost with an index cost derived from the Marshall Valuation Service ("MVS"), which is based on the relevant construction characteristics of the proposed project. The standard provides that, if the projected cost per square foot exceeds the MVS benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the MVS benchmark and those portions of the contingency allowance, inflation

[29] See discussion, *supra*, at p. 22.
[30] See discussion, *supra*, at p. 27.
[31] See discussion, *infra*, at p. 54.
[32] See discussion, *infra*, at p. 59.
[33] See discussion, *infra*, at p. 59.
[34] See discussion, *infra*, at p. 63.
[35] See discussion, *infra*, at p. 64.
[36] See discussion, *infra*, at p. 86.
[37] See discussion, *infra*, at p. 102.

allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

In order to compare the cost of a proposed construction project to that of similar projects as part of a cost-effectiveness analysis, a benchmark cost is typically developed using MVS. The MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses, including hospitals. The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs do not include costs of buying or assembling land, pilling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, and general contingency set aside for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[38]

A benchmark cost is developed using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs for a particular project the base costs are adjusted for a variety of factors using MVS adjustments such as including an add-on for sprinkler systems, the presence or absence of elevators, the number of building stories, the height per story, and the shape of the building (the relationship of floor area to perimeter). The base cost is also adjusted to the latest month and the locality of the construction project.

Finally, in order to compare its costs to the MVS benchmark, an applicant needs to adjust the estimated cost of their projects to exclude costs not included in the MVS costs such as site improvement costs.

Applicants' Response

In the applicants' August 2016 modifications, the central utility plant equipment was reclassified and MVS construction cost comparison was revised based on the modified project. The applicants developed an MVS benchmark of $423.02 per square foot and adjusted the estimated project costs to exclude costs not covered by MVS such as site development costs, the cost of hillside construction, the offsite cost of connecting to utilities including connection fees, the cost of meeting LEED standards, and interest payments on debt during construction that will be used for equipment. In addition, the applicants adjusted the project costs to exclude extraordinary costs that were considered not to be comparable to the MVS standard, including the cost of canopies, the cost of redundant electric and water lines, and the cost of helipads and the premiums for paying prevailing wages and employing minority business enterprises required by

[38] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2014).

State and Prince George's County regulations. The result is a project cost estimate of $408.40 per square foot, which is below the MVS benchmark that was developed by the applicants.

Reviewer's Analysis and Findings

As previously discussed, I held a project status conference on May 17, 2016,[39] to which the applicants responded with an August 31, 2016 modified project plan that used the MVS base cost for Class A, good quality hospital construction and Class A-B good quality mechanical penthouse construction as of November 2015. The applicants' calculation of the benchmark included adjustments for the mix of departmental square feet, and for perimeter and story height for the specific characteristics of the building design. They also adjusted the cost per square foot for each story more than three floors above the ground. After these adjustments, the benchmark cost was adjusted to the current month and the location. The MVS current cost multiplier is updated monthly, with the latest available update being September 2016; the local multiplier is updated quarterly, with the most recent being July 2016.

In my analysis of the applicants' calculation of the benchmark I made a few changes, most notably to the departmental cost differential factor where the applicants' calculations omitted some departments. This results in my calculating a higher departmental cost adjustment factor, and thus a higher MVS benchmark of $435.01 per square foot compared to the applicants' $423.02 MVS benchmark.

I also reviewed the applicants' adjustments to the estimated project costs to come up with a project cost comparable to the costs included in the MVS costs. The result of my calculation is a $427.20 per square foot project cost for comparison to the benchmark. This is significantly more than the $408.40 per square foot calculated by the applicants. One major difference is that I did not accept their adjustment for a premium cost for the minority business enterprise requirement. I do not question the existence of the requirement, but I am not convinced that such a requirement should add costs to a project over and above the additional costs of paying prevailing wages, for which the applicants made an adjustment that I accept. Another difference in the comparable cost of the project between my calculation and that calculated by the applicants is the amount of architectural and engineering fees excluded from the comparison because they relate to costs not included in the MVS costs. This difference is primarily related to my treatment of the adjustment for the minority business enterprise premium.

[39] Prior to holding the project status conference, I compared the project costs of the January 2015 replacement application to a benchmark costs for good quality Class A hospital constructions given in the MVS guide and adjusted for the particulars of the proposed project as provided for in the guide. I found that the costs of the project as proposed in the replacement application exceeded this benchmark. My finding was based in part on my reclassification of approximately $32 million of moveable equipment associated with a proposed central utility plant ("CUP"), not covered by the MVS cost, to fixed equipment, which is included in the MVS costs. The reason that I reclassified these costs is that the replacement application budget included no fixed equipment costs for the CUP, a structure that was designed to contain major components of the hospital's heating, ventilation, and air conditioning system that are included in the MVS costs. I believed that most of this equipment should be classified as fixed, and at the May 17, 2016 status conference requested that the applicants revisit their classification.

The bottom line is that my calculation of the project cost ($427.20 per sq. ft.) is $7.81 per square foot (1.8%) less than the benchmark of $435.01 per square foot that I calculated from the Marshall Valuation Service for a project with similar building characteristics. Therefore, there would not be any exclusion from any rate request submitted to the HSCRC for excessive capital cost of the hospital construction portion of this project.

I find that the project complies with this standard.

(8) Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicants' Response

Dimensions stated that this standard is inapplicable.

Reviewer's Analysis and Findings

Because the proposed project does not include non-hospital space, I find that this standard does not apply.

(9) Inpatient Nursing Unit Space

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicants' Response

Using the Acute Care Chapter definition as a benchmark, the applicants state that all of the inpatient nursing unit spaces are less than 500 square feet per bed. A summary of the square feet per bed for the inpatient nursing units follows:

Table VI--6: Inpatient Nursing Unit Space per Bed Summary,

Unit/Function	Net SF	Beds	Net SF/Bed
Medical/Surgical	14,143	34	416.0
Medical/Surgical	14,129	33	428.2
Medical/Surgical	7,436	17	437.4
Intensive Care	14,577	32	455.5
Intermediate Care	14,974	33	453.8
OB/GYN	10,587	27	392.1
Behavioral Health	13,039	28	465.7
Pediatrics	400	1	400.0

Source: DI #92, p.12

Reviewer's Analysis and Findings

This standard provides that the cost for space built or renovated for inpatient nursing units that exceeds 500 square feet per bed must be excluded from any rate increase related to the capital cost of the project.

I find that the application is consistent with this standard.

(10) Rate Reduction Agreement

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicants' Response

The applicants responded that the most recent Reasonableness of Charges calculations showed PGHC had charges that were 8.76% above its peer group; however, the latest calculation done by HSCRC was in 2011, and the applicants pointed out that this standard is outdated as Maryland hospitals are now subject to the Global Budget Revenue or Total Patient Revenue methodologies.

Reviewer's Analysis and Findings

I find that this standard is inapplicable in this review because the rate reduction agreements contemplated by the standard have been replaced by automatic rate reductions.

(11) Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or
(c) Demonstrate why improvements in operational efficiency cannot be achieved.

Applicants' Response

The applicants' response to this standard in the August 31, 2016 modifications[40] described a number of what it described as "performance improvement opportunities at PGHC in the near term and at PGRMC in the long term that will enable Dimensions to improve its financial performance and ensure financial feasibility following the opening of PGRMC."(DI #92, p.17) Some of the efficiency improvements mentioned include improvements in revenue cycle management, reducing denied claims, improved bad debt collections, reducing ALOS, improvements in supply chain management and purchasing, and reducing overtime and premium pay.[41]

The applicants also gave the following examples of design features that that they state will save time/effort:

- The design of the new hospital will drive operational efficiencies …. The lean concept of "pulling" both services and staff expertise to the patients is aimed to reduce handoffs, transports, and unproductive time, while at the same time improve the quality of patient care…. Efficiency increases in the new facility will be … in patient flow and staff work-flow directly related to the architectural design and improvements in productivity due to the state-of-the-art building systems and equipment. (DI #92, p.25)

- These design efficiencies are projected to reduce the hospital's staffing ratio by 0.15 FTEs per adjusted average occupied bed (AOB) or 2.1%. (DI #92, p. 29)

- Combined with performance improvements and volume growth, the staffing ratio is projected to decline from 7.07 FTEs per adjusted AOB in 2017 to 6.45 FTEs per adjusted AOB in 2023. (DI#92, p. 29)

[40] I will focus only on the response that I received in the August 31, 2016 modified application. At the project status conference, I asked the applicants to provide a complete and detailed analysis of how this project will improve operational efficiency and reduce staffing hours and cost per unit of service, and to do so in a way that answers the fundamental question of how much efficiency gain is being obtained in the replacement hospital by comparing current FTE/patient day ratios with the ratios that could be achieved at the same volume in the new hospital. I asked for it to be presented in that manner so as to remove the effect of economy of scale gains that would normally be expected to result from higher production volumes at any facility without design changes. I will focus only on the response that I received in the August 31, 2016 modifications to the application.

[41] I note that these examples are process improvements that could/should be implemented independent of the proposed project.

Table IV-7 below, excerpted from the modified application, shows a total 8.08% reduction in FTEs per adjusted AOB at the proposed replacement hospital, and posits that 2.1% of that will be attributable to efficiencies in building design in 2023. (DI #92, p.29)

The applicants expect that the 2.1% staffing reduction attributable to building design will be distributed within the following departments: nursing; emergency services; pharmacy; laboratory; environmental services; patient transport; central sterile processing; maintenance; and food services. They estimate that the savings attributable to design efficiencies will reduce costs by $11.3 million in 2023, out of a total projected performance improvement from all sources of $53.8 million.

Table IV-7: Projected Reduction in Staffing Ratio Apportioned by Cause

Statistic	Budget 2017	Impact of Assumptions on Projected 2023				Projected 2023
		Performance Improvements	Due to Building Design Efficiency	Due to Volume Growth *	Total	
Adjusted Average Occupied Beds (AOB)	218.2	--	--	16.3	16.3	234.5
% Change in Adjusted AOB	--	--	--	7.5%	7.5%	7.5%
FTEs per Adjusted AOB	7.07	(0.25)	(0.15)	(0.22)	(0.62)	6.45
% Change in FTEs per Adjusted AOB	--	-3.5%	-2.1%	-3.1	-8.8%	-8.8%
FTEs	1,542.8	(54.5)	(32.5)	56.9	(30.1)	1512.7
%Change in FTEs	--	-3.5%	-2.1%	3.7%	1.9%	--

* FTEs are projected to increase at 50% variability with the increase in Adjusted AOB, thus reducing the ratio of FTEs per Adjusted AOB. (DI#92, p.29)

Finally, the applicants state that UMMS engaged ADAMS Management Services Corporation, described as an independent qualified healthcare planner, to conduct a peer review of the plans for PGRMC and provide input regarding the design, planning, and layout and provide insight into how to improve it. The applicants' state that, in a report dated May 5, 2016, "ADAMS concluded that the overall design development plan of PGRMC is inviting, well organized, and efficient, with appropriate separation of flows and paths for the exceptional delivery of healthcare that will be received by patients within its walls. The design is flexible, adaptable, has significant capacity to grow and change, and can evolve with the nuances of the US healthcare delivery system." (DI #92, p.27)

Reviewer's Analysis and Findings

The applicants provided estimates of staffing efficiencies that would be gained as a result of the project. In some cases, these are operational performance improvements that could be pursued regardless of whether there is a new facility. In others, they are efficiencies specifically tied to design of the new hospital. Productivity improvements related to projections of additional volume that will grow at a higher rate than the need for additional staff related to these volume

increases (i.e., the lower unit cost resulting from a higher scale of production) represent a major part of the gains hoped for by the applicants.

I find that the applicants have complied with this standard. However, I continue to have concerns with respect to the higher price position that Dimensions is likely to continue to have at this hospital, after relocation and replacement, relative to its peers and competitors in Maryland. As HSCRC staff pointed out in their September 21, 2016 comments, the relatively high charges of PGHC are, to some extent, related to the relatively poor socioeconomic conditions prevalent in its service area, reflected in the relatively high level of indigent patients it serves. Factoring in these conditions would make the charge comparison of PGHC with its peers less unfavorable. I also note that HSCRC staff states that it "will recommend that PGHC's rate structure be subject to efficiency measures developed by HSCRC staff in the future." (DI #97, p.4)

(12) Patient Safety

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

Applicants' Response

The applicants' identified five design and operational characteristics of the proposed replacement hospital that are likely to have a positive impact on patient safety. These improvements include:

1. Acuity-adaptable rooms to reduce errors associated with patient transfers and handoffs;
2. Situating multidisciplinary work spaces in designated areas for team collaboration to reduce communication errors;
3. Using copper-lined materials on heavily-touched surfaces to decrease hospital acquired infections, installing a fresh air handling unit within the HVAC system for improved air circulation, and placing sinks and disinfectants in functional areas for easier convenience;
4. Room design modifications that place a patient's private bathroom in closer proximity to the patient's bed, adding grab bars to the bed sides to reduce the chance of a fall, and locating charting stations and disinfectants in more user friendly areas in patient rooms; and
5. Investing in inpatient computerized provider order entry and electronic medication record technology to reduce potential drug-related transcription and medication administration errors.

Reviewer's Analysis and Findings

I have considered the design features for this project and conclude that they will enhance and improve patient safety at the new facility. Therefore, I find that the design of this project has appropriately taken patient safety into consideration and that the project is consistent with this standard.

(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.

This standard is related to a general review criterion applicable to all health care facility projects that require CON approval. The Viability of the Proposal criterion, COMAR 10.24.01.08G(3)(d), requires consideration of the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in regulations, as well as the availability of resources necessary to sustain the project. In addressing this standard and the review criterion, some overlap is unavoidable, but I have attempted to minimize duplication in this Recommended Decision.

Applicants' Response

The assumptions made by the applicants for the PGHC relocation in their August 31, 2016 modified filing are summarized in the following table. Changes in projected inpatient volume are explained in more detail in the discussion under the Need criterion, COMAR 10.24.01.08G(3)(c), *supra*, p. 86.

Table IV-8: Applicants: Key Assumptions Used in August 2016 Financial re PGHC

Statistic	Assumptions and Basis for Assumptions
Service Volume	Prior to relocation discharges will increase by an average of 1% per year from FY 2016 to FY 2020, driven by execution of Dimensions cardiovascular business plan. After relocation of the new replacement hospital projected increases are as follows: • MSGA - 7% increase in discharges from 2021 through 2023 driven by population growth, relocation, and market recapture. ALOS to decrease 12 to 15% to the statewide average depending on age group. • Psychiatric - 9% increase in discharges from 2021 through 2023 driven by population growth and increase in use rates. ALOS to remain at FY 2015 level of 6.32 days. • Obstetrics - 5% increase in discharges from 2021 through 2023 driven by relocation and market recapture. ALOS to decrease by 2% to statewide average of 2.56 days. • Outpatient services, including use of observation beds, assumed to increase at same rates as inpatient discharges.
Revenue	**Assumption and Basis for Assumption**
Gross Charges (FY 2018 – 2023)	
Annual Update Factor (2018-2023)	0.0% for projections without inflation
Population Adjustment	0.58% annual increase
Market Share Adjustment • Interim Period (2018 – 2020) • Post Hospital Relocation (2021-2023)	• 50% variability with revenue recognized in the year after growth • 50% variability related to market recapture with revenue recognized immediately in the year of volume growth
Redistribution of Dimensions' GBR	$30 million redistribution of Dimensions' GBR in 2019, allocating $30 million to PGHC.
Other Revenue	
State Grant - Operating subsidy	$11 million in 2017, $22 million in 2018, $13 million in 2019 and 2020, and $4 million in 2021 and 2022
County Grant - Operating subsidy	$7 million in 2017-2018, $8 million in 2019 and in 2020, and $4 million in 2021 and in 2022
McGruder Grant	Approximately $1million
Expenses	**Assumptions and Basis for Assumptions**
Operating Expenses Salaries Benefits Other Operating	• Assumes reduction of 87 FTEs based on Peer Group comparison • Benefits equivalent to 24% of salaries as included in 2017 PGHC budget • Other expenses reflects changes in adjusted admissions
Expense Variability	50% variable cost factor throughout the projection period
Performance Improvements	$53 million cumulative reductions in cost related to revenue cycle, quality, utilization, labor, and supply chain
Physician/Ambulatory Development Support	Includes physician fees for hospital based services, subsidy of physician practice losses and annual investments in physicians and ambulatory platform development beginning in FY 2018
Interest Expense • New Hospital Building • Line of Credit	• $158.8M bond issuance at 5.5% over 30 years, with $117.8M for new hospital cost • $28.5M loan required at opening of new hospital to fund 80 days of cash on hand at DHS in FY 2021 with assumed interest of 3.0% per annum. Five years term of loan.

Source: August 31, 2016 modifications (DI #92, Exh. 62, pp. 11-12)

In their response to this standard in the January 16, 2015 replacement application and in the assumptions summarized above, which were submitted with the August 2016 project modifications, the applicants stated that their utilization projections were consistent with observed historic trends in use of each applicable service by the projected service area populations. They also stated that their revenue estimates were consistent with utilization projections and were based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicants. Additionally, the applicants stated that staffing and overall expense projections were consistent with utilization projections and were based on the applicants' current expenditure levels and reasonably anticipated future staffing levels with Dimensions assuming a reduction in FTEs. Dimensions also stated that the projected expenses included depreciation, interest, and other operating expenses associated with the new building. (DI #30, p. 140)

In their August 31, 2016 modification, the applicants projected that PGRMC will generate $26,124,000 in excess revenues over expenses in FY 2023, the first year without State and County support. MWPH projected that it will generate revenues over expenses in FY 2023 of $412,000 from its PGRMC unit and $7,962,000 from its entire operation. (DI #92, Exh. 62, Table G1, Exh. 63, Tables G2 and J) Projection for PGHC/PGRMC are shown below.

**Table IV-9: Applicants: Actual Revenues and Expenses (2014-2015)
and Projected Revenues and Expenses (2016-23)
PGHC at Cheverly, 2016-20 and PGRMC at Largo, 2021-23
Current Dollars (in thousands of dollars)**

Uninflated in (000s)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
REVENUE										
Gross Patient Service Revenues	**$264,820**	**$279,066**	**$286,688**	**$291,136**	**$296,157**	**$334,211**	**340,403**	**347,534**	**354,679**	**360,239**
Net Adj. to rev. (Bad Debt,, Contract Allow., Charity)	(54,480)	(41,286)	(36,688)	(43,490)	(36,354)	(41,030	(43,918)	(47,010)	(48,420)	(49,179)
Net Patient Services Revenue	210,340	237,780	249,980	247,647	259,803	293,181	296,485	300,524	306,529	311,060
Other Op. Rev incl. state & county support	28,257	26,412	12,987	25,050	36,516	27,867	27,764	14,700	14,660	5,805
NET OPERATING REVENUE	**$238,597**	**$264,191**	**$262,967**	**$272,696**	**$296,318**	**$321,048**	**$324,249**	**$315,224**	**320,919**	**$316,885**
EXPENSES										
Total Salaries & Wages (incl. benefits)	133,828	134,820	135,011	135,823	131,325	125,506	123,932	124,665	125,990	127,633
Contractual Services	35,391	35,310	38,608	36,214	36,260	36,348	35,438	35,835	36,278	36,717
Total Interest, Depr. & Amortization	8,862	8,300	8,444	8,250	9,679	11,152	12,581	33,359	33,547	33,866
Supplies	31,619	36,787	39,331	38,704	37,951	37,562	37,584	37,361	37,709	38,237
Other Exp. Incl. Physician/Ambulatory Support	31,258	31,285	37,536	42,436	68,938	93,700	95,520	64,061	63,773	54,288
TOTAL OPERATING EXPENSES	**246,501**	**258,929**	**261,427**	**284,153**	**304,268**	**305,055**	**295,281**	**297,297**	**290,741**	**246,501**
NET INCOME (LOSS) From OPERATIONS	**(2,361)**	**17,690**	**4,038**	**11,269**	**12,165**	**16,780**	**19,194**	**19,943**	**23,622**	**26,124**

Source: August 31, 2016 Modified Application (DI #92, Exh. 62, Table G1)

As shown in the table of assumptions above, Dimensions is proposing that HSCRC increase PGHC's GBR by $30 million in 2019, described as a redistribution of the global budget revenue of the Dimensions Health System, which is intended to provide for investment in information technology infrastructure, population health efforts and the capital cost of the replacement hospital. Dimensions has announced plans to transition Laurel Regional Hospital ("LRH") to an outpatient health care campus beginning in 2019. $30 million is approximately half of LRH's inpatient revenue. Dimensions is assuming that the balance of LRH's inpatient revenue will be redistributed to other hospitals under HSCRC's market shift policy. Dimensions also assumes that a portion of LRH's GBR associated with outpatient services will remain at LRH to support its conversion to an outpatient campus. (DI #97) The proposed redistribution of revenue is detailed in the following table.

Table IV-10: Applicants: Dimensions Healthcare System's Projected Redistribution of Global Revenue (with inflation in millions of dollars)

Dimensions Facility		Projected 2019**		
	HSCRC Approved 2017 GBR	Without Redistribution*	With Redistribution	Redistribution
Prince George's Hospital	$291.1	$314.3	$344.3	$30.0
Laurel Regional Hospital	103.3			
Laurel Freestanding Medical Ctr.		72.4	42.4	($30.0)
Bowie Health Center	19.9	21.9	21.9	$0
System Total	$414.4	$408.6	$408.6	$0

Source: Dimensions September 13, 2016 Response Additional Information Questions (DI #__,, p.2)
* Assumes that $30 million will be distributed to other hospitals under the HSCRC market shift policy to account for changes in inpatient market shares.
** Revenue includes inflation (the previous table that shows $334,211,000 in Gross Revenue for PGHC in 2019 does not include inflation)

Applicant's Response

Mount Washington Pediatric Hospital assumptions for PGHC/PGRMC unit volume are as follows:

- Inpatient volume assumptions are based on use rate (number of admissions per projected Maryland population aged 0-4);

- Assumed use rate for FY 2017-FY 2023 is based on average use rate from FY 2012-FY 2016. Growth is expected due to new waiver with population health model, encouraging hospitals to move patients to lower-cost settings. Increased admissions also expected to result from closer relationship between PGHC and UMMS, an owner of Mount Washington Pediatric Hospital;

- Assumed average length of stay is based on ALOS FY 2012 - FY 2016

- Average length of stay assumed to increase 0.25 days per year during FY 2017 - FY 2023. Increase is expected due to general hospital payment and population health model, encouraging hospitals to move patients more quickly to lower-cost setting.

MWPH outpatient volume assumptions are based on current levels of demand. Pediatric rehabilitation and psychology are projected to grow 50% in the first year at PGRMC; then double the previous volumes for each service in the following year. Clinic volumes are projected to remain stable, and volume assumptions for other operations including its inpatient unit are very similar, with difference in basis of use rate due to unit expansion in FY 2013. Outpatient volume for other operations are projected to increase more modestly, at 3% per year. Changes in unit inpatient volume are explained in more detail in the discussion under the Need criterion. (DI #92, Exch. 63, p. 16)

MWPH based its financial assumptions for both its unit and overall operations: on FY 2016 revenues and expenses; a 2.05% rate increase for FY 2017 that was approved by HSCRC; inflation

estimated at 2.5% per year; bad debts and charity care at historical levels; and expense variability at 50%. (DI #92, Exh. 63, p. 16)

Interested Party Comments

Anne Arundel Medical Center

Anne Arundel Medical Center did not have any comments with respect to the applicants' response to this standard

Doctors Community Hospital

In its comments on the January 2015 replacement application, DCH questioned the financial feasibility of the proposed project. A number of DHC's questions related to the policies and actions of the HSCRC, including: whether HSCRC would approve a revenue increase of $21 million related to the capital costs of the project; and whether HSCRC would approve a GBR increase for PGHC for market share shifts in the year such shifts occur. DCH stated that these policy issues needed to be resolved for the project to be feasible even if all other assumptions were acceptable. DCH offered its opinion that, if any of the projected volume increase were not to be determined to be associated with market shifts, the 50% variability factor would likely not apply and PGRMC would not receive the increases in revenue built into the applicants' projections for the relocated hospital. DCH pointed out that, while HSCRC had not adopted market shift adjustment policies when the application was filed, staff proposals to date only accounted for shifts among Maryland hospitals and required budget neutrality. Therefore, DCH postulated that there would be no source of additional revenue for PGRMC's recapture of market share from DC hospitals, which would mean that Dimensions significantly overstated projected growth in revenues. (DI #46, pp. 11-15)

Doctors Community Hospital also questioned Dimensions' assumptions regarding reductions in contract allowances, reductions in salaries and wages prior to opening the new facility, and the failure to include routine capital expenditures, principal payments, and financing activities in the determination of financial feasibility. (DI #46, pp. 17-20)

Applicants' Response to Comments

The applicants responded to DCH's comments regarding a GBR rate increase and other adjustments to PGHC's GBR, pointing to PGHC's 2014 GBR that permitted Dimensions to petition for a rate increase, which it intended to do. It was noted that PGHC had been receiving operational support from the State and County governments and that one of the goals of the project is to eliminate the need for such subsidies. They stated that it is reasonable to assume that HSCRC will approve the adjustment in revenues that will be requested. Dimensions also pointed to the statement in the Maryland All Payer Model Agreement with the Centers for Medicare and Medicaid Services, which includes a provision that "the construction of the new hospital facility in Prince George's County is a factor that may warrant an adjustment to the model". (DI #50, pp.7-9)

The applicants challenged DCH's assumption that the absence of a proposed policy means that there will be no revenue granted under these circumstances, stating that such an assumption is neither reasonable nor realistic. The applicants stated that the HSCRC is not likely to leave hospitals without revenue when volume increases occur because the hospital will be providing care for Marylanders who have returned to Maryland seeking care in their own communities. For purposes of this application, Dimensions assumed that the revenue adjustment for Maryland residents returning from out-of-state hospitals will be similar to the market shift adjustment policy that is now under development for in-state market share adjustments (i.e., the hospital achieving the market shift will receive 50% of variable cost). It was noted that HSCRC eventually will adopt policies on these adjustments and will decide whether or not to grant waivers or other special arrangements. The applicants stated that there are many reasons to treat the proposed replacement hospital more favorably than other hospital applicants. (DI #50, pp. 9-10)

As to DCH's questioning of projected deductions from revenue, particularly contract allowance, the applicants pointed to improvements in PGHC's total deductions, particularly bad debts, and its expectation of recapturing patients will be covered by Medicare and commercial payors with lower or no contractual allowance discounts. Regarding salaries and wages, the projected reduction in staff FTEs per occupied bed at PGRMC is based on State and national benchmarks for trauma hospitals. They noted that PGHC's staffing ratio for FY 2016 to date was lower than projected. In response to the DCH position that the determination of financial feasibility requires the inclusion of a number of additional expenditures, the applicants noted that they submitted projections of revenues and expenses that include the non-cash items required by the Commission for its determination of financial feasibility. (DI #50, pp. 10-12)

Health Services Cost Review Commission Comments on August 2016 Modifications

On September 21, 2016, HSCRC staff responded[42] to my September 8, 2016 memorandum formally asking that it review and comment on the financial feasibility and underlying assumptions of the modified application. I asked for HSCRC's opinion and comment on: the appropriateness and adequacy of the PGHC's assumed sources of funds and the reasonableness and necessity of the applicants' assumed redistribution of Dimension Health Systems' global revenue budget and the acceptability of such an approach to HSCRC. I also asked whether such an approach is preferable to the former request for a revenue increase for the capital cost of the project. Also concerning rate adjustments for the project, I asked whether HSCRC would agree to the adjustment of rates for market shifts in the year that they occur instead of the year following. I further asked about the ability of the proposed replacement to be competitively priced compared to other hospitals and for HSCRC's perspective on the applicants' case for how the project will improve operational efficiencies.

HSCRC staff's September 21, 2016 response is summarized in the following table.

[42] HSCRC's memorandum is located at Appendix 6.

Table IV-11: HSCRC's Comments on the Modified Proposed Project

Reviewer's Questions	HSCRC Response
Are the sources of funds assumed by the applicants appropriate?	HSCRC Staff stated: "The sources of funds assumed by the applicants appear appropriate with the understanding that the County and State will provide the funds in the amounts shown. Beyond the funds granted and the land contributed, [Dimensions] must borrow the balance of funds needed including funds to ensure that an adequate number of Days of Cash on Hand are available, which may be required in the bond documents."
Revenue Projections	
Is it reasonable, acceptable, and preferable to redistribute the Dimension's Health System's global budget revenue to successfully relocate and transition to operation of a new replacement hospital?	HSCRC staff stated that "reallocating resources within a system is a preferable approach and is consistent with the All Payer Model goals." HSCRC staff also stated that such a reallocation does not add additional cost to the healthcare system as a whole.
Is the reallocation of the $30 million dollars within the system necessary for project feasibility and viability of PGHC?	HSCRC's response was that "[w]hether the total $30 million is necessary is questionable given the level of the expenses [PGHC] has built into its projections, and the fact that its rates are currently higher than other competitor and peer hospitals." HSCRC also stated that "[Dimensions] will be subject to efficiency measures, and if the level of funding is too high, it will be subject to adjustment."
Will HSCRC agree to recognize market shifts immediately rather than in the year following volume growth?	The HSCRC staff stated that they have recently begun to implement rate changes for market shifts on a more current basis than we have in the past…..Also, [we have] made other current market shift adjustments. For example, HSCRC implemented concurrent market shift adjustments when Holy Cross Germantown opened, and several facilities were adversely affected thereby. When HSCRC makes concurrent market shift adjustments, it subsequently corrects for differences between estimated and actual shifts."
What is the ability of the proposed replacement hospital to be competitively priced?	HSCRC staff remains "concerned that the projected unit rates for PGHC will be well above other general hospitals in its region as well as in similar peer group hospitals…While [Dimensions] has projected an increase in volumes at a variable cost rate of 50%, the increase in volume is not sufficient to significantly reduce the PGHC's prices." . HSCRC staff noted that PGHC has a trauma service and a large share of indigent patients, and that "[t]rauma services and higher costs related to health and socioeconomic costs of treating indigent patients serve to increase relative rates."
What is the HSCRC staff perspective on the operational efficiencies and reductions in staff hours and unit costs associated with this project?	HSCRC staff opined that the efforts to improve collections Dimensions identified are achievable and may even exceed the results Dimensions projected in the modification. HSCRC Staff believes that the projected performance improvements related to reduced length of stay and unnecessary admissions are achievable and could potentially be higher. HSRC staff believed that Dimensions' projected reductions in staffing costs to be achieved by improved recruiting efforts, management of staff, and in supply chain management and drug and contract service cost reductions are credible. HSCRC staff noted that PGHC's projected operating cost per EIPA decreases each year beginning in FY 2017 as expense performance improvements will be implemented and volumes increased. Again, HSCRC staff stated that they "believe that these operational expense performance improvements projected by PGHC are reasonable, and that actual improvements could be greater than anticipated."

Source: September 21, 2016 Memorandum from Hospital Services Cost Review Commission (DI #97)

The HSCRC staff questioned whether the entire $30 million GBR reallocation to PGRMC is necessary for the project, given the level of the expenses DHS has built into its projections, and the fact that its rates are currently higher than other competitor and peer hospitals. HSCRC staff also noted that transition expenses and infrastructure and population health investments are among the other expenses that will need to be funded. (DI #97, pp. 1-2)

Commenting on the ability of PGRMC to be competitive after relocation, HSCRC staff pointed out that PGHC's own estimates show its current rates are on average 19.5% above the other general hospitals within its region. Looking to the future, HSCRC staff compared projected PGRMC rates with that of its regional competitors. HSCRC staff assumed that the other hospitals in PGHC's region will be granted approved revenue increases of 2.3% annually for the 7 years ending June 30, 2023, for a cumulative increase of 16.1%, compared to the 24.2% increase over those seven years projected by Dimensions. That 8.1% spread, added to the existing spread of 19.5%, would result in rates that would be at least 27.6% higher than the other hospitals in its region by the end of the projection period in the CON. (DI #97, pp. 2-3)

HSCRC staff also compared PGHC's current revenue per equivalent discharge to its peers on a calendar year-to-date basis through July 31, 2016, showing PGHC to be approximately 12% higher than the average charges of a peer group of similar hospitals (including MedStar Harbor Hospital, MedStar Union Memorial Hospital, Sinai Hospital, Mercy Hospital, and Johns Hopkins Bayview). By 2023, PGHC's projected charges per case would be approximately 20% higher than this peer group after taking into account the redistributed Dimensions revenue and projected future volume changes at PGHC. (DI #97, p. 4)

Reviewer's Analysis and Findings

Assumptions

Dimensions and MWPH submitted detailed assumptions for their projections of patient volume and financial performance as part of the August 31, 2016 modified application that satisfy the requirements of the standard.

Utilization Projections

This standard requires that utilization projections be consistent with observed historic trends of use by the service area population of the hospital or State Health Plan need projections, if relevant. I find MWPH's need projections are reasonably related to the needs of the statewide population served. In my analysis of Dimensions' utilization projections in the January 2015 replacement application, discussed in more detail under the Need criterion, I concluded that the projections were not consistent with observed trends and assumed highly aggressive recapture of market share from other hospitals, especially D.C. and Virginia hospitals. Therefore, I recommended at the May 17, 2016 project status conference that MSGA and obstetric bed capacities be reduced as part of an overall reduction in the size of the replacement hospital.

The applicants responded by reducing the number of MSGA beds at the proposed replacement hospital based on a re-examination of Dimensions' need analysis and a determination that MSGA use rates declined at a faster rate than previously projected. Dimensions also assumed this trend will continue throughout the projection period. Thus, I find that the utilization projections are consistent with observed historical trends for the region.

However, the applicants did not change their aggressive market recapture assumptions for PGRMC. While I do not think that the aggressive market recapture assumptions can be achieved in the projection time frame, I do believe that the construction of a new facility at a new location operated by the UMMS should experience incremental improvement in market share. Therefore, I am concerned that PGRMC will fall short of its projected discharges, which would require higher prices as discussed below.

Revenue Estimates

This standard calls for the revenue estimates to be consistent with utilization projections and current charge levels. I find that MWPH's revenues are appropriately related to projected utilization and current charges. As for PGRMC, the relationship of revenue to utilization does not strictly apply because the basic revenue of hospitals is determined by HSCRC in the GBR and TPR process. A hospital's GBR is updated annually for inflation, population growth in its service area, and a number of other factors including shifts in market share between Maryland hospitals. The payment model also encourages hospitals to minimize readmissions and minimize admissions associated with conditions that could have potentially been prevented. The payment model was developed to reduce the incentive to increase volume that was inherent in the former payment model and to encourage the shifting of services to outpatient locations outside the hospital. Charges are then generally set so that the target global budget revenue will be met at the expected level of use.

While the revenue projection in the January 2015 replacement assumed that HSCRC would approve a rate increase of approximately $21 million[43] to cover some of the additional capital costs of this project, the current proposal does not include such an increase. Instead Dimensions is proposing to shift $30 million in revenue from other operating entities within its health system to PGHC. Dimensions proposes to use this redistributed revenue for IT infrastructure, population health efforts, and physician recruitment in addition to covering its higher capital costs.

I specifically asked HSCRC whether such assumptions are reasonable and acceptable and whether it is preferable to a partial rate request revenue adjustment. HSCRC staff responded that they believe "reallocating of resources within a system is a preferable approach and is consistent with the All Payer Model goals."[44] HSCRC staff added that this method does not add additional costs to the health care system as a whole. HSCRC staff also pointed out that they have worked with other health care systems to allow the reallocation of resources as they moved service and

[43] In its May 4, 2015 comments, Doctors Community Hospital questioned whether the HSCRC would approve such a requested rate increase. (DI #46, p.11)

[44] HSCRC's September 21, 2016 response to my request for review and comment cited a partial rate application for $25 million. The former replacement application included assumed a rate adjustment for capital of $21.5 million and a shift of $4.2 million in GBR from Laurel Regional Hospital to PGHC.

providers from one campus to another. (DI #97)

Another important component of Dimensions' revenue projections is the recognition of additional revenue by HSCRC for market shifts after opening of the replacement facility in the year that it occurs instead of the following year, which is the current practice. I also asked HSCRC about this, and HSCRC staff responded that they have begun to make rate changes for market shifts on a more current basis and have worked with other healthcare systems to ensure that revenues are moved as expenses are moved within the system. HSCRC also pointed to its experience making concurrent market shifts upon the opening of Holy Cross Germantown Hospital that adversely affected several nearby facilities, but made the additional point that, if such market shifts are not actually achieved, adjustments will be made in the following year. (DI #97) As to revenue adjustments to account for the shift of Maryland residents from D.C. hospitals to PGRMC, I share Dimensions' belief that HSCRC will have to adjust PGRMC's GBR to recognize additional revenue. In conclusion, I find that Dimensions' revenue projections are reasonable given the project costs, the expected changes in market share, and the current payment model.

While I believe that the payment model will recognize sufficient revenue for PGHC to sustain the relocated facility, I am still concerned with the high cost of the hospital's services relative to its competition and peers, as pointed out by HSCRC staff. Most concerning is the likelihood that the proposed project will widen the rate gap, hindering PGRMC's efforts to improve its market share. Failing to meet its volume targets will put further upward pressure on rates. That is why strong managerial leadership will be essential to the overall success of this project.

Staffing and Overall Staff Expense Projections

While Dimensions is projecting increases in volume at PGRMC, it is also projecting a small decrease in total FTEs of about 0.8% as it works to bring staffing in line with its peer group. As discussed under the efficiency standard, a total 8.08% reduction in FTEs per average adjusted occupied bed (AOB) is projected, primarily as a result of economies of scale related to volume increases, but also as a result of efficiencies related to building design. Salaries, wages, and benefits are also projected to decrease about 6% in current dollars from the amount budgeted for FY 2017 as Dimensions and UMMS work to reduce the high costs of PGHC, which Dimensions estimated to be 19.5% higher than other hospitals in its region and HSCRC staff estimates to be 12% higher than a group of peer hospitals. (DI #97, p. 4) Dimensions anticipates labor savings via the collective bargaining process, which has already resulted in cooperation between union and management that will lead to operational efficiencies. Other efforts will improve recruitment leading to reduced use of more expensive agency nurses and reduced turnover. (DI #96, pp.23-24)

Dimensions also projected a small decrease in contract service of 4.9% between FY 2016 and 2023. HSCRC staff calculated that the average operating expense in current dollars per equivalent inpatient admission exclusive of capital expenses and physician support are projected to decrease by 12% between 2016 and 2023. I note that HSCRC staff believe that these performance improvements are reasonable and that actual improvements could be greater.

Based on the above, I find that the projected expenses are consistent with projected utilization given PGHC's current high cost and the need to reduce such costs. However, Dimensions should make every effort to further reduce expenses where it can consistent with the provision of high quality care so that the required rate increase can be minimized.

Financial Performance

This standard requires that a hospital document the ability to 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. The applicants have submitted Dimensions' reasonable projection that shows the replacement hospital generating the required excess revenues over total expenses without the current State and County support that has been sustaining it, if the utilization projections are achieved. Dimensions projects an operating profit of $26,124,000 for FY 2023 before accounting for inflation and $7,973,000 after accounting for inflation. MWPH projected that it will generate revenues over expenses in FY 2023 of $412,000 from the PGRMC unit and $7,962,000 from its entire operations before inflation. I find that the applicants have satisfied the financial feasibility standard.

While Dimensions has satisfied the financial feasibility standard, I recognize that PGHC's current high charges, the likelihood of increases as a result of the proposed project, and the risk of not achieving projected volume present continued challenges to the financial stability of the hospital. However, I believe that failure to make a major investment in the hospital physical plant and operations would risk the loss of more volume that would make the poor present financial situation even worse. Moreover, failure to replace and relocate PGHC will adversely affect access of Prince George's County residents to needed health care services in a safe and modern hospital environment.

(14) Emergency Department Treatment Capacity and Space

(a) An applicant proposing a new or expanded emergency department shall classify its service as low range or high range based on the parameters in the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians Emergency Department Design: A Practical Guide to Planning for the Future, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

Applicants' Response

The applicants' classified the proposed PGRMC emergency department service indicators as low, middle, or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future*, as detailed in the following table.

Table IV-12: Applicants: Threshold Indicators for Proposed PGRMC Location Based on ACEP Guidelines

Indicators for Adult ED	Low Range Threshold	High Range Threshold	Proposed for PGRMC	Classification (Low, Medium, High)
ALOS	<2.5 hours	>3.5 hours	3.1 hours	Medium
Location of Observation Beds	Outside ED	Inside ED	Outside ED	Low
Time to Admit	<60 minutes	>90 minutes	= 90 minutes	Medium
Turnaround Time Dx Tests	<30 minutes	>60 minutes	= 60 minutes	Medium
% Admitted Patients	<18%	>23%	= 18 %	Medium
%Non-urgent/%Urgent	<1.1/1	>1/1.1	1/1.4	High
Age of Patient	<20% Age 65+	>25% Age 65+	13% Age 65+	Low
Admin/Teaching Space	Minimal	Extensive	Extensive	High
Imaging within ED	No	Yes	Yes	High
Specialty Components	No	Yes	Yes	High
Flight/Trauma Services	No	Yes	Yes	High

Source: Prince George's Regional Medical Center Replacement Application (DI #30, p. 151)

Reviewer's Analysis and Findings

This standard requires an applicant to classify its ED as "low-range" or high-range" based on the parameters in the most recent edition of planning guidelines published by the American College of Emergency Physicians. The standard also requires the number of treatment spaces and departmental space to be consistent with those guidelines. I concur with the classification of the ED at the proposed replacement hospital as reflected in Table IV-12.

I find that the application has met this standard.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicants' primary service area and the impact of these patient groups on emergency department use;

(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

Applicants' Response

ED Volume

In its original projections of ED visit volume, the applicants cited PGHC's recent growth in ED volume (13.1% growth from FY 2007 through FY 2013) and an anticipated increase in EMS transports,[45] and stated that continued growth in visit volume was anticipated. Dimensions also consulted with the Prince George's County Fire Department/EMS to estimate how relocating the hospital might impact the number of EMS transports to the hospital. (DI #30, pp. 147-150; DI #36, pp. 19-21) Taking the information about EMS transports, the historical visit volume, and the projected service area population into account, the applicants projected that the ED visit volume for the relocated hospital would be 60,202 in 2022.

Subsequent to the project status conference, these projections were modified, as shown below.

Table IV-13: Applicants:
Actual (2013-2015) and Projected ED Visits

Year	Total ED Visits
2013	51,881
2014	50,229
2015	49,756
2016	50,651
2017	51,563
2018	52,491
2019	53,435
2020	54,397
2021	55,376
2022	56,372
2023	57,387

Sources: 2013 and 2014 from DI #36;
2015-2023 from DI #92, Exh. 62, Table F1.

ED Space

PGHC has a total of 46 treatment spaces, a count that includes three triage spaces. In its replacement application, January 2015, the applicants proposed 52 treatment spaces within PGRMC's proposed department, with 38,990 departmental gross square feet ("DGSF"). That space included 5,165 DGSF for trauma and 3,000 DGSF for radiology. (DI #30, pp.143, 150) That application measured the proposed ED square footage (38,990) and treatment spaces (52) against the recommendations in the American College of Emergency Physicians ("ACEP") Guidelines, as detailed in Table IV-14.

[45] The applicant states that data from the Fire/EMS Department indicates that for 2012 there were 21,900 transport calls from PGHC's Cheverly catchment area there were 28,702 calls from what would have been the PGRMC/Largo catchment area.

Table IV- 14: Applicants: Proposed Emergency Department Square Footage & Treatment Space Ranges for an ED with 60-70K Visits

	Departmental Gross Square Feet		Treatment Spaces	
	Low Range	High Range	Low	High
50,000 ED Visits	25,500	34,000	30	40
60,000 ED Visits	29,750	39,950	35	47
70,000 ED Visits	33,000	44,550	40	54
PGRMC Proposed (60,202 ED Visits projected in 2022)	**38,990 DGSF**		**52**	

Source: January 2015 Replacement Application (DI #30, pp. 151-52)

Again, subsequent to my recommendations at the project status conference, Dimensions revised the project plan, reducing proposed ED treatment spaces to 45, and the size of the ED to 37,733 DGSF.

Interested Party Comments

No interested party comments were submitted regarding American College of Emergency Physicians response to this standard.

Reviewer's Analysis and Findings

This standard requires that the number of emergency department treatment spaces and departmental space proposed by an applicant be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians, Emergency *Department Design: A Practical Guide to Planning for the Future*. At the May 17, 2016 project status conference, I recommended that the applicants "reduce the number of Emergency Department treatment spaces to no more than 45 spaces and bring the size of the ED in line with this treatment capacity, consistent with American College of Emergency Physicians (ACEP) guidelines that are incorporated by reference in the SHP".

My recommendation that the size and number of treatment spaces should be reduced was driven by my finding that visit volume projected for the replacement hospital was too high and that the number of treatment spaces requested was too high for the projected visit volume. While I found the methodology used by the applicants to have some validity, their use of 2012 as the base year missed the more recent declines in visit volume. A broader look at ED volume trends shows a decline from 2011 to 2015, as illustrated in Table IV-15.

Table IV-15: Prince George's Hospital Center Emergency Department Visit Volume from CY20113 – CY 2014

Year	ED Visits	Percent Change (%)
2011	51,267	--
2012	53,445	4.3%
2013	50,643	-5.2%
2014	50,550	-0.2%
2015	50,606	0.1%
Change, 2011- 2015	-661	-1.3%

Source: HSCRC Discharge and Outpatient Data Bases

I was also concerned that the applicants' methodology relied on estimated transport visits instead of actual data on those visits. Finally I was concerned that the methodology did not take into account any change in market share for the non-transport visits as a result of the change in location. For these reasons, I undertook my own projections, using 2014 as the base year. My calculation was built as follows:

- I calculated the 2014 ED use rate for each Prince George's County zip code area and multiplied that use rate by the 2024 projected population for the particular zip code area to arrive at the total projected 2024 ED visits for that zip code area;

- I calculated the projected ED visits that would go to PGRMC from each zip code area by multiplying the 2024 projected total ED visits for each zip code area by PGHC's average 2014 market share for the Prince George's County zip code areas of comparable proximity rank[46] to PGHC; and

- I adjusted for ED visits from outside of Prince George's County by assuming that the relationship between in-County and out-of-County visits observed in 2014 will be maintained in 2024. Visits from Prince George's County made up about 79.7% of PGHC's total ED visits in 2014. Applying that ratio to the 2024 projections yields a total of 55,130 visits to the relocated hospital in Largo. This is shown in the following table.

[46] Where PGHC ranks compared to other hospitals in terms of the time it takes to drive from the population center (population weighted centroid) of each zip code area to each hospital. Spatial Insights generated the driving time from each Maryland and District of Columbia zip code to each Maryland and District of Columbia hospital using Freeway 2013 ("Freeway") drive time analysis software. The population-weighted centroid of each zip code area was calculated based on the population distribution measured at the census block level, which is a smaller geographic area than the zip code area. The Freeway software then generated the drive time between each zip code area and each existing hospital and PGRMC's proposed new location. Freeway uses a compressed representation of the street network with road linkages divided into six categories: rural local; rural arterial; rural freeway; urban local; urban arterial; and urban freeway. The "heavy" traffic speeds were assigned to all links, i.e., 20 miles per hour for urban local, 30 for urban arterial, and 40 for urban freeway. Heavy traffic conditions are described as rush hour in major metropolitan areas.

Table IV- 16: Projected 2024 Prince George's Regional Medical Center Emergency Department Visits

2014 PGHC ED Visits from Prince George's County Zip Code Areas	40,262
2014 Total ED Visits to PGHC	50,550
Percent Originating from Prince George's County Zip Code Area	79.65%
Projected 2024 ED Visits to PGRMC from PG's County	43,910
2024 Total ED Visits	55,130

Source: HSCRC Discharge and Outpatient Data Bases and Projected 2024 Population by Zip from Neilsen

Thus, I concluded that approximately 55,000 ED visits would be expected at PGRMC in 2024. Next I consulted the ACEP Guidelines (excerpted in the table that follows) to assess the appropriate number of treatment rooms and space required at that volume.

Table IV- 17: High and Low Range Estimates of Emergency Departmental Size and Treatment Spaces for Selected Visit Volumes

	Departmental Gross Square Feet		Treatment Spaces	
	Low Range	High Range	Low	High
50,000 ED Visits	25,500	34,000	30	40
60,000 ED Visits	29,750	39,950	35	47
70,000 ED Visits	33,000	44,550	40	54

Source: American College of Emergency Physicians, Emergency Department Design: A Practical Guide to Planning for the Future (February 2006).

Given that a "high range" ED with a volume of 50,000 visits would need 40 treatment spaces, while one with 60,000 visits would need 47 treatment spaces, I concluded that, at a projected volume of approximately 55,000 visits, PGRMC will be adequately served by 45 treatment spaces. Therefore, at the May 17, 2016 status conference, I requested that the project be modified to reduce the number of treatment spaces to 45 and to reduce the ED square footage accordingly.

In its August 31, 2016 modified project plan, the applicants proposed 45 ED treatment rooms. At a DGSF of 37,733, it has also proposed a space proposal that is consistent with the range set forth in the ACEP Guidelines.

I find that the modified project plan meets this standard.

(15) Emergency Department Expansion

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost

alternative facilities or programs;
(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and
(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

Applicants' Response

Subsection (a) of this standard requires an applicant to describe efforts made in cooperation with its medical staff to reduce the use of the ED for non-emergency medical care. The applicants pointed out that Dimensions spends more than $15 million annually in physician subsidy payments to attract and retain physicians to care for the low income and indigent populations in Prince George's County. (DI #30, p. 146)

One initiative to reduce unnecessary ED visits that the applicants' describe is PGHC's establishment of an inter-disciplinary team to create outpatient care plans for "frequent flyers."[47] Each client's care plan includes a medical history and, upon arrival at the ED, each such frequent flier patient receives a medical screening exam regardless of the complaint, and has all lab and diagnostic results recorded to the patient's electronic medical record . Each documented discharge care plan is based on the patient's most frequent complaint, and includes referrals to outpatient resources. Both the patient and the ED Medical Director sign off on the care plan, and when the patient presents to the ED again, the ED case manager or a member of the inter-disciplinary team reviews the plan with the patient. (DI #30, p. 146)

Another initiative is a partnership PGHC has established with Medical Mall Services of Maryland ("MMSM"), a hospital-to-home transitions care services provider for frequent flyers called Health Connect. The Health Connect program provides assistance with medication reconciliation, ensuring follow-up care, and reviewing precursors that should prompt a patient to seek care before a crisis. The applicants' state that partnering with MMSM has been shown to reduce readmissions by 20%. (DI #30, pp. 146-47)

Subsection (b) of this standard requires an applicant to demonstrate its efforts to effectively maximize the use of its current ED space. The applicants cited changes made to PGHC's triage process that have resulted in more efficient use of its ED space. Specifically, it has changed the triage process during the ED's rush hours by increasing the number of providers in the triage area and placing patients in rooms immediately. The applicants cite positive results accruing from those moves, including: (1) patients' door-to-bed time decreased from 75 minutes to 37 minutes; (2) door-to-provider time decreased from 80 minutes to 53 minutes; and (3) door-to-disposition time went from 224 minutes to 208 minutes. This has resulted in a modest decrease in average length of stay in the ED from 297 minutes to 293 minutes. The applicants also reported that the percentage of patients leaving PGHC without being triaged or seen improved from an average of 7.23% to 5.22% between the first half of 2013 and second half of 2014. Some tactics that enabled this improvement include adding an extra provider during high volume hours, a revamping of stock medications, and the use of expedited orders. (DI #30, p.153)

[47] Patients who have had 5 or more visits to the ED since January 2013

Subsection (c) requires that bed and other facility and system capacity be consistent with greater ED volumes. The applicants did not provide a specific response to this section but the proposed PGRMC has been designed with system capacities that Dimensions believes are consistent with the relocation, modernization, and enhanced medical staff and reputation of the hospital.

Interested Party Comments

No comments were submitted on the applicants' responses to this standard.

Reviewer's Analysis and Findings

I find that the application demonstrates that PGHC has made efforts both internally and externally though partnerships with other healthcare organizations to decrease the use of the ED for non-emergency care. It has also added resources to the ED and changed the way it processes patients in an effort to reduce the time patients wait for treatment and the time they spend in the ED. The statistics submitted by the applicants' show that these changes have had a modest impact.

The applicants' responded appropriately to my recommendations to right-size this project, including bringing the size of the Emergency Department into accordance with the parameters set by ACEP.

I find that the applicants have met this standard.

(16) Shell Space.

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

The standard is not applicable because the project does not include conventional shell space.

COMAR 10.24.11 State Health Plan for Facilities and Services: General Surgical Services

Introduction

COMAR 10.24.11 ("General Surgical Services Chapter") guides CON reviews involving non-specialized surgical facilities. The chapter supplements COMAR 10.24.10 ("Acute Care Hospital Services Chapter") in the review of general hospital projects involving expenditures for non-specialized surgical facilities, and provides that such hospital applicants "shall address all standards applicable to its proposed project" in both the Acute Care Hospital Services and the Surgical Services Chapters of the SHP. The General Surgical Services Chapter specifically provides that a hospital does not have to address standards in that chapter that are completely addressed in responses to standards in the Acute Care Hospital Services Chapter.

PGHC's current operating room ("OR") capacity consists of ten general and special purpose ORs and two caesarean ORs ("C-section rooms"). At the Largo replacement hospital, the applicant originally proposed to construct nine general and special purpose ORs in space designed for ten ORs, with unfinished space is labeled as storage space. At the May 17, 2016 project status conference, I requested that the applicant "reduce the number of finished operating rooms by at least one operating room, eliminate the unfinished OR, and reduce the 10-OR suite to an 8-OR suite." In its August 31, 2016 modifications, the applicants scaled back the number of finished operating rooms to eight as I requested, and retained storage space adjacent to the finished ORs that is sufficient to add two additional ORs later, subject to the Commission's issuance of a CON.

Interested Party Comments

No interested party commented on the application's compliance with standards in the General Surgical Services Chapter. Anne Arundel Medical Center commented on the applicants' capacity assumptions for cardiac surgery, which I will discuss in the section of my Recommended Decision that addresses compliance with COMAR 10.24.17 ("Cardiac Surgery Services Chapter").

.05A. General Standards.

Introduction

The standards in the General Surgical Services Chapter that duplicate standards covered in the Acute Care Hospital Services Chapter are listed below and were addressed in the preceding section of this report, which discussed compliance with the Acute Care Hospital Services Chapter, COMAR 10.24.10, and will not be repeated here.

.05A(1) Information Regarding Charges
.05A(2) Charity Care Policy
.05A(3) Quality of Care
.05B(7) Construction Costs
.05B(8) Financial Feasibility

Among the remaining applicable standards are several that prescribe policies, facility features, and staffing, and/or service requirements that an applicant must meet, or agree to meet prior to first use. Those include:

.05A(4) Transfer Agreements
.05B(4) Design Requirements
.05B(5) Support Services

Reviewer's Analysis and Findings

I have reviewed the CON application and have confirmed that the hospital has provided documentation: that it has written transfer and referral agreements with hospitals capable of managing cases that exceed its capabilities; that the project meets the design requirements for general hospital surgical facilities in Section 2.2 of the FGI Guidelines; and that the proposed replacement hospital will continue to provide the required support services (laboratory, radiology, and pathology). The text of these standards, as well as the location within the application where compliance is documented, is attached as Appendix 4.

I find that the proposed project meets the requirements of these three standards.

.05B. Project Review Standards.

(1) Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Applicants' Response

The applicants stated that the replacement hospital's service area for surgical services will be the same as that assumed for the MSGA services. (DI #30, p. 177) The replacement hospital's

inpatient medical/surgical service area was determined using methods that the Commission has employed in analyzing other proposed hospital relocations.[48]

Reviewer's Analysis and Findings

The applicants' assumption with respect to the likely surgical service area of the relocated hospital is reasonable. I find that the applicants have complied with this standard.

(2) Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospitals likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

Applicants' Response

PGHC currently has ten operating rooms.[49] Its OR inventory includes one room dedicated for trauma patients, and two rooms dedicated for cardiac surgery. Dimensions proposed in the 2015 CON replacement application to construct nine operating rooms at the replacement hospital

[48]The Commission has developed a basic approach for projecting how a hospital's service area and market share (and thus volume) are likely to change as a result of a relocation, which is based on the market share/proximity rank relationship, the relationship between: (1) the ranking of its proximity to a zip code area population centroid, expressed as travel time, compared to that of other hospitals, and (2) its market share.

[49] The applicants have noted that one of the general purpose ORs is principally used for cystoscopy procedures. (DI #36, Exh. 54)

in Largo, with "storage space" of sufficient size to add a tenth OR. (DI #36, p. 23) Six of the proposed nine ORs would function as mixed-use, general purpose ORs, and three would remain as special purpose ORs. (DI #30, p. 178)

Dimensions projected future inpatient surgical case volume based on the ratio of a base year's (2014) inpatient surgical case volume to that base year's MSGA discharges. It applied that ratio to projected MSGA discharges in order to project inpatient surgery cases. Outpatient surgical volume was then projected based on the ratio of 2014 outpatient surgical case volume to 2014 inpatient surgical case volume.

Dimensions next projected OR utilization by assuming that the 2009 to 2014 average minutes-per-case for inpatient non-cardiac and non-trauma cases and for outpatient cases will be the average OR time experienced in the future. It assumed a room turn-around time of 25 minutes per case, consistent with assumptions used in the General Surgical Services Chapter. The resulting need projection was for 5.68 mixed-use, general purpose operating rooms. (DI #36, pp. 24-26)

Table IV-18: Dimensions' Projection of Need for Mixed-Use, General Purpose Operating Rooms for Prince George's Regional Medical Center (based only on cases performed in sterile ORs)

2014 MSGA Admission	7,603
2014 Non-Cardiac/Trauma Inpatient OR Cases	1,995
Ratio of Inpatient Surgery Cases to MSGA Admissions	0.26
MSGA 2022 Admissions Projected by Dimensions	11,217
Projected Inpatient Surgery Cases	2,943
2014 Outpatient Surgery Cases	1,807
Ratio of Outpatient to Inpatient Cases	0.91
Projected 2022 Outpatient Surgery Cases	2,666
Total Projected 2022 Non-Cardiac/Non-Trauma Cases	**5,609**
Average Non-Cardiac/Non-Trauma Minutes Per Inpatient Surgery Case	110.16
Average Minutes Per Outpatient Surgery Case	68.72
Room Turn-around (Clean-up) Minutes Per Case (All cases)	25.00
Projected Non-Cardiac/Non-Trauma Inpatient Minutes	324,239
Projected Outpatient Minutes	183,200
Room Turn-around Minutes	140,231
Total OR Minutes	**647,670**
Optimal Capacity per Mixed-Use, General Purpose OR (Minutes per Year	114,000
Number of Mixed-Use, General Purpose ORs Needed	**5.68**

Source: Dimensions March 13, 2015 response to completeness questions (DI #36, p.25)

In the August 31, 2016 modified project plan the applicants' reduced the projection of MSGA discharges at PGRMC and reduced the number of finished general ORs to eight as I requested, maintaining the three special purpose ORs it currently operates. It retained the

configuration of its operating room suite and adjacent storage space so that it can accommodate OR expansion (contingent on CON approval) in the future.

Interested Party Comments

No interested party commented on the application's compliance with this standard.

Reviewer's Analysis and Findings

This standard requires an applicant proposing to establish or replace a hospital or ambulatory surgical facility to demonstrate the need for the number of operating rooms proposed for the facility. An applicant's need demonstration must utilize the operating room capacity assumptions and other guidance included in Regulation .06 of the General Surgical Services Chapter and must demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility**.** The standard further directs an applicant to consider historic trends in the use of surgical facilities by inpatients and outpatients, the operating room time required for surgical cases projected at the replacement hospital, and how surgical case volume is likely to change as a result of the change in location.

The applicants' have projected inpatient surgical case volume at the new location based on the historic relationship of inpatient surgery cases to MSGA admissions at PGHC. The applicants' projection of MSGA admissions at the new location used service area population as one of a number of factors. Dimensions expects that its service area market share of MSGA hospitalizations will improve as a result of the new hospital, its location, which will enable the expansion of medical staff who will perform surgery. Dimensions projected outpatient surgical case volume based on the historic relationship of outpatient surgery case volume and inpatient case volume. .

While I find this approach to be reasonable, I did not fully agree with the MSGA discharge projections developed by Dimensions. As explained in greater detail in my analysis and findings under the Need criterion,[50] I have taken a more conservative approach in forecasting use rates (discharges per population), based on recent trends and the manner in which the hospital payment model put in place in Maryland in 2014 is likely to reduce hospitalization rates. I have also concluded that the market share improvement is not likely to occur as quickly as the applicants have assumed. Thus, while the applicants' projected 11,217 MSGA discharges in 2022 (a 49% increase over an eight-year period), I project 8,690 discharges in 2024 (a 16% increase over the 7,525 discharges that PGHC experienced in 2014).

I also evaluated the reasonableness of the ratios and the time-per-surgery case used in the applicants' projections. The applicants used 2014 data regarding the ratio of inpatient surgeries to MSGA admissions and the ratio of outpatient surgery to inpatient surgery. I also analyzed data for 2012 and 2013 and observed that the ratio of inpatient surgeries to MSGA discharges has declined over this time period, as shown in the following table. I also saw that the ratio of outpatient

[50] See discussion of COMAR 10.24.01.08G(3)(b) at Section IV-B of the Recommended Decision, *infra*, p. 86.

surgery to inpatient surgery increased over this time period. I consider these trends to be consistent with a health care system that is encouraging the use of outpatient care over inpatient care where possible. I find that the applicants' use of the 2014 ratios is reasonable.

Table IV-19: Prince George's Hospital Center
Ratios of Inpatient Surgery Cases to MSGA Admissions and
Outpatient Surgery Cases to Inpatient Surgery Cases*

Fiscal Year	MSGA Admissions	Inpatient Surgery Cases	Ratio of IP Surgeries to MSGA Admissions	Outpatient Surgery Cases	Ratio OP Surgeries to IP Surgeries
2012	7,422	2,454	0.331	1,738	0.708
2013	6,634	2,226	0.336	1,927	0.866
2014	7,525	1,996	0.265	1,807	0.905

*Inpatient surgical cases exclude trauma and cardiac surgery.
Sources: Excerpt 2012 MSGA admissions contained in March 13, 2015 response to completeness questions (DI #36, p. 26 and Exh. 50, Table F1); 2012 MSGA admissions contained in original October 4, 2013 application (DI #5A, p. 226)

The applicants' projected the utilization of the ORs in minutes by multiplying the projected surgical volumes by average minutes per case for inpatient non-cardiac/non-trauma cases and for outpatient cases for the period from 2009 through 2014. In order to test the reasonableness of using the averages for this time period, I reviewed Dimensions' data as detailed in the following table. I note that the average time-per-inpatient case has been steadily increasing over this time and that the average time-per-outpatient case has also been increasing, but at a slower pace and not as consistently as the average time-per-inpatient case. I conclude that the applicants' use of the five-year average is reasonable.

Table IV - 20: Prince George's Hospital Center
OR Minutes/Case FY 2009 – FY 2014

Fiscal Year	Inpatient Non-Cardiac or Trauma Minutes/Case	Outpatient Minutes/Case
2009	97.9	66.47
2010	98.45	65.38
2011	102.38	63.87
2012	108.59	67.61
2013	122.59	74.76
2014	131.06	74.22
Average	**110.16**	**68.72**

March 13, 2015 Response to Completeness Questions (DI #36, Table 59 (Revised)p. 24)

Having found that the applicants' methodology and assumptions regarding future time per case are reasonable, I prepared my own projected surgical case volume projections and OR utilization projections based on my projection of a more conservative number of MSGA admissions, as detailed in the following table.

Table IV-21: Projection of Mixed-Use, General Purpose Operating Room Need at Prince George's Regional Medical Center

Projected 2024 MSGA Admissions	8,690
2014 Ratio of Inpatient Surgery Cases to MSGA Admissions	0.265
Projected 2024 Inpatient Surgery Cases	2,305
2014 Ratio of Outpatient to Inpatient Cases	0.905
Projected 2024 Outpatient Surgery Cases	2,087
Total Projected 2024 Non-Cardiac/Non-Trauma Cases	**4,392**
Average Non-Cardiac/Non-Trauma Minutes per Inpatient Case	110.16
Average Minutes per Outpatient Case	68.72
Room Turn-around (Clean-up) Minutes Per Case	25.00
Projected Non-Cardiac/Non-Trauma Inpatient Minutes	253,920
Projected Outpatient Minutes	143,402
Room Turn-around Minutes (all cases)	109,794
Total OR Minutes	**507,117**
Optimal Capacity per Mixed-Use, General Purpose OR (Minutes per Year)	114,000
Number of Mixed-Use, General Purpose ORs Needed	**4.45**

Based on my assessment of the need for mixed-use, general purpose operating rooms, I requested at the May 17, 2016 project status conference that the project be modified to include only eight finished general purpose ORs, allowing PGRMC to retain the capacity of three special-purpose ORs that PGHC currently operates. The modified project plan includes only eight finished ORs. I note that, at least until recently, PGHC's relatively low volume of cardiac surgery cases indicates that it had been using the two cardiac surgery ORs at an extremely low level of room capacity; however, I do not take issue with this choice by Dimensions and support the hospital's desire to maintain this service and continue the process it has begun to revitalize its cardiac surgery program. The Cardiac Surgery Chapter of the State Health Plan does not require a cardiac surgery program hospital to operate two dedicated cardiac surgery operating rooms. I do not recommend that continued dedication of two rooms to cardiac surgery be a condition of any CON issued for this project. However, I understand that the hospital may conclude that two dedicated cardiac surgery ORs are needed in case emergency cardiac surgery is needed for a patient when the other cardiac surgery OR is in use.

Dimensions did not fully comply with the spirit of my May 17, 2016 recommendations regarding OR capacity, although it complied with the letter of my request. I asked Dimensions to "reduce the number of finished operating rooms by at least one operating room …, eliminate the unfinished OR, and reduce the 10-OR suite to an 8-OR suite." I did not require elimination of the square footage, which the modifications to the application retain as "storage space".[51] I note that the operator of the replacement hospital will be required to obtain Commission approval for additional operating rooms if expansion of capacity is proposed in the future.

[51] As I noted in my May 26, 2016 letter (and have since repeated), my recommended "bed and other capacity reductions . . . are important but secondary considerations if the modified application filed no later than August 31, 2016 achieves a redesign that meets my recommended cost targets."

I find that the project complies with this standard.

(3) Need - Minimum Utilization for Expansion of an Existing Facility.

This standard is not applicable to this project.

(4) Design Requirements

See Appendix 4.

(5) Support Services

See Appendix 4.

(6) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

Applicants' Response

The applicants and the building's designers state that the following facility design elements will enhance the patient safety environment for the surgical services department:

- The ORs in the proposed PGRMC facility will be larger than PGHC's current ORs, allowing each room to be equipped with video equipment and boom technology throughout the suite. The design will allow both the RN and anesthesiologist access to and visibility of the monitoring equipment.

- The surgical suite will have the correct balance and location of prep and recovery areas to improve patient flow and facilitate an appropriate level of nursing care.

- The new ORs will provide improved air filtration for infection control with a minimum of 25 air changes provided in a laminar flow air distribution pattern.

- Use of a "same handed design" will standardize the OR configuration, which will help "standardize work process with consistent placement of critical supplies and equipment."

- Durable monolithic flooring with an integral base will eliminate the opportunities for contamination from damaged or degraded surfaces experienced with traditional sheet flooring alternatives. Antimicrobial surfaces will be used where appropriate to limit infections.

- The design of the surgical services area will maintain visual connections among staff work areas to reduce wrong-site surgeries caused by communication errors.

- Integrating computerized physician order entry technology will help reduce medication errors.

(DI #30, p. 182 and DI #36, pp. 26-27)

Reviewer's Analysis and Findings

The applicants' have documented their consideration of patient safety in the design of the new surgical services department. I find that application is consistent with this standard.

COMAR 10.24.12 - State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetrical Services

COMAR 10.24.12.04 - Review Standards.

Introduction

I note that the standards in this section are intended to guide CON and CON exemption reviews that involve new acute hospital inpatient obstetric services, existing services proposed to be relocated to newly constructed space, and existing services proposed to be located in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to an applicant for a new perinatal service. Standard (15) applies only to an applicant with an existing obstetric service.

Interested Party Comments

No interested party commented on the application's compliance with standards in the Obstetric Services Chapter.

(1) Need. ***All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.***

.

Applicants' Response

The applicants have designed the replacement hospital to have 22 post-partum beds that will be configured in a nursing unit that also contains five MSGA beds, presumably for clean gynecological cases. The existing PGHC has a physical bed capacity of 42 post-partum beds and has allocated 34 licensed acute care beds to this service in FY 2017.

The applicants developed an obstetric ("OB") bed need assessment for a target population of females aged 15 through 44 who reside in a projected service area for the Largo site. The applicants defined the service area by identifying the zip code areas in which the relocated PGRMC would be at least the fourth-closest hospital measured by drive-time. This formulation was based on an analysis of PGHC's 85% relevance service area for OB services, which generally included zip code areas in which PGHC was the first through fourth most proximate hospital. (DI #30, p. 155) The service area assumed for OB services at the replacement hospital includes over 50 zip codes, most within Prince George's County.

The projected OB case volumes in the defined service area have been declining. Relocating the hospital from Cheverly to Largo reduces the total service area population by 16.5% (DI #30, p. 156), but the projected reduction in women of child-bearing age is more modest, at 5.4% (2022). [52] The applicant projects a 2% decline in the OB use rate, from 66.7 discharges per thousand females aged 15-44 in 2012, to 65.3 per thousand in 2022 and subsequently to 64.9 per thousand in 2023. (DI #30, p. 155-157 and DI #96, p. 7-8)

The application projects that most of the decline in service area population and demand will be offset by capturing more of the market demand in the service area, which is largely Prince George's County. (DI #30, p. 157) PGHC's OB market share declined from 22% in 2011 and 2012 to 17.4% in 2013. The applicants project that the replacement hospital will rebuild its OB share to 19% by 2023, in part with out-of-service-area patients, and that the obstetrical unit will admit 2, 437 patients by 2023. At that volume, assuming that the average length of stay would be at the statewide average (2.65), and have a target occupancy rate of 75%, the applicants project a need for 22 beds in the obstetrical unit. The table below shows the current utilization of PGRMC's obstetrical program as modified August 31, 2016.

Table IV-22: Applicants' Current and Projected Obstetrics Utilization
FY 2013 - FY 2022

Obstetrics	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Number of Licensed Beds	36	38	38	34	34	34	34	22	22	22
Discharges	2,283	2,525	2,252	2,331	2,331	2,331	2,331	2,366	2,401	2,437
Patient Days	5,829	6,462	5,823	6,014	6,002	5,990	5,978	6,063	6,156	6,247
ALOS	2.55	2.56	2.56	2.56	2.56	2.56	2.56	2.56	2.56	2.56
Occupancy	44.4%	46.6%	41.9%	48.5%	48.4%	48.3%	48.0%	75.5%	76.7%	77.8%

Source: DI #96, Exh. 62, Table F1

[52] Source: Nielsen Claritas.

Interested Party Comments

No interested party submitted comments that addressed the need for obstetrical beds.

Reviewer's Analysis and Findings

Like the applicants, I have reviewed trends in use rates, using assumptions about service areas for the services similar to the applicants and based on patterns MHCC has observed in general hospital service areas, and also considered trends in ALOS and how well PGHC has maintained ALOS in line with its case mix. Finally, I reviewed the applicants' assumptions about PGRMC's future market share in its service area. The applicants project improved market share for the relocated hospital for a number of acute inpatient services. This is the case with obstetric hospitalization.

My forecast does not differ greatly from that of the applicants. I used a slightly lower average length of stay assumption in projecting the demand for OB beds, in line with PGHC's case mix and, like the applicants, I also assumed that the replacement hospital would gain market share, but at a more modest level than the applicants' target. These assumptions only partially offset the demographic and population use rate impact on reducing demand for postpartum bed capacity.

While the application projects a very steady level of use, with average daily census ("ADC") only ranging between 16 and 17 patients over the forecast period, my forecast was that demand for postpartum bed days may decline approximately 19% between 2014 and 2024 (a 14% decline in discharges). This yields an ADC forecast of approximately 14 patients in 2024.

For this reason, at the May 17, 2016 project status conference, I included OB bed capacity as an area for the applicants to consider in reducing the overall space at the replacement hospital. I noted that nineteen beds would be sufficient for the OB ADC that PGRMC would experience if my assumptions proved closer to the mark.

The applicants achieved the recommended space reduction, while maintaining the 22 postpartum beds and even increasing the amount of space dedicated to postpartum services from their 2015 replacement application. I note, however, that the replacement hospital will reduce postpartum space by approximately 36% from that at the existing hospital. In considering the three-bed difference in OB beds produced by the applicants' and my bed need forecast models, I have decided to accept Dimensions' decision to maintain a 22-bed postpartum unit. I have reconsidered my use of a 75% target occupancy rate (even though that was the target occupancy rate used by the applicant) because such an occupancy target may be a little high for the average daily census that I projected. The Obstetrics Services Chapter does not prescribe a target occupancy rate for OB beds but, as a point of reference, I note that the target occupancy rate for a pediatric unit with an average daily census ("ADC") of 7-24 beds is 65%. At a target occupancy rate of 65%, PGRMC would need 22 beds for the 5,202 patient days and the ADC of 14.2 that I projected for 2024.

I find that the applicant has complied with this standard.

(2) The Maryland Perinatal System Standards. ***Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.***

Introduction

That this standard is most applicable to new perinatal program development and is not specifically relevant to relocation of a general hospital with existing perinatal services.

Applicants' Response

PGHC is currently designated as a Level III[53] Perinatal Referral Center by the Maryland Institute for Emergency Medical Services Systems ("MIEMSS"). (DI #30, p. 157) According to the June 2014 Maryland Perinatal System Standards, a Level III hospital:

> Provides subspecialty care for pregnant women and infants … [including] acute delivery room and neonatal intensive care unit (NICU) care for infants of all birth weights and gestational ages … offer continuous availability of neonatologists … provide sustained life support with multiple modes of neonatal ventilation … [ready accessibility of] a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists …. Maternal care spans the range of normal term gestation care to the management of extreme prematurity and moderately complex maternal complications. Board-certified obstetricians have programmatic responsibility for obstetrical services. Board-certified maternal-fetal medicine specialists have programmatic responsibility for high-risk obstetrical services. Level III perinatal hospitals accept risk-appropriate maternal and neonatal transports.

The applicants note that, in response to PGHC's 2013 application for re-designation as a Level IIIb center, MIEMSS identified some standards that were not met, and issued a letter designating PGHC's Perinatal Referral Center as a Level IIIb on a one-year provisional basis, followed by four-years of probation that began on August 27, 2013. As a condition of this designation, the letter also requested that PGHC develop a Corrective Action Plan to address the concerns and deficiencies identified by MIEMSS.

PGHC filed its Corrective Action Plan and submitted subsequent quarterly reports detailing the hospital's progress in addressing this written work plan. On August 8, 2014, MIEMSS

[53] With the adoption of the June 2014 updates to the Maryland Perinatal System Standards, the previously designated Level IIIb center at PGHC, a designation consistent with the 2008 standards, was redesignated as a Level III center. For further information, see *Comparisons of Major Differences Between Maryland Perinatal System Standards 2008 and 2014*, available at: http://phpa.dhmh.maryland.gov/mch/Documents/Comparison_of_Major_Differences_Between_Maryland_Perinatal_System_Standards_2008_and_2013_updated.pdf.

conducted a follow-up site survey visit to review the progress of PGHC's corrective action plan in addressing areas of non-compliance with the perinatal standards. (DI # 30, Exh. 38) This resulted in MIEMSS issuing an August 26, 2014 letter concluding that PGHC complied with the requirements for a Level IIIb Perinatal Referral Center and modifying the program's designation status to "probation" for the remainder of the four-year designation cycle. While PGHC has probationary status, MIEMSS will continue to conduct follow-up site survey visits at six-month intervals throughout the remainder of the four-year designation cycle. MIEMSS stated that "should PGHC demonstrate continual ongoing compliance and sustainability in meeting the perinatal standards, [MIEMSS] would evaluate the need to continue with the six-month follow-up visits."

Reviewer's Analysis and Findings

The applicants provide a Level III perinatal service and proposes to continue to provide this level of service in the relocated hospital. I find that, based on MIEMSS' designation of PGHC as a Referral Center, the application complies with this standard.

(3) Charity Care Policy.

See discussion of this standard in the discussion of charity care standard in the Acute Care Hospital Services Chapter, COMAR 10.24.10.04B(2) Section IV-A, of this Recommended Decision, *supra*, p. 17.

(4) Medicaid Access. ***Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:***

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

Applicants' Response

The applicants state that "Dimensions provides care to all individuals, regardless of ability to pay or identity of payor" and that its policy is "to accept a patient for Medicaid obstetric services if the patient is a Maryland resident and has a pending Medicaid application filed." (DI #30, p. 158) The applicants point out that, in the first four months of FY 2015, there was an average of 179,359 Medicaid enrollees in Prince George's County.[54] The applicants note that all obstetricians and maternal fetal medicine physicians with privileges at PGHC participate in the Medical Assistance "Medicaid" program and accept Medicaid patients as required in this standard. (DI #30, p. 158)

[54] Applicants cite DHMH's Maryland Medical eHealth Statistics: http://www.chpdm-ehealth.org/mco/mco-enrollment_action.cfm.

Reviewer's Analysis and Findings

I find that the application is consistent with this standard.

(5) Staffing. ***Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, postpartum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.***

Applicants' Response

The applicants provided clinical staffing information for PGHC's obstetrical program for 2014 and projected 2022, itemizing staff FTEs by unit (i.e., labor and delivery, Postpartum, and Neonatal Intensive Care Unit) and by average salary and total expenses by FTE category. The applicants project a reduction in staffing at the replacement hospital. The following table provides staffing information for the obstetric service.

Table IV-23: PGRMC Obstetrical Staffing Projections
Current (2014) and Projected (2022)

Employee Category	2014 FTEs	2022 FTEs	Average Salary/ FTE	2022 Total Expense
Labor and Delivery	49.8	42.2	$87,355	$3,687,515
Postpartum	46.1	47.5	$89,589	$4,255,186
NICU	34.8	28.5	$99,549	$2,838,736
Total	130.7	118.2	$91,194	$10,781,436
Benefits (calculated @28.9%)				$3,115,075
Total Salaries and Benefits				$13,896,511

Source: DI #30, p. 159.

Reviewer's Analysis and Findings

I find that the applicants have complied with this standard.

(6) Physical Plant Design and New Technology. ***All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.***

Applicants' Response

The applicants identified the following features that will improve patient safety on the OB unit in the replacement hospital in Largo:

- Sufficient triage rooms so that patients will always be placed in a room with appropriate care and supervision;

- Dedicated recovery space for the c-section rooms (currently, patients recover in any available labor and delivery room);

- Labor and delivery rooms that provide an appropriate balance between patient privacy and visibility for clinicians; and

- Incorporation of an alarm system to maintain security on the unit.

(DI #30, page 160)

The applicants addressed further design and plan features with the PGRMC facility in their response to the Patient Safety standard, COMAR 10.24.10.04B(12).[55]

Reviewer's Analysis and Findings

The application complies with this standard.

COMAR 10.24.12.04, Standards (7) through (14).

None of these standards is applicable to this review, since each addresses a proposed new program. The standards include a standard for nursery services, community benefit planning, the source of patients, availability of physicians in non-metropolitan jurisdictions, designation of bed capacity for obstetric services, minimum admissions volume, impact on the health care system, and financial feasibility. I note that the Obstetric Services Chapter's minimum volume standard for approval of a new hospital obstetric service in a metropolitan area is 1,000 admissions. PGHC's case volume is well above that minimum.

(15) Outreach Program. ***Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01B.***

Applicants' Response

The applicants state that Dimensions works collaboratively with community partners that serve as referral sources for women in need of obstetrical and gynecological services. Among the community partners are: the Prince George's County Health Department; community health centers; local physicians; social services agencies; and other organizations in the County and surrounding area who identify uninsured, under-insured, and indigent patients and women in need of prenatal care (and seek to prevent low birth weight and infant mortality). (DI #30, p. 163)

[55] See discussion in Section IV-A, *supra*, p. 42.

The applicants also noted that Dimensions provides free community programs that help identify and refer women to the hospital's obstetrical services program. Some examples of these programs are: Beautiful Beginnings Tour; Childbirth Preparation Classes; free HIV testing; smoking cessation; and support groups such as Alcoholics Anonymous, Preemie Parent, Survivors of Rape/Sexual Assault, and WomenHeart. Since 2011, Dimensions has been a joint participant with the Pregnancy Aid Centers, Inc. ("PAC") to increase prenatal care for women in need. (DI #30, p. 164) PAC addresses the needs of low income and uninsured high-risk pregnant women who reside in Prince George's County, collaborating with Dimensions Healthcare Associates, an affiliate of Dimensions Healthcare System, to provide prenatal health services to African-American and Latina women and adolescents by determining a care plan for medically high-risk and low-risk maternity patients that includes referral to PGHC for delivery and surgical services if necessary.

Reviewer's Analysis and Findings

The applicants have provided a number of examples of Dimensions' outreach programs that serve low income and uninsured women who seek obstetrical, gynecological, and perinatal care.

I find that the applicant complies with this standard.

COMAR 10.24.17 State Health Plan for Facilities and Services: Specialized Health Care Services – Cardiac Surgery and Percutaneous Coronary Intervention Services

Background

The proposed project seeks to relocate an existing cardiac surgery and percutaneous coronary intervention ("PCI") service from Cheverly to Largo in Prince George's County. As noted in the Surgical Services standards section,[56] two of the proposed eight ORs will continue to be dedicated to cardiac surgery.

The State Health Plan chapter covering Cardiac Surgery and Percutaneous Coronary Intervention Services that was in effect when the original application in this review was filed provided that the provisions of the Chapter applied to the establishment of a new program to deliver adult or pediatric cardiac surgery and to the establishment of a new percutaneous coronary intervention ("PCI") program.[57] COMAR 10.24.17 ("Cardiac Surgery Chapter") was subsequently repealed and replaced, and now contains updated CON standards. This updated chapter was a response to 2011 and 2012 legislation reforming regulatory oversight of cardiac surgery and PCI services in Maryland. The current Cardiac Surgery Chapter, like the one it replaced, requires a hospital proposing to establish cardiac surgery services to demonstrate that it can achieve a minimum volume of 200 cases per year by the end of the second year of operation.

[56] See COMAR 10.24.11.05B(2) in Section IV-A of this Recommended Decision, *supra*, p. 22.
[57] COMAR 10.24.17.02E (effective March 19, 2012; replaced November 9, 2015).

Under the 2012 legislation and the 2014 revised Cardiac Surgery Chapter, hospitals in Maryland that provide cardiac surgery and PCI services will be subject to periodic evaluation of their performance in providing these services, through a formal process called certificate of ongoing performance review.[58]

Applicants' Response

The applicants stated that, because the relocation of cardiac surgery and PCI programs from PGHC to PGRMC does not involve creation of a new cardiac surgery service, this chapter of the State Health Plan is not applicable. MHCC staff posed several completeness questions on the initial CON Application concerning the provision of cardiac surgery at the new location. In response, the applicants described PGHC's cardiac surgery program and answered the completeness questions. The applicants stressed the importance of having cardiac surgery services available at PGHC, which is a Level II Trauma Center. They also pointed to Prince George's County's high death rate due to heart disease (224.2 per 100,000 population compared to a rate of 194.0 per 100,000 for the State and 130.2 in Montgomery County, as reported in the University of Maryland School of Public Health's report, *Transforming Health in Prince George's County, Maryland: A Public Health Impact Study, July 2012*). The applicants noted that Dimensions was collaborating with the University of Maryland Medical Center to rebuild it cardiac surgery program. (DI #30, p.189)

Interested Party Comments

Anne Arundel Medical Center

AAMC made a number of comments questioning whether the cardiac surgery program as proposed could meet the standards contained in COMAR 10.24.17.[59] It critiqued the application for not systematically addressing the Cardiac Surgery Chapter's standards. It stated that the applicants failed to demonstrate that the relocated cardiac surgery program would attain a minimum annual volume of 200 cardiac surgery cases by the end of the second year of operation and questioned the ability of PGRMC to rebuild its market share to a level that would attain the necessary minimum volumes. (DI #44, p.4)

Doctors Community Hospital

DCH did not comment on the applicants' compliance with cardiac surgery standard.

[58] The Certificate of Ongoing Performance reviews were scheduled to begin in 2016 but have been delayed due to protracted negotiations with the Society of Thoracic Surgeons ("STS") concerning data analyses needed by MHCC for which STS would be the best source. Recently, MHCC has reached agreement with STS on this work, and the first ongoing performance reviews of cardiac surgery should begin in late 2016 or early 2017.

[59] AAMC has a pending CON application seeking to establish a new cardiac surgery program. Issues regarding AAMC's ability to show that it can meet the volume requirement in the current Cardiac Surgery Chapter may be an issue in that review, but it is not an issue in this review.

Applicants' Response

The applicants' response pointed out that the Cardiac Surgery Chapter that was in effect when the application was filed did not specifically reference relocating a cardiac surgery program stating that "to relocate the existing PGHC cardiac surgery program to the replacement hospital, Dimensions is not required to meet any of the standards of the Cardiac Surgery SHP. Accordingly, all of AAMC's comments miss the mark." Despite that, the applicants stated that Dimensions was working on revitalizing its cardiac surgery program in partnership with UMMS, under the leadership of Dr. Jamie Brown and acknowledged that, in the future, the hospital would be required to obtain a Certificate of Ongoing Performance. (DI #50, p.21)

Reviewer's Analysis and Findings

The current Cardiac Surgery Chapter's standards are not applicable to the relocation of PGHC's cardiac surgery services. However, although the Cardiac Surgery Chapter in effect when this application was filed did not specifically reference relocation of a cardiac surgery program, a discussion of PGHC's cardiac surgery program is relevant.

When the original application was filed in 2013, PGHC had what can only be described as a failed cardiac surgery program. Review of the Maryland Discharge Data Base shows that the program hit bottom in calendar year ("CY") 2013, when only eight cardiac surgery cases were performed at PGHC. PGHC is the only hospital in Maryland that has consistently failed to reach an annual case volume of 200 cardiac surgery cases this mark in recent years. Under the current Cardiac Surgery Chapter, such a program is subject to consideration for closure.

The applicants acknowledges the failure of PGHC's cardiac surgery program. Dimensions appears to have had substantial success in rebuilding its program under the medical leadership of UMMS. In CY 2014, 29 cardiac surgery cases were performed and, in CY 2015, the program reached a case volume of 105. Partial data available for 2016 suggests that PGHC is likely to reach between 125 and 150 cardiac surgery cases in the current year.

As I previously noted, the current Cardiac Surgery Chapter's standards regarding relocation of a cardiac surgery program are not applicable in this review. However, the cardiac surgery program at PGRMC will be required to meet standards in the current Cardiac Surgery Chapter to obtain a Certificate of Ongoing Performance to continue the program after its relocation.

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COMAR 10.24.07 State Health Plan for Facilities and Services: Overview, Psychiatric Services, and Emergency Medical Services

I considered the proposed project's compliance with the applicable standards in COMAR 10.24.07 ("Psychiatric Services Chapter") of the State Health Plan. The Psychiatric Services Chapter is out of date due to changes that have occurred since its development regarding the use of psychiatric beds and the dramatic changes in use of hospital psychiatric beds (especially with

respect to average length of stay) and the role and scope of State psychiatric hospital facilities. In this section of my Recommended Decision, I review standards that are still relevant and applicable.

Interested Party Comments

No interested party commented on the application's compliance with standards in the Psychiatric Services Chapter.

Availability

Standard AP 1a: Bed Need

The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicants' Response

The application addressed the Psychiatric Bed Need standard in response to Standard .04B(2), Identification of Bed Need and Addition of Beds, in the Acute Hospital Services Chapter and in response to CON review criterion regarding need, COMAR 10.24.01.08G(3)(b). The applicants' response and my analysis are presented in more detail there.

Reviewer's Analysis and Findings

This standard requires an applicant to specify how many child, adolescent, and adult acute psychiatric beds it seeks so that the bed need for each age group can be assessed independently. An adult acute psychiatric program is planned for the replacement hospital, which is the patient population PGHC currently serves. The proposed replacement hospital will contain a physical bed capacity for 28 adult acute psychiatric beds, the number PGHC currently allocates for licensure, a reduction from the 31 beds of physical capacity PGHC reports for its current psychiatric unit. I note that, for inpatient and outpatient behavioral health programming, the applicants report that the replacement hospital will have approximately 25% more building space than the current hospital. The table below provides the actual (2013) and projected utilization for the current and proposed replacement psychiatric unit.

Table IV-24: Historic and Projected Psychiatric Utilization FY 2013 – FY 2022

Psychiatric	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Number of Licensed Beds	28	28	28	28	28	28	28	28	28	28
Discharges	1,399	1,359	1,348	1,348	1,348	1,348	1,348	1,357	1,366	1,375
Patient Days	7,392	8,264	6,541	6,282	6,260	6,197	6,135	7,896	7,870	7,921
ALOS	5.3	6.1	4.9	4.7	4.6	4.6	4.6	5.8	5.8	5.8
Occupancy	72.3%	80.9%	64.0%	61.3%	61.3%	60.6%	60.0%	77.0%	77.0%	77.5%

Source: DI #30, Exh. 1, Table F1.

My forecast model for acute psychiatric services supports the 28 beds of physical capacity proposed for acute psychiatric services at the replacement hospital.

I find that the application is consistent with this standard.

Standard AP 2a: Procedures for Psychiatric Emergency Inpatient Treatment

All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

Applicants' Response

The applicants' states that the adult inpatient psychiatric unit will have "written procedures of providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week, with no special limitation for weekends or late night shifts." (DI #30, p. 166) This program will have appropriate staffing for a program operating 24/7, with a licensed psychiatrist and a licensed psychiatric crisis clinician available on call at all times.

Reviewer's Analysis and Findings

I find that the application satisfies this standard.

Standard AP 2b: Emergency Facilities

Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

Applicants' Response

The applicants' state that DHMH currently designates "PGHC's Emergency Department to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition, and expects the ED at the replacement facility to serve this function as well." (DI #30, p 166)

They note that PGHC's Behavioral Health Services, Assessment and Stabilization Center ("ASC") is a comprehensive, hospital-based psychiatric service separate from the hospital's main ED. After the ED has medically cleared a psychiatric patient, s/he is transferred to the ASC for clinical assessment, evaluation, medical activities and interventions necessary to stabilize psychiatric or co-occurring psychiatric and substance abuse issues. (DI #30, p. 167) The ASC is staffed 24 hours per day/seven days per week. The replacement facility will continue to provide this evaluation service.

Reviewer's Analysis and Findings

I find that the application is consistent with this standard.

Standard AP 2c: Emergency Holding Beds

Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicants' Response

The applicant states that the current unit at PGHC has two seclusion rooms and that the replacement facility will have one inpatient seclusion room. (DI #30, p. 167)

Reviewer's Analysis and Findings

The inpatient unit at PGRMC will have sufficient resources for emergency placement and seclusion rooms. I find that the application satisfies this standard.

Standard AP 3a: Array of Services

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicants' Response

In response to this standard, the applicants state that PGHC's adult inpatient psychiatric program currently provides and that the replacement hospital will continue to provide an array of services that includes individual psychotherapy, group therapy, family meetings and education, social services, and art therapy and addiction counseling. (DI #30, p. 167) The Assessment and Stabilization Center's staff, which include licensed therapists, psychiatric nurses, case managers, and other staff specially trained in providing care to psychiatric inpatients, are dedicated to the psychiatric unit. The replacement hospital will offer services such as physical therapy, respiratory therapy, and medical intervention by departments that serve the entire hospital.

With regard to the provision of chemotherapy prior to discharge, the applicants state that the psychiatric unit will transfer the psychiatric inpatient to a specialty unit within the hospital, where a chemo-certified nurse will administer the drugs to the patient.

Reviewer's Analysis and Findings

I find that the applicants have met this standard.

Standard AP 3c: Psychiatric Consultation Services
All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicants' Response

The applicants state that PGHC's inpatient psychiatric unit has licensed psychiatric physicians available on staff as employees and through contractual arrangements. These physicians provide services that include: psychiatric crisis management (arrangement for psychiatric admissions to the unit or transfers to an appropriate facility); psychosocial crisis assessments; psychiatric referrals; and individual and group therapy. (DI #30, p. 168) PGHC has a Maryland-licensed psychiatrist as the medical director, who is responsible for assuring that consultative services are available for the inpatient psychiatric unit. The replacement facility will employ these same practices.

Reviewer's Analysis and Findings

PGHC currently offers and will continue to provide consultative services and a number of therapy groups and services to support the inpatient psychiatric program at the proposed PGRMC. I find that the application is consistent with this standard.

Accessibility

Standard AP 5: Required Services
Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;
(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or
(iii) necessary evaluation to define the patient's psychiatric problem and/or
(iv) emergency treatment.

Applicants' Response

The applicants state that PGHC has the required policies and procedures and provides the services in accordance with this standard, and that the replacement hospital will continue to provide these services for those patients with a psychiatric primary diagnosis. (DI #30, p. 169) They note that, at PGHC, the ED nurse triages patients with a primary psychiatric diagnosis, and the emergency physician performs an assessment to rule out a medical primary diagnosis. If assessed with a medical primary diagnosis or if assessed to require emergency medical treatment,

the patient is either treated in the ED, admitted to inpatient care, or transferred to an appropriate facility for medical care upon the orders of the ED physician.

If assessed with a psychiatric primary diagnosis, the patient is transferred to the Behavioral Health Services' Assessment and Stabilization Center ("ASC") for a psychiatric evaluation. If the patient requests admission for psychiatric care, the ASC clinicians and staff will obtain the patient's insurance information and either admit the patient to PGHC for psychiatric care or contact hospitals with the appropriate type of psychiatric bed if not available at PGHC. If the patient is admitted to PGHC for psychiatric care, the ASC staff will escort the patient to the inpatient unit. The patient remains at the ASC until the patient is transferred to PGHC's inpatient unit, or stabilized and cleared for release by the consulting psychiatrist. If a psychiatric bed is needed outside PGHC, once an outside facility agrees to accept the patient, the ASC clinician arranges transportation. The ASC nurse completes the paperwork for the transportation of the patient to the appropriate inpatient psychiatric service provider.

Reviewer's Analysis and Findings

I find that the application is consistent with this standard.

Standard AP 6: Quality Assurance

All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations, including: children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

Applicants' Response

The applicants responded to this standard by stating that PGHC's Behavioral Health Services program currently meets and will continue to meet this standard with regard to written quality assurance programs, program evaluation, and treatment protocols. (DI #30, p. 170) They state that PGHC's Behavioral Health Services program includes a 28-bed short-term inpatient care unit, which includes both voluntary and involuntary admissions, and outpatient services. PGHC's Plan for Quality Improvement (DI #30, Exhibit 39) includes: (1) staff participation in departmental and hospital wide projects such as restraint monitoring, pain assessment, falls, chart reviews and other applicable activities; (2) concurrent review of medical record documentation; (3) cross-training of assessment and stabilization, inpatient psychiatric unit, and partial hospitalization program staff to ensure that staff is knowledgeable to float as needed to ensure adequate staffing; and (4) routine meetings with all Behavioral Health Services departments to promote a team concept. The replacement facility will operate with these quality assurance program components and similar program evaluation and treatment protocols for adult psychiatric patients.

The current psychiatric unit serves adults exclusively and this patient population will continue to be the only one served at the replacement hospital. PGHC does not operate a distinct substance abuse program or a distinct, specialized program for geriatric patients. Based upon a clinician's individual assessment, non-adult patients or older patients needing a specialized

geriatric program will be referred to another facility that has the appropriate program for these patients.

Reviewer's Analysis and Findings

I find that the application is consistent with this standard.

Standard AP 7: Denial of Admission Based on Legal Status

An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicants' Response

The applicants state that, at PGHC, a patient's legal status is not now and, at the replacement hospital, will not be a basis for admission to the hospital's adult acute psychiatric or any other unit at the hospital. (DI #30, p. 170)

Reviewer's Analysis and Findings

I find that the application complies with this standard.

Standard AP 8: Uncompensated Care

All acute general and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12-month period.

See discussion of this standard in the discussion of the charity care standard COMAR 10.24.10.04A(2) in the Acute Care Hospital Services Chapter, Section IV-A of this Recommended Decision, *supra*, p. 17.

Quality

Standard AP 12a: Clinical Supervision

Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicants' Response

The applicants state that a qualified psychiatrist is the current Medical Director of the inpatient unit at PGHC and that a qualified psychiatrist will provide clinical supervision of the program at the replacement facility. (DI #30, p. 172)

Reviewer's Analysis and Findings

I find that the applicants have met this standard.

Standard AP 12b: Staffing Continuity
Staffing of acute inpatient psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

Applicants' Response

The applicants state that the acute psychiatric program will employ, either directly or through contractual arrangements, licensed therapists, counselors, and registered nurses who will be available on the unit 24 hours per day/seven days per week. (DI #30, p. 172)

Reviewer's Analysis and Findings

I find the applicants have satisfied this standard.

Continuity

Standard AP 13: Discharge Planning and Referrals
Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicants' Response

The applicants report that the PGHC inpatient psychiatric unit has written discharge planning policies and works with psychiatric experts to build upon the referral arrangement and community networks in order to provide seamless transition of patients to a full range of other services upon discharge. (DI #30, p. 173

Reviewer's Analysis and Findings

I find that the application is consistent with this standard.

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.

Introduction

I addressed the question of the need for this project in my review of compliance with the Acute Hospital Services Chapter's Cost Effectiveness standard, COMAR 10.24.10.04B(5).[60] The next section in this Recommended Decision, consideration of the costs and effectiveness of alternatives to this proposed project, the criterion in COMAR 10.24.01.08G(3)(c), will also touch on the issue of project need.[61] Two standards reviewed earlier addressed the need for specific service capacities: emergency department space and treatment capacity, in the Acute Hospital Services Chapter, at COMAR 10.24.10.04B(14);[62] and operating room capacity, in the General Surgical Services Chapter, at COMAR 10.24.11.05B(2).[63]

In the January 2015 replacement application, the applicants addressed the need for the proposed bed capacity of the relocated hospital, as required by COMAR 10.24.10.04B(2). At that time, the applicants proposed an increase in MSGA bed capacity relative to the existing hospital's licensed bed capacity and used similar methodologies to assess the need for each inpatient service. However, as I explained in my analysis and finding that the application is consistent with that standard, the number of MSGA beds proposed for the replacement hospital no longer constitutes an addition of MSGA beds beyond the current licensed capacity of PGHC and MWPH. Increases in inpatient volume at PGHC have meant that the State's dynamic licensing law provides a larger pool of licensed bed capacity for allocation by Dimensions to MSGA services. For this reason, I will first describe the applicants' demonstration of need for each inpatient service below, followed by a summary of Doctors Community Hospital's comments that address the need for the particular inpatient service, and the applicants' responses to comments. I end with my analysis of the application's compliance with this criterion and my findings.

Applicants' Response

Applicants: The Need for Replacement and Relocation of PGHC

As previously addressed in my discussion of COMAR 10.24.10.04B(5), the applicants presented an analysis of PGHC's existing facility and site that did not support continued use of the existing hospital building for acute care functions. The applicants stated that replacement or expansion on site would involve significant disruptions, an extended time frame, higher estimated costs, and an inability to properly address all program and adjacency requirements. (DI #30, p. 102)

Applicants: Service-Specific Bed Need

The proposed replacement hospital was originally designed with the capacity for a total of 216 acute inpatient beds, including 165 MSGA beds, 22 obstetric beds, 28 psychiatric beds and one pediatric bed, with all beds in single-patient occupancy rooms. The design also included space

[60] See discussion in section IV-A of this Recommended Decision, beginning at p. 27, *supra*.
[61] See discussion in section IV-C of this Recommended Decision, beginning at p. 102, *infra*.
[62] See discussion in section IV-A of this Recommended Decision, beginning at p. 54, *supra*.
[63] See discussion in section IV-A of this Recommended Decision, beginning at p. 64, *supra*.

for 15 beds to be licensed and operated by Mount Washington Pediatric Hospital. The project included (and still includes) 20 dedicated observation beds, which are not part of acute hospital bed capacity available for admission of inpatients.[64] In response to the May 17, 2016 project status conference, the applicants redesigned the replacement hospital and reduced the general hospital bed capacity to 205 beds, eliminating 11 MSGA beds.

Applicants: Need Projections in the January 2015 Replacement Application

In projecting future inpatient utilization, the applicants stated that they took a number of factors into account, including:

- Changes in the service area population resulting from the relocation of the hospital;
- Projected increases in the 65 and older population of Prince George's County;
- Recent Prince George's County inpatient utilization rates, national, and Maryland inpatient use rates were considered; and
- PGHC's existing recent initiatives to reduce inpatient case volume (e.g., conversion of one-day inpatient stays into observation cases and progress in reducing readmissions/avoidable admissions).

Applicants: Service Area Determinations

The applicants defined a likely service area for each general hospital inpatient service proposed for the replacement hospital at Largo. The applicants stated that they utilized the methodology outlined in the 2012 Recommended Decision regarding Adventist HealthCare, Inc.'s initial CON application proposing the relocation of Washington Adventist Hospital (Docket No. 09-15-2295). The application split PGHC's 2013 inpatient discharges into three MSGA age groups and single age groups for each of the other services as follows:

- MSGA 15-64
- MSGA 65-74
- MSGA 75+ (age group broken out from the MSGA 65+ age cohort at the request of the HSCRC)
- Obstetrics (females 15-44)
- Pediatrics 0-14
- Psychiatry 18+

To determine the zip code areas to include in the expected 85% service area for the Largo site, the applicants used the drive times from zip code areas to the region's hospitals.[65] Their time

[64]Observation is categorized by HSCRC as an outpatient service, although patients may be observation patients for longer than 24 hours.

[65]Applicants' source: Spatial Insights, 2012 US TIGER version of Freeway software product at moderate

estimates used the population centroids of each zip code area, which were sorted by proximity, as defined by drive time, to PGHC's current location.

- The 2013 discharges within those sorted zip code areas were summed until they equaled 85% of PGHC's total 2013 discharges within each age cohort.

- Discharges from out of state zip code areas were excluded from the service area definition.

- The zip code areas that fell within the 85% of total discharges for each cohort were grouped by a ranking of PGHC's proximity relative to other hospitals that serve those zip code areas. The service area for MSGA 15-64 was defined as those zip code areas that contributed less than 85% (78.3%) of PGHC's total 2013 MSGA 15-64 discharges because the rest were predominately out of state volumes.

- The hospital rankings were then applied to the zip code areas surrounding the future Largo site for PGRMC to determine those zip code areas for which PGRMC would be the closest up to the highest ranking of the zip code areas that contributed 85% or more of PGHC's 2013 discharges for that service and age group[66] except for the MSGA15-64 age group for which the zip code areas accounted for 78.3% of discharges. (DI #30, pp. 54-55)

Applicants: Impact of Changes in Population and Use Rates

Based on population data from Claritas,[67] the applicants determined that, in 2012, the service area identified for the proposed hospital location had less population than PGHC's existing service area population. The analysis also showed that the 2022 projected population for the proposed service area is less than the 2012 population of the existing service area except for the older population groups (65-74 and 75+) where the projected population for the proposed service area is greater than the 2012 population for these age groups, all as detailed in the following table.

Table IV-25: Applicants: Comparison of PGHC and PGRMC Service Area Populations in 2012 and PGRMC Projected 2022

Age Groups	PGHC Service Area 2012 Population	PGRMC Service Area Population		
		2012	2022	Percent Change
75+	42,466	34,792	51,601	48.3%
65-74	68,447	55,106	92,052	67.0%
15-64	746,598	644,648	658,017	2.1%
0-14	198,006	168,128	173,139	3.0%
TOTAL	**1,055,517**	**902,674**	**974,809**	**8.0%**

traffic levels. (DI # 30, p. 54)

[66] For some services zip code areas of the same proximity ranking accounted for more than 85% of the discharges. For example, for OB discharges, the 85% service area was reached with zip code areas for which PGHC was the fourth closest hospital among those hospitals offering inpatient obstetric services. These zip code areas accounted for 90.8% of PGHC's 2013 OB discharges.

[67] Claritas is now owned by Nielsen.

Psychiatric (18+)	813,989	670,188	737,554	10.1%
Obstetrics (female 15-44)	197,916	169,791	160,659	-5.4%

Source: Replacement Application (DI #30, p. 66)
Note: The psychiatric and obstetric populations are subsets other age groups included above and the total.

To project future hospital use, the applicants relied upon forecasts from a health care analytics consultant (Sg2) and an actuarial consultant (Milliman). The projected changes in inpatient utilization rates were developed in conjunction with a review of 10-year inpatient utilization forecasts. Forecasts for the years of 2013, 2018, and 2023 were based on a projected national ten-year decline of total discharges of 3.7% and a projected national inpatient utilization rate decline of 9.7% from 125.7 to 113.5 per 1,000 population. The forecast includes all DRGs including neonatal/newborn discharges. Factors considered include: population growth; economic factors; changes in healthcare technology; policy formation; and changes in the provision of care. Milliman projected that, under moderate levels of management, inpatient admission rates (exclusive of newborns) per 1,000 population would drop from 103 in 2011 to 88 in 2021, a 14.6% decline. (DI #30, pp. 62-64)

The applicants calculated the Prince George's County 2012 utilization (discharge) rate including newborns to be 107.5 per 1,000 population, compared to Sg2's calculation of a national rate of 125.67. Based on this comparison and the forecasted national trends, the applicants concluded that it was appropriate to assume that a reduction in MSGA utilization rates of 11.2% would occur over the projection period. The applicants also expect obstetric rates to decline by 2%, pediatric rates to increase in 2013 and then decline from 2014 through 2017, and the psychiatric use rate to remain unchanged over the projection period. The applicants assumed that rates in later years would level off as the drivers of the declines (e.g., reductions of readmission rates, reduced avoidable admissions, and the success of patient-centered medical home management initiatives) would have expended much of their potential and be offset by changes in population, particularly growth in the elderly population, high-level users of hospital services. (DI #30, pp. 64-65)

The projected 2022 use rates were multiplied by the 2022 projected population at the age group level for the proposed PGRMC service area to determine the expected service area discharges by service and age group. Total discharges by zip code area were determined using each zip code area's proportion of the total service area discharges in 2013. (DI #30, p. 65)

Applicants: Change in Market Share Due to Relocation

For each of the zip code areas in PGRMC's projected service areas, the applicants started with the initial expected market share at PGRMC based on PGHC's average market share for zip code areas of a similar proximity ranking in FY 2013. Using PGHC's 2013 data, the applicants calculated the average market share for all of the zip code areas where PGHC was the closest hospital. They then applied this average market share to all zip code areas where PGRMC would be the closest hospital, in terms of travel time.

Two examples by the applicants are described below.

- PGHC is currently the third closest hospital to zip code area 20716 and, in 2013, had a 5.0% market share of the discharges of MSGA 15-64 year olds from that zip code area. PGRMC in Largo would be the closest hospital to that zip code area. In 2013, PGHC had an average market share of 21.2% of MSGA 15-64 discharges in zip code areas where it ranked as the closest hospital. Therefore, the applicants assumed an initial market share for the replacement hospital of 21.2% for that zip code area.
- Similarly, PGHC was ranked as the closest hospital to zip code area 20710 in 2013 and had a market share of 30.1% of MSGA 15-64 discharges. Upon moving to Largo, PGRMC would be the fourth closest hospital for this zip code area. In 2013, PGHC's average market share in zip code areas where it ranked as the fourth closest hospital was 3.4%. For this reason, the applicants assumed the same initial market share for zip code area 20710 for the replacement hospital in Largo.

The applicants followed this procedure to determine the initial expected market share for each service and age group for each zip code area in the service area defined for the relocated hospital. (DI #30, pp. 66-68)

Following the basic methodology summarized in the 2012 Washington Adventist Hospital initial Recommended Decision, the applicants adjusted the initial expected market share to account for the relative strengths of other hospitals in each zip code area. For each zip code area within each of the six cohorts, an independent proximity adjustment calculation was performed taking into account hospitals with more than a 3% market share in PGRMC's service area zip code areas ("proximity hospitals"). All other hospitals' market shares were assumed to remain the same after PGHC's relocation. (DI #30, pp. 68-69)

The applicants calculated these adjusted expected market shares by assuming that the future total market share of PGRMC and the proximity hospitals will equal the total market share of PGHC and the proximity hospitals observed in 2013. As an example, for zip code area 20716 (noted above), PGHC had a 2013 MSGA market share of 5.0% for the 15-64 age group and PGRMC is expected to have an initial market share of 21.2% based solely on the change of the hospital's proximity ranking due to relocation. The applicant noted that, in 2013, the proximity hospitals and their market shares were: 30.2% for Anne Arundel Medical Center; 15.4% for Doctors Community Hospital; 9.7% for MedStar Washington Hospital Center; 6.4% for Holy Cross Hospital; 4.7% for Johns Hopkins; and 3.1% for MedStar Georgetown University Hospital. The total of these hospitals' market shares plus PGHC's was 74.4%. Substituting the initial expected market share for PGRMC in Largo for PGHC's market share brings the total to 90.7%. The applicants adjusted the market shares of the proximity hospitals and PGRMC to total 74.4%, reducing the expected market share for PGRMC from 21.2% to 17.4%. The applicants also calculated expected market shares for each of the proximity hospitals, and determined that, as a result of the relocation, Anne Arundel Medical Center's market share for the 15-64 age group would decrease from 30.2% to 24.7% and Doctors Community Hospital's expected market share would decrease from 15.4% to 12.6%. (DI #30, pp. 69-70)

Similar calculations of proximity-adjusted markets shares were performed for each of the other zip code areas by service and age group. The resulting projected changes in the PGRMC's

market share for its expected 2022 Largo service-specific service areas are shown in the table below. (DI #30, p. 70)

Table IV-26: Applicants: Projected Changes in Discharges and Market Shares from PGHC's current to Largo Service Areas as a Result of Projected Changes in Population, Use Rates, and Relocation Proximity Adjustments

	PGHC Discharges and Market Share in Defined PGRMC Service Area 2013		Projected Changes in Discharges			Total Projected FY 2022 Discharges & Market Share	
	Discharges	Market Share	Projected Population	Use Rate Adjustment	Relocation Proximity Adjustment	Discharges	Market Share
MSGA & Pediatric	5,286	7.6%	976	-434	349	6,177	8.0%
Obstetric	1,955	17.4%	-104	-24	-130	1,697	16.2%
Psychiatric	1,078	29.0%	92	8	3	1,179	29.0%
ALL SERVICES	**8,319**	**9.9%**	**965**	**-453**	**222**	**9,053**	**9.9%**

Source: January 2016 Replacement Application (DI #30, p. 71)

Applicants: Market Recapture

In addition to the projected changes in projected volume resulting from changes in use rates, population, and market share adjustments due to relocation, the applicants projected increased volume due to market recapture. Specifically, they identified growth opportunities for the replacement hospital by analyzing data by service line back to 2001 to determine historical trends and growth areas for the relocated hospital. The applicants concluded that there were significant growth opportunities in the cardiac, vascular, oncology, orthopedics, and trauma service lines, based on interviews with physicians, recruitment plans, and new clinics and programs. The application noted that Dimensions has been working with the University of Maryland School of Medicine to assist with some specialty physician needs. (DI #30, pp. 70-71)

To project the volume of discharges associated with the recapture of market share, the applicants: (1) allocated the projected volumes to the 26 MSGA service lines as well as obstetrics and psychiatry based on the FY2013 allocation of discharges by service line by age group and service; and (2) multiplied the projected discharges for each service line by the market share expected at PGRMC for each of these service lines (based on PGHC's historic market shares for that service line and specific strategic plans for that service line, including the recruitment of additional physicians).

The applicants' projected discharges and market shares after these recapture adjustments are detailed in the following table. (DI #30, pp. 76-80)

Table IV-27: Applicants: Comparison of Projected Changes in Discharges and Market Shares Pre- and Post-Market Recapture Assumptions

	FY 2013 PGHC from PGRMC Expected Service Area		FY 2022 Pre-Market Recapture Projections for PGRMC from its Expected Service Area		FY 2022 Post-Market Recapture Projections for PGRMC from its Expected Service Area	
Service	**Discharges**	**Market Share**	**Discharges**	**Market Share**	**Discharges**	**Market Share**
MSGA & Peds.*	5,286	7.6%	6,177	8.0%	9,165	11.9%
Obstetrics	1,955	17.4%	1,697	16.2%	1,991	19.0%
Psychiatry	1,078	29.0%	1,179	29.0%	1,179	29.0%
TOTAL	**8,319**	**9.9%**	**9,053**	**9.9%**	**12,335**	**13.4%**

Source: January 2015 Replacement Application (DI #30, pp. 71, 79-81)
* Includes 28 projected pediatric discharges and 9,137 MSGA discharges in FY 2022 from PGRMC service area zip code areas.

Applicants: Projected Total 2022 Discharges

The applicants adjusted the projected discharges shown above for out-of-service area discharges based on the percentage of 2013 out-of-service-area discharges for each service and age group.[68] These out-of-area discharges ranged from 10% to 28%. (DI #30, pp.80-81; DI #36, pp. 17-18)

Applicants: Average Length of Stay

The applicants stated that initiatives implemented by Dimensions to decrease ALOS have generated progress, and that further programs were planned to further improve its position with the goal of placing the hospital at the Statewide ALOS. Thus, the applicants projected decreases in ALOS for MSGA and OB patients who will be admitted to PGRMC, as detailed below.

Table IV-28: Applicants' Projected Changes in PGHC Average Length of Stay FY 2013 to FY 2022

Age Group	Actual 2013	Projected 2022	Percent Change
MSGA 75+	6.51	5.00	-23.3%
MSGA 65-74	6.83	5.24	-23.3%
MSGA 15-64	5.40	4.47	-17.1%
Pediatrics	2.63	2.63	0.0%
Obstetrics	2.78	2.65	-4.7%
Psychiatric	5.45	5.76	5.7%
Average for All	5.29	4.53	-14.4%

Source: January 2015 Replacement Application (DI #30, p 81
Note: the overall projected decrease in MSGA average length of stay is 19.0%

Applicants: Patient Days, Occupancy Rates, and Bed Need

The applicants multiplied their 2022 average length of stay assumptions by the projected 2022 discharges by service and age group to arrive at a projection for patient days at the new

[68] 0-14 for Pediatric and 15-64, 65-74, and 75+ for MSGA.

facility in 2022. The following table details the result of this step and the projected occupancy rates at the proposed bed capacities.

Table IV-29: Applicants: Projected 2022 Discharges, Patient Days, ALOS, and ADC PGHC Replacement Hospital

Service/Age Group	Total Discharges	ALOS	Patient Days	Average Daily Census	Proposed Beds (1/16/15)	Bed Occupancy Rate
MSGA						
15-64	6,343	4.47	28,353			
65-74	2,367	5,24	12,403			
75+	2,507	5.00	12,535			
Total MSGA	**11,217**	**4.75**	**53,311**	**146.1**	**165**	**88.5%**
Pediatric	32	2.63	84	0.2	1	0.3%
Obstetric	2,193	2.65	5,809	15.9	22	72.3%
Psychiatric	1,375	5.76	7,921	21.7	28	77.5%
TOTAL	**14,818**	**4.53**	**67,125**	**183.9**	**216**	**85.1%**

Source: January 2016 Replacement Application (DI #30, pp. 81-82); March 13, 2015 Response to Completeness Questions (DI #36, Exh. 50, Table F1)

The applicants propose to relocate the 15 MWPH beds from PGHC to the new PGRMC facility. Over the past five years, about 6% of admissions to the MWPH unit have come from PGHC. About 33% have come from Johns Hopkins Hospital and 11% have come from Johns Hopkins Bayview Medical Center. Another 8% have come from Children's National Medical Center in Washington, D.C. (DI #30, p. 206)

Because MWPH is a statewide resource, the applicants used the statewide pediatric population as the base of projections. Only the Maryland Department of Planning's statewide population for age 0-4 were used, because MWPH at PGHC seldom has any patients older than four years old. (DI #30, p. 207) Future use rates were projected using a number of methods including the average of the 2013 and 2014 use rates, and the rate of increase from 2009 through 2014. Using the latter method and the average length of stay over the four-year period from 2010 through 2014,[69] the applicants projected a need for 14.5 beds in the MWPH unit by 2022 and 15.6 beds by 2024 at an assumed average annual occupancy rate of 65%. (DI #36, p. 30 and Exh. 56)

Interested Party Comments

Anne Arundel Medical Center did not have any comments with respect to the applicants' response to the Need criterion

Doctors Community Hospital

Doctors Community Hospital's comments focused on standard B(2) of the Acute Care Hospital Services Chapter of the State Health Plan, Identification of Bed Need and Addition of Beds, which requires that a proposal to increase capacity of MSGA beds be justified in one of four ways.[70] DCH questions the need for the number of MSGA beds proposed in relationship to the

[69] The average length of stay was 24.3 days.

[70] I note that, while the January 2015 replacement application proposed an increase of MSGA beds above

need analysis in the Acute Care Hospital Services Chapter. DCH highlighted the decline in utilization that is reflected in the change in the Commission's projected minimum gross MSGA need for Prince George's County from 671 beds (published March 26, 2010 and in effect when Dimensions submitted its original 2013 application) to a minimum bed need projection for 487 beds (published March 7, 2014 and in effect when Dimensions submitted its 2015 replacement application).

DCH pointed out that the 2010 projection was based on older data that did not reflect the more recent decline in utilization. It also pointed to the decline in licensed MSGA beds in the five Prince George's County hospitals from 663 to 552 between FY 2010 and FY 2015. DCH stated that this reduction in licensed beds was in part a result of declining discharges and patient days at the hospitals. DCH noted that the total decrease for the five hospitals from 2009 through 2013 was 6,014 discharges (13%) and 11,031 patient days (5.5%). It further noted that patient days decreased an additional 33,715 days (17.8%) from 2013 to 2014. Finally, DCH cited the Commission's projection of a negative minimum net bed need in reaching the conclusion that there is no need for additional MSGA beds in the County. (DI #46, pp. 4-8 and Exh. F)

In summary, DCH stated that, in light of the likely continuation of a decline in inpatient utilization, the applicants have not presented sufficient evidence of need for additional MSGA beds by the population to be served. It noted that the fact that a significant percentage of the County's residents choose to receive hospital care at hospitals in bordering counties and in D.C. and Virginia does not mean that there is unmet need. DCH also raised questions about the projected market recapture assumed by the applicants, noting that these assumptions yield high impact projections. (DI #46, pp. 7-11)

Applicants' Response to Comments

In response, the applicants stated that they had demonstrated the compliance of the project with COMAR 10.24.10.04B(2), the standard in the Acute Care Hospital Services Chapter that addresses MSGA bed need, and with the Need criterion. The applicants pointed out that DCH only challenged the need for MSGA bed capacity and responded primarily in terms of the wording and interpretation of the bed need standard in the Acute Care Hospital Services Chapter. They noted that PGHC's total licensed beds and licensed MSGA beds would be increasing, thus rendering any further argument concerning consistency with the standard moot. (DI #50, pp. 3-5)

The applicants also responded to DCH's questioning of the reasonableness of their market recapture assumptions, citing a March 13, 2013 response to completeness questions in which they provided the detailed strategies being implemented to recapture volume in specified service lines. They also pointed out PGHC's positive volume growth for the period July 2014 to December 2014, as documented in data released by the HSCRC on April 22, 2015, in which PGHC experienced a

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the number of PGHC's licensed beds at the time, the number of acute care hospital beds licensed at PGHC has subsequently increased to the point where they exceed the number of beds proposed for the relocated hospital. See also, the discussion of DCH's comments and my analysis regarding COMAR 10.24.10.04B(2), Identification of Bed Need and Addition of Beds, in Section IV-A of this Recommended Decision, beginning at page 22, *supra.*

12.9% increase in Equivalent Case Mix Adjusted Discharges in its primary service area,[71] including an increase of 6.5% in admissions and observation cases. The applicants said that this trend would continue into the second half of FY 2015.

Reviewer's Analysis and Findings

I initially note that some aspects of need for this proposed project and its service capacity are addressed in my review of other standards and criteria in this Recommended Decision. Both the Cost Effectiveness standard, COMAR 10.24.10.04B(5),[72] and the project review standard regarding Emergency Department Treatment Capacity and Space, COMAR 10.24.10.04B(14),[73] are addressed in the Acute Hospital Services Chapter. Discussion of the need for operating rooms is discussed in my review of the General Surgical Services Chapter, at COMAR 10.24.11.05B(2).[74] I will not repeat those discussions here. Thus, my discussion of this criterion will focus on the need for bed capacity in the three acute care services that PGHC provides at a substantive level: MSGA; obstetric; and psychiatric.

The need criterion requires the Commission to consider the applicable need analysis in the State Health Plan. Where there is no need analysis, the Commission is required to consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs. While the applicants responded to this criterion in part with references to other parts of the January 2015 replacement application, I have described, with a fair amount of specificity, their methodology for projecting the proposed bed need capacity for each of the inpatient services planned for the Largo replacement hospital. The applicants' demonstration of need for the MWPH unit was submitted in response to the need criterion.

While the applicants' response to need focused on bed need for the inpatient categories of services to be provided at the relocated hospital, this criterion is broader. Therefore, although I will provide a detailed discussion of the bed need questions specifically addressed by the applicants under this criterion, I will also briefly summarize my other need-related findings here.

I conclude, as have many others, that Prince George's County needs a new general hospital that is modern, financially stable, and sustainable over the long-term, and also competitive with other hospitals and health care providers in the Washington, D.C. metropolitan area. I saw the need first-hand in my September 2015 visit to the Prince George's Hospital Center campus. The facilities are old and outdated, and poorly designed for meeting current needs, let alone future demands. The physical plant has clearly outlived its usefulness. PGHC is the sole provider of some critical medical services in the County and an important provider of other inpatient and outpatient diagnostic and treatment services needed by the community. It must become the attractive alternative for physicians, patients, and payors that the current PGHC is not.

[71] This measure is based on changes in volume excluding undesirable utilization such as readmissions and admissions for ambulatory-sensitive conditions.
[72] See discussion in Section IV-A of this Recommended Decision, *supra*, p. 26.
[73] See discussion in Section IV-A of this Recommended Decision, *supra*, p. 55.
[74] See discussion in Section IV-A of this Recommended Decision, *supra*, p. 64.

As previously noted, the Need criterion provides that if no State Health Plan analysis of need applies, the Commission shall consider whether or not an applicant "has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs." The Commission projects need for MSGA and pediatric beds. While there is a need standard for obstetric beds in the Obstetric Services Chapter, there is neither a specific methodology nor specific bed need projections for obstetric beds. As I pointed out earlier, the bed need projection standard in the Psychiatric Services Chapter is out of date. I previously described and analyzed the applicants' demonstration of need for all of these service and summarize my analysis and findings below.

The January 2015 replacement application proposed the construction of a replacement general hospital with 216 acute care beds, 165 medical/surgical[75] beds, 22 obstetrics beds, one pediatric bed, and 28 acute psychiatric beds. Both the existing hospital and its proposed replacement house "a hospital within a hospital" in space leased to co-applicant Mt. Washington Pediatric Hospital, which has 15 special hospital-pediatric beds.

I find the applicants' projections of need for MWPH's special hospital-pediatric beds are appropriate to the needs of the statewide population that MWPH serves, and note that the SHP's needs analysis for pediatric beds is prepared on a jurisdictional basis. The needs analysis in the SHP projects need for both MSGA and pediatric beds that is detailed in the following table.

Table IV-30: State Health Plan Need Projections for MSGA and Pediatric Beds in Prince George's County

	2022 Gross Bed Need		FY 2017 Licensed & Approved Beds	2022 Ned Bed Need	
	Minimum	Maximum		Minimum	Maximum
MSGA	487	663	569	-82	+94
Pediatric	2	2	6	-4	-4

Source: *Maryland Register*, Volume 41, Issue 5, pp. 356-357 (March 7, 2014); MHCC Annual Report on Selected General and Special Hospital Services, Fiscal Year 2017

I note that the original proposal for 165 MSGA beds and one pediatric bed at the replacement hospital represent small decreases in beds that would contribute to meeting the minimum bed need. However, it was not clear that all of the proposed bed capacities were necessary at the replacement hospital, a specific question that cannot be answered at the aggregate level of Prince George's County found in the Commission's bed need projections. My thinking on this issue has been influenced by recent trends in demand for hospital bed capacity, which are broader and more important indicators of demand in the future than stabilization and increases seen at PGHC in relatively brief recent time periods. I have also reviewed this project in light of the Maryland hospital payment model, which is still fairly new. Its full impact on system demand is not yet known but it does incorporate and will continue to evolve incentives for reducing inappropriate demand for inpatient hospital care. Therefore, I conducted a detailed analysis of the

[75] These beds are categorized, for Maryland health planning purposes, as medical/surgical/gynecological/ addictions "MSGA" beds and include general medical/surgical beds and intensive or critical care beds.

applicants' projection methodology and ultimately prepared my own projections as detailed in the following discussion.

Need for Acute Care Beds

I note that, over the last fifteen hospital licensure years,[76] Prince George's Hospital Center has experienced a decline in acute care average daily census of 39 patients (14.1%).[77] During this period, acute care average daily census ("ADC") at PGHC peaked in fiscal year (FY) 2002, at 207.1 patients and hit its lowest point, just under 153 patients, in FY 2012, a slide of over 26% over a ten-year period. While PGHC has experienced an increase in acute care ADC since that trough, to 169.3 patients in FY 2015, data provided by HSCRC on May 3, 2016 shows that both readmissions and admissions associated with conditions that could have potentially been prevented through more effective outpatient care delivery increased between calendar years 2014 and 2015.[78] This is a direction contrary to the goals of Maryland's new hospital payment model.

The applicants' project that PGHC's acute care ADC will increase by approximately 9% between 2015 and 2022, primarily based on an assumption that the replacement hospital will make substantial gains in regional market share, with much of this market recapture assumed to come from Washington, D.C. hospitals.

My analysis indicates that the applicants' utilization projections are aggressive, especially as they relate to gains in market share. I share Doctors Community Hospital's concern with the reasonableness of the assumptions. The projections of future volume are also likely to be too high because the applicants assumed that the MSGA discharge rate would level off after 2017, an assumption that runs counter to the SHP bed need methodology that calls for the discharge rates over the 10-year projection time frame to be based on recent trends, which have been declining. I note that this leveling off is also counter to the trends projected by Sg2 and Milliman, the two sources used by the applicants as a basis for their use rate assumptions. While one might argue that such leveling off is justified by the fact that recent evidence suggests that Maryland's discharge rate has been slightly lower than the national average in recent years, the current incentives in the Maryland payment model are likely to continue to drive such rates lower.

I foresee a market in which hospitalization rates are likely to continue to decline in line with recent trends and the objectives of the payment model established in Maryland in 2014. I also assume that the Medicare length of stay for medical/surgical patients, which is falling, will experience some further reduction and non-Medicare length of stay will see a slight increase. Most importantly, I have concluded that it is not likely that the gains in market share projected by PGHC will come as quickly as Dimensions has forecast and it is prudent to assume that the relocated hospital will be moderately successful in rebalancing competition among the systems and

[76] The twelve-month periods ending on March 31 of each year; here, through FYE March 31, 2015.
[77] This period corresponds with Maryland's current process for licensing acute care beds. ADCs and fiscal years referenced here are those used in licensing, the twelve-month periods that end on March 31.
[78] I note that this volume increase was cited by PGHC in responding to the HSCRC staff's October 23, 2015 assessment of the risk HSCRC staff saw in the competitiveness of the hospital's rate if volume increases were not achieved; however, PGHC's response did not address the disappointing direction that readmissions or Prevention Quality Indicators took in 2015.

independent hospitals drawing patients from Prince George's County and the surrounding jurisdictions.

My analysis used Prince George's County as the service area for projecting need rather than the applicants' approach, which developed a service area based on the zip code area proximity, zip code area patient volume, and shifting market shares. While I considered a quantitative approach to identifying future service areas for the relocated hospital, I concluded that such methods were relatively uncertain. Given that the hospital is currently a major provider for Prince George's County and the intent of this project is to enhance that standing significantly, I concluded that using all zip code areas in the County was the best geographical area for projecting future need.

I developed projections for three categories of beds: MSGA; obstetrics; and psychiatric. I projected discharges by zip code areas for the year 2024 based on the five-year and 10-year discharge rate trends by service and age groups, consistent with the variables used in the SHP analysis for MSGA beds, and the projected 2024 population for that age group[79] in that zip code area provided by Nielsen. This calculation produced projections of total discharges by payor and age group for each zip code area. I multiplied total discharges by market share assumptions that assumed that PGRMC will have some success in "rebranding" and becoming more like other similar Maryland/D.C. suburban hospitals with respect to its market power. My market share assumptions were based on the proximity rank of the future PGRMC to Prince George's County zip code areas and assumed that PGHC's market share/proximity rank relationship when it relocates to Largo will be more like that experienced by a group of "benchmark" Maryland hospitals in the DC metro market.[80]

Thus, while I do not assume that the applicants' market recapture assumptions can be achieved in the projection time frame, I do believe that the construction of a new facility at a new location operated by the University of Maryland Medical System should experience incremental improvement in market share. The scenario used in my analysis gives some currency to the applicants' assumption that the rebranding and resource infusion planned for the new Prince George's Regional Medical Center will indeed enable it to perform more like other similarly-situated DC suburban hospitals. However, this improvement is softened by assuming that PGRMC, within the first five years of operation, will achieve a market share improvement that will increase its share halfway between its current share and the level of market share that has been achieved by the benchmark hospitals. It is important to remember that the observed market shares of the more successful hospitals in the Maryland suburbs of D.C. should not be viewed as a model for the future, because these hospitals have achieved higher market shares in an era when their regional market has included older, weakening hospitals such as (PGHC and Laurel Regional). Washington Adventist is positioned to be a stronger competitor in the near future with its new Silver Spring hospital campus and a modernized outpatient campus in Takoma Park (a path also planned for

[79]MSGA discharge rates examined were based on Medicare and Non-Medicare discharges and the population projections used were for two age groups, the population aged 15-64 and that aged 65 and older. For obstetrics, both the discharge rate and the population projection were for females 15-44. Psychiatric use rates are for adults aged 15 and older, consistent with the patient population proposed to be served at the replacement hospital.

[80] Adventist Shady Grove, Holy Cross Silver Spring, Washington Adventist, and Suburban Hospital.

Laurel Regional) and PGHC is also hoping to boost its competitiveness with this project. But the future is more likely to involve a gradual rebalancing of market strength and my assumptions reflect this notion.

My calculations[81] resulted in projection of a need for: 154 MSGA beds, 11 fewer than proposed; 19 obstetric beds, three fewer than proposed; and 31 psychiatric beds, three more than proposed. Therefore, I recommended that the applicants modify the project design to reduce constructed space and cost and shared by projections that indicated some reductions in MSGA and obstetric beds could be included in the redesign. I also requested that Dimensions provide a persuasive justification of the need to have a single licensed pediatric bed. I have discussed Dimensions response to this request under Project Review Standard B(3) of the Acute Hospital Services Chapter, Minimum Average Daily Census for Establishment of a Pediatric Unit.[82]

Changes to Application after Project Status Conference

Subsequent to the May 17, 2016 project status conference, the applicants updated the market analysis that was included in the replacement application in order to assess the recommended bed capacity reductions. As a result of these updates and my recommendations, the applicants reduced the MSGA bed capacity by 11 beds.

The applicants state that the need analysis presented in the 2015 replacement application was based on FY 2013 actual utilization. In re-examining its need analysis, the applicants used PGHC's FY 2015 actual utilization as a starting point. Using this more recent data, the applicants recognized that utilization rates declined at a faster rate than previously projected, and assumed that this trend will continue throughout the projection period. The applicants considered other factors as well, the most influential of which was the increased emphasis placed on potentially avoidable utilization. Since several of the tests under the Maryland All-Payer Model Agreement with the Centers for Medicare & Medicaid Services are tied to quality, per capita health care spending, and potentially avoidable utilization, it is reasonable to assume further declines in use rates are likely to occur. The HSCRC has designed policies around those goals. The combined impact of actual utilization trends from FY 2013 to FY 2015 and further emphasis on potentially avoidable utilization led the applicants to include 154 MSGA beds (122 general medical/surgical beds and 32 intensive care beds) in the replacement hospital. (DI #92, p. 6)

[81] I summed PGRMC's projected discharges by zip code area and adjusted for out-of-area discharges based on PGHC's 2014 experience. Total projected discharges were then multiplied by length of stay equal to PGHC's 2014 case-mix-adjusted length of stay for each service and payer group to arrive at the projected patient days, which were divided by 365 to arrive at the average daily census and divided by a target occupancy rate to project the number of needed beds; 80% for MSGA, 75% for obstetrics, and 85% for psychiatric. My calculation accounted for the following: (1) with respect to my defined service area, in 2014 Prince George's County zip code areas accounted for 82% of PGHC's MSGA Medicare discharges in 2014 and 75% of its Non-Medicare discharges, 93% of its obstetric discharges, and 86% of its psychiatric discharges, (utilization forecasts for this service area were adjusted accordingly, to account for these varying levels of relevance); and (2) The case mix-adjusted ALOS for MSGA patients (both Medicare and non-Medicare) and for psychiatric patients is higher than the ALOS assumed in the replacement application.

[82] See discussion in section IV-A of this Recommended Decision, *supra*, p. 24

With respect to my request that the number of obstetric beds be reduced from 22 to 19, the applicants' state that Dimensions reviewed its projections and considered factors similar to those discussed above. The applicants noted that the obstetric bed use rate in the expected service area increased between 2013 and 2015 rather than decreased and, further, that most of the opportunity to reduce potentially avoidable utilization is in MSGA services, not obstetrics. Nevertheless, the applicants assume that there is some limited opportunity to reduce potentially avoidable utilization and that the use rate for obstetrics would decline modestly (0.8% from FY 2015 to FY 2023). They project an FY 2023 obstetric use rate for the PGRMC service area of 64.9 discharges per thousand females of child-bearing age. Assuming that this population of 170,626 persons in PGRMC's defined service area (based on Nielsen projections), they project a total of 11,070 obstetric discharges from the PGRMC service area. Assuming an obstetrics market share of 19.0% for PGRMC, as projected in the 2015 replacement application (DI #30, p. 77), there would be 2,100 such discharges from PGRMC to service the area. Based on PGHC's FY 2015 actual utilization, out-of-service-area discharges for obstetrics are assumed by the applicants to add 16.1% more discharges, which converts to a total of 2,437 obstetric discharges from PGRMC in FY 2023. PGRMC's obstetrics average length of stay in FY 2015 was 2.61 days, but Dimensions uses PGHC's case mix-adjusted average length of stay of 2.56 days to project 6,247 obstetrics patient days at PGRMC. Based on an assumed average annual occupancy rate for obstetrics of 75%, the projected days justify a need for 23 beds. As such, Dimensions respectfully decided not to follow my recommendation and the August 2016 redesign continues to include 22 OB beds. (DI #92, pp. 7-8)

In response to the May 17, 2016 status conference, the applicants re-designed the replacement hospital to provide 205 acute care inpatient beds, all in private rooms. A comparison of the latest proposed beds by service to the current capacity and licensed beds is detailed in the following table.

Table IV-31: Current Room and Bed Capacity and Bed Capacity for Replacement Hospital

Service	Current Licensed Beds	Existing Physical Capacity		Proposed Bed Capacity		Change Proposed Physical Bed Capacity and Current Licensed Bed Capacity	Change in Number of Rooms
	FY 2017	Beds	Rooms	Beds	Rooms		
MSGA	169	204	137	154	154	-15	+17
Obstetrics	34	42	42	22	22	-12	-20
Pediatrics	2	12	6	1	1	-1	-5
Psychiatric	28	38	18	28	28	0	+10
TOTAL	233	296	203	205	205	--28	+2

Source: DI #92, Exh. 62, Table A.

The number of patient rooms for all services will slightly increase through the replacement of PGHC with the Largo hospital. Having all private rooms is the design standard for general hospitals. The replacement hospital is planned to contain 28 fewer beds than PGHC's current licensed bed complement and physical capacity for 91 fewer beds than at PGHC. The application proposes psychiatric bed capacity equal to PGHC's current licensed capacity for this service but

the proposed 28 beds are ten fewer than PGHC's current physical psychiatric bed capacity. (DI #92, Exh. 62, Table A; MHCC, Annual Report on Selected Maryland General and Special Hospital Services)

The applicants have satisfied my recommendation with respect to the reduction in MSGA beds. Although the applicants decided not to modify the size of the obstetric unit, as I requested, I note that my use of Prince George's County zip code areas as the base service area for projecting OB bed need differs from the service area assumed by the applicants.

I have decided to accept Dimensions' decision to maintain a 22-bed postpartum unit. I have reconsidered my use of a 75% target occupancy rate (even though that was the target occupancy rate used by the applicant) because such an occupancy target may be a little high for the average daily census that I projected. The Obstetrics Services Chapter does not prescribe a target occupancy rate for OB beds but, as a point of reference, I note that the target occupancy rate for a pediatric unit with an average daily census ("ADC") of 7-24 beds is 65%. At a target occupancy rate of 65%, PGRMC would need 22 beds for the 5,202 patient days and the ADC of 14.2 that I projected for 2024.

In conclusion, I have previously found that the existing hospital needs to be replaced and that the proposed relocation best meets that need. I find that the applicants have demonstrated a need for the 15-bed unit of Mount Washington Pediatric Hospital that would be relocated from PGHC to PGRMC. I find that the need for the acute inpatient service bed capacity proposed for the replacement hospital, with respect to MSGA, obstetric, and acute psychiatric beds reflected in the August 2016 redesign, has been demonstrated by the applicants. I continue to have doubts about the need to admit pediatric patients at the replacement hospital, but I support the general approach in the replacement hospital to provide all general hospital pediatric services (emergency care, observation, and inpatient care) in a single, integrated unit located in the ED.

I find that the applicants have demonstrated need for the redesigned project presented in their August 2016, in compliance with this criterion.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3)(c) <u>Availability of More Cost-Effective Alternatives</u>.
The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

<u>Applicants' Response</u>

In responding to this criterion, the applicants referred to the information they presented in response to the related Cost-Effectiveness project review standard, at COMAR 10.24.10.04B(5).[83] I refer the reader to that section of the report for detail but I will summarize here. The applicants outlined project objectives and options for achieving those objectives and discussed the impracticality of achieving the facilities modernization needed through renovation of the existing

[83] See discussion in section IV-A, beginning at p. 27, *supra.*

PGHC physical plant and provided an overview of its evaluation of the four top site alternatives for relocation.

With respect to MWPH, the applicants stated that they concluded that the continuation of MWPH's relationship with Dimensions is its most cost effective alternative for continuing operation of its small special hospital unit currently operating at PGHC. It was reported that MWPH determined early in the planning process that it would not make sense to seek to lease space at any alternative facility, and that closing the unit was never a serious or prudent consideration, as closure would reduce access for families across the State. (DI #30, p.210)

In response to MHCC staff's completeness questions related to an optimal site for MWPH, the applicants replied with patient origin information for FY 2014 that showed that almost half of MWPH admissions at PGHC came from Prince George's County. (DI #37, p.43) Later, in response to my suggestion at the May 17, 2016 project status conference that one way to meet the goal of reduced space might be to relocate MWPH to another location, the applicants stated that MWPH analyzed whether it could continue providing this specialized care in the community by relocating its existing 15-bed program at PGHC to alternative existing hospital space in Prince George's County. The other four hospitals in the County are Doctors Community Hospital, Fort Washington Medical Center ("FWMC"), Laurel Regional Hospital ("LRH"), and MedStar Southern Maryland Hospital Center. FWMC was eliminated because it only has 34 licensed beds. LRH was eliminated because Dimensions has announced a plan to eliminate the provision of inpatient services on the LRH campus. The MedStar hospital was eliminated because, much like PGHC, it is an aging facility that "faces significant space constraints and a need for modernization." Finally, MWPH concluded that DCH[84] "is not a viable option … because it lacks services critical to MWPH's ability to safely and efficiently operate [because MWPH must] be located in a hospital that has its own NICU, together with the ancillary services that support that unit" along with staff who are trained to treat small children.. (DI #92, p.17)

Reviewer's Analysis and Findings

I first note that Anne Arundel Medical Center did not comment on the applicants' response to this criterion. The comments of Doctors Community Hospital regarding the Cost-Effectiveness project review standard, COMAR 10.24.10.04B(5) can be found in Section IV-A of this Recommended Decision, at page 27, *supra*.

In that section of this Recommended Decision, I found that the applicants justified the choice of modernization alternatives (i.e., relocation and replacement) and its choice of site. However, I initially found and noted at the May 17, 2016 project status conference held in this review, that the project in the 2015 replacement application was not a cost effective design alternative, being too big and, consequently, too costly. I asked the applicants to scale back the size and cost of the project and, in general, am satisfied with the changes made in the project plan based on my recommendations.

As a consequence of the changes made to the project, I find that the applicants have provided a basis for comparing the cost effectiveness of the proposed project with the cost

[84] DCH only provides adult medical and surgical services.

effectiveness of providing the service through alternative existing facilities. I find that the project, as modified in the applicants' August 31, 2016 filing and is consistent with this criterion, is a cost-effective approach to meeting the needed objectives.

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.

Applicants' Response

The estimated total project cost for the replacement hospital is $555,350,000.[85] Uniquely, this project heavily relies on State and Prince George's County grants of $416 million, or approximately 75% of the project expenses. The applicants project that the sale of bonds will raise an additional $117.8 million. Arbitrage on the bonds is projected to yield an additional $9.2 million and the site is being donated. Dimensions plans to obtain a bridge loan to finance this project until all the government appropriations are received. Under 2016 legislation,[86] operating and capital funding commitments by the State and County were made contingent upon UMMS becoming the sole corporate member of Dimensions and assuming responsibility for governance of Dimensions. In accordance with that law and with my requirement for clarity regarding governance, as stated at the May 17, 2016 project status conference held in this review, an August 30, 2016 Memorandum of Understanding was entered among UMMS, Dimensions, and Prince George's County.

The applicants' revenue and expense schedule for PGHC and the replacement hospital is shown below and includes two years of actual results and eight years of projected revenues, expenses, and income.

[85] A detailed accounting of project costs and funding sources is found in Table I-3, Section I-A of this Recommended Decision, *supra*, page 3.
[86] SB 324 (Chapter 13 of the 2016 Laws of Maryland).

Table IV- 32: Applicants: Actual Revenues and Expenses PGHC: FY 2014 & FY 2015; Projected Revenues and Expenses ($000s), PGHC: FY 2016 - FY 2020; and Projected Revenues and Expenses PGRMC: FY 2021 - FY 2023

	Actual ($000s)		Projected ($000s),							
	FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**	**FY22**	**FY23**
Net Patient Revenue	210,340	237,780	249,980	247,647	264,099	302,002	310,476	319,681	330,901	341,474
Other Revenue-State	10,000	10,772	-	11,466	22,932	13,413	13,347	4,426	4,404	-
Other Revenue-County	12,165	6,959	6,668	6,736	6,736	8,557	8,515	4,426	4,404	-
Other Operating Rev.	6,092	8,680	6,320	6,847	6,992	6,099	6,252	6,408	6,568	6,732
Net Operating Revenue	238,597	264,191	262,967	272,696	300,759	330,071	338,589	334,941	346,278	348,206
Project Depreciation	--	--	--	--	--	--	--	23,811	24,311	24,954
Project Amortization	--	--	--	--	--	--	--	79	79	79
TOTAL OPERATING EXPENSES	240,958	246,501	258,929	261,427	291,839	320,602	330,287	327,185	337,778	340,233
NET INCOME (LOSS)	**(2,337)**	**17,696**	**4,056**	**11,280**	**8,932**	**9,480**	**8,313**	**7,767**	**8,499**	**7,973**

Source: DI#92, Table H.1.

The applicants provided more than 250 letters of support, including statements of support from: Senate President Thomas Miller; Speaker Michael Busch; the entire Prince George's County delegation of the Maryland House of Delegates: numerous State Senators and Delegates,; Prince George's County Executive Rushern Baker III; the Prince George's County Council; the Charles County Commissioners; Dr. William E. Kirwan (then-Chancellor of the University System of Maryland); Dr. Wallace D. Loh (President of the University of Maryland); Dr. Jay A. Perman (President of the University of Maryland, Baltimore);, and Dr. Charlene M. Dukes (President of Prince George's Community College); and numerous health care providers, business and religious leaders.

Both the State of Maryland and Prince George's County have demonstrated significant financial commitment for the project, and the Prince George's County Health Department has collaborated in efforts to improve the primary care infrastructure and is also a supportive Interested Party in this review.

Interested Party Comments

Anne Arundel Medical Center

AAMC commented on the January 2015 replacement application but did not comment on the August 2016 modification of the project. AAMC's comments regarding viability can be summed up in this excerpt from its 2015 comments:

> Prince George's County has had tremendous difficulty attracting and retaining a strong medical community of physicians …. Given the health care practitioner shortage facing the County, it is doubtful that PGRMC can become viable as a $650,000,000, 215-bed hospital without first investing in ambulatory care, especially primary care, in the County. (DI #44, p.7-8)

AAMC cites the 2015 replacement application which speaks of a shortage of primary care providers, and also cites studies by the University of Maryland School of Public Health and the

RAND Corporation which identify a lack of primary care resources as the County's primary health care issue.[87] AAMC further states that this "shortfall in medical community support translates into a shortfall of patient support for PGHC [which] cannot be viable without a local physician base … with adequate volume." AAMC believes that the applicants have not shown the existence of physician support necessary to make the replacement hospital viable. AAMC urges the Commission to require Dimensions to commit to the creation of the needed support within the medical community.

Doctors Community Hospital

Like AAMC, DCH commented on the 2015 replacement application but did not comment on the 2016 modifications. In its comments, DCH did not specifically address the Viability criterion, but its comments did include discussion of the project's financial feasibility, which are referenced earlier in this report, under the financial feasibility standard.[88] In its summation regarding financial feasibility DCH suggests that "there are numerous unanswered questions that must be answered in order to determine whether the new hospital is financially feasible … in a manner that will permit the new hospital to generate the new revenue it requires," and suggested that redesign of the project to decrease costs would be appropriate. (DI #46, p.20)

Applicants' Response to Comments

The applicants responded to AAMC's comments by pointing out that the existing hospital's physician base produced volume that resulted in a 23-bed increase in its FY 2016 license. They also noted their provision of affidavits that spoke to "ongoing initiatives of Dimensions and its partner stakeholders [that] will increase the number of primary care physicians and specialists in the County." (DI #50, p.25)

The applicants' response to DCH's comments regarding financial feasibility are included under that standard in Section IV-A of my Recommended Decision that addresses the Acute Care Services Chapter's standard regarding financial feasibility, COMAR 10.24.10.04B(13).[89]

Reviewer's Analysis and Findings

This criterion requires consideration of three aspects of viability: (1) availability of resources to implement the proposed project; (2) the availability of resources necessary to sustain the proposed project; and (3) community support for the proposed project.

I note that I convened a project status conference on May 17, 2016, at which I expressed concerns similar to those raised by the interested parties. Like AAMC, I believed that the viability of the proposed PGRMC, as well as the successful realization of lifting the community's health

[87] University of Maryland School of Public Health, *Transforming Health In Prince George's County, Maryland: A Public Health Impact Study* (July 2012), and Assessing Health and Health Care in Prince George's County (2009), http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR655.pdf.

[88] See discussion in section IV-A of this Recommended Decision regarding COMAR 10.24.10.04B(13), beginning at p. 43, *supra.*

[89] Ibid.

status, will depend on the ability of Dimensions and its partners to build a robust primary care system. I asked for a detailed summary of progress made to-date as well as a description of current and future plans to recruit the needed primary care resources.

Like DCH, I was concerned about the size and cost of the project relative to the likelihood that it would achieve the volume projections and productivity improvements necessary to sustain it. I informed the parties that "[i]n my view, reducing the cost of this project should reduce the risk that this project will be inefficiently used and should improve the chances of overcoming the other gaps that HSCRC staff found in its review of the CON application."[90]

The applicants responded to my requests by reducing the size and cost of the project and reducing some of the planned service capacities of the replacement hospital. The redesign of the project reduced the project cost estimate by approximately $100,000,000.

Responding to my interest in ensuring that the primary care infrastructure to support the project and serve the community's needs will be built, the applicants described a set of initiatives. (DI #92, pp. 36-40) I was impressed by this response. Chief among the initiatives outlined are efforts being implemented either by the Prince George's County Health Department, by Dimensions, or jointly, and that include:

- Creation of three primary care practices in high-need areas;
- The addition of four Federally Qualified Healthcare Centers; and
- The formation of a Health Enterprise Zone and a Health Enterprise Zone Community Health Worker Program.[91]

Availability of Resources to Implement the Proposed Project

This project is strongly supported by the financial commitments of the State and Prince George's County, including over $400 million for the project itself and operational subsidies to support PGHC during the period in which the project is being constructed. The site, valued at $12,350,000 is being contributed by the County. This major down payment will limit the project's borrowing needs to approximately $118 million. I believe that the level of public support, as evidenced by the State and County project funding and subsidies, as well as the pending UMMS ownership and responsibility for governance of Dimensions, will enable Dimensions to obtain the bond financing proposed.

Availability of Resources Necessary to Sustain the Proposed Project

For years PGHC has relied upon the State and County to subsidize its operations and has

[90] See Project Status Conference Summary and attachment (DI #83).

[91] The Community Health Worker program in the Health Enterprise Zone includes goals to: facilitate access to care; connect residents to health insurance registration tools and primary care medical practices; provide assistance and navigation with various social services resources; promote medication adherence and health literacy education resources; and coordinate care to minimize hospital readmissions. (DI #92, p.38)

obtained approval for higher charges than its peer hospitals in order to sustain itself. Direct subsidies are scheduled to continue until a replacement hospital is put into operation, at which time the replacement hospital is projected to no longer need subsidization to achieve a positive bottom line.

I continue to have concerns, shared by HSCRC, that PGRMC's relatively high prices will hurt its competiveness. In its September 21, 2016 comments on the recent modifications to the project, HSCRC staff expressed concerns that "the projected unit rates for PGHC will be well above other general hospitals in its region as well as in similar peer group hospitals throughout the State." (DI #97, p. 5) (attached as App. 6) On the other hand, I am encouraged by the measures outlined earlier[92] that are being pursued to improve operational efficiencies and reduce costs. I also believe that the expected efficiencies associated with a modern design will be achievable with leadership provided by UMMS. This belief is bolstered by HSCRC staff's view, as stated in its opinion, that "the performance improvements identified by PGHC in their CON modification are achievable. Furthermore, we believe that PGHC will exceed the savings estimated from performance improvements, which will have a positive impact on the projected income statements."

Community Support

This proposed project has a high level of commitment and support from community and political leadership. I am impressed by the collaborative efforts being made by the County Health Department, Dimensions, and UMMS toward the goal of building a more robust primary care system in Prince George's County and believe that these efforts and the formal entry of UMMS in a position of leadership in the rebuilding of Dimensions bode well for future success.

Conclusion

The applicants have documented the availability of resources necessary to implement the project. I am cautiously optimistic that the ongoing managerial efforts to improve efficiency and lower costs, coupled with efforts by HSCRC to hold hospitals accountable for improving productivity, will meet with success. I want to emphasize that the leadership of UMMS must continue to work on efforts to make the successor hospital to PGHC as cost-competitive as possible and, in the current environment, such efforts cannot rely on anticipated growth in volume alone.

I find that the financial and non-financial resources necessary to launch and sustain the proposed project are available.

E. Compliance with Conditions of Previous Certificates of Need

COMAR 10.24.01.08G(3)(e), Compliance with Conditions of Previous Certificates of Need. ***An applicant shall demonstrate compliance with all terms and conditions of each previous***

[92] See discussion in Section IV-A, *supra*, p. 40, regarding COMAR 10.24.10.04B(11), the General Acute Care Services Chapter's efficiency standard,

Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

Applicants' Response

Although the CON application form requires an applicant to respond regarding CONs issued since 2000, the applicants reported on several prior to that date.

- PGHC received CON approval on January 14, 1997 to establish an 18-bassinet neonatal intensive care unit (Docket No. 96-16-1901).
- MWPH received CON approval on February 18, 1994 for the emergency relocation of 27 special hospital – pediatric beds from MWPH to Montebello Rehabilitation Hospital (Docket No. 94-24-1741).
- MWPH received CON approval on October 8, 1996 to relocate 15 special hospital – pediatric beds from MWPH to PGHC, with these beds remaining licensed to MWPH under a lease arrangement with PGHC (Docket No. 96-24-1966).

In each case, the applicant was able to comply with the terms and conditions of each Certificate of Need.

Reviewer's Analysis and Findings

This standard requires that the applicant report all CONs issued either to PGHC or MWPH since 2000. While the Commission has not issued a CON to Dimensions during this time period, the applicants provided an accounting of their compliance with earlier CON awards.

F. Impact on Existing Providers and the Health Care Delivery System

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers.
"An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system."

Applicants' Response

The applicants stated that they projected the impact of the proposed relocation on existing health care providers by following the methodology employed in the Reviewer's Recommended Decision on the relocation of Washington Adventist Hospital (Docket No. 09-15-2295). In addition, the applicants project substantial market share gains by the proposed replacement hospital and characterizes this impact as "recapturing" market share that PGHC has lost over the past decade (as described earlier under the Need criterion). This anticipated impact on other hospitals is related to the vision articulated by Dimensions that the replacement hospital will be perceived as a regional medical center for all of Prince George's County and the Southern Maryland region, with a focus on providing specialty care in trauma, cardiovascular, neonatal,

cancer, and subspecialty medical and surgical services.

The application assumed that approximately two thirds of the incremental volume growth projected from market share recapture will come from D.C. and Virginia hospital, particularly in the service lines of cardiovascular, cancer, neurosurgery, and medical/surgical subspecialty care. (DI #30, p. 215) The applicants projected that, by 2022, the market share recapture would add 3,282 discharges that would not have occurred at PGHC without this project. To support the assumption that a large proportion of the recaptured market would come from D.C. and Virginia hospitals, they noted that 30% of the discharges originating in the top 10 Maryland zip code areas of PGHC's service area went to D.C. or Virginia hospitals.

The applicants maintain that there is a significant potential to recapture Prince George's County residents who are migrating to D.C. and Virginia hospitals for care. As displayed below, almost 28% left PGHC's service area for DC or Virginia hospitals. Among patients with secondary and tertiary level diagnoses, almost 32% went to DC/Virginia hospitals. The applicants reported that Dimensions is recruiting subspecialty physicians to improve local access to such services, thereby reducing the need for patients to travel to Washington, D.C. or Virginia for such care. (DI #30, pp. 216-217; DI #36, p. 34; DI #49, p.4)

Table IV-33:
Applicants: Comparison of Secondary and Tertiary Medical/Surgical Discharges to Total of Prince George's County Resident Discharges by Hospital Jurisdiction FY 2013

	Total Discharges	Percent of Total	Secondary and Tertiary Discharges *	Percent of Total
All Prince George's residents discharged from any Maryland, D.C., and Virginia hospital	95,230	100%	11,165	100%
From any Maryland hospital	68,842	72.3%	7,606	68.1%
From any D.C. hospital	23,644	24.8%	3,310	29.6%
From any Virginia hospital	2,744	2.9%	249	2.2%
From PGHC	10,571	11.1%	1,115	10.0%

Source: Applicants' May 11, 2015 Response to Request for Additional Information, (DI #49, p. 4)

*161 MS-DRGs including DRGs related to cardiac surgery/interventions, cancer, neurosurgery, and other types of highly acute cases.

To assess impact on other facilities, the applicants allocated the discharges that PGRMC is expected to recapture on a service line basis between those who will return from Maryland hospitals and those who will return from out-of-state hospitals. First, the applicants made market share recapture assumptions for MSGA discharges. The recapture assumptions for out-of-state hospitals ranged from 0% for substance abuse to 80% for cardiac surgery and medical oncology/hematology, with an overall assumed percentage of 68%. The percent of market recapture from out-of-state for obstetrics was projected to be 60%, and no market recapture was expected for psychiatry. (DI #30, p. 218; DI #36, pp. 39-40) Next, the recaptured MSGA discharges were allocated by service line and age group based on the FY2013 proximity-adjusted market share by zip code area within each age group. (DI #30, pp. 218-19) The applicants' analysis of the impact on select hospitals' total discharges from PGRMC's expected service area

and the percent impact relative to projected discharges before relocation and market recapture adjustments is shown in the following table.

Table IV-34: Applicants' Projection of Impact of PGHC Relocation on the Inpatient Volume of Selected Maryland and District of Columbia Hospitals in the Expected Largo Service Area

Hospital	Discharges From Largo Service Area				
	Actual	FY 2022 Projection Adjusted for population growth and use rate decline		Change Due to Relocation and Market Recapture	
	FY 13	Without PGRMC project	With PGRMC Market Recapture		
Doctors Community	9,552	10,866	10,759	(107)	-1.0%
MedStar Southern Maryland	12,127	13,670	13,127	(543)	-4.0%
Holy Cross	5,535	5,822	5,757	(65)	-1.1%
Anne Arundel	4,335	4,843	4,423	(420)	-8.7%
Total All MD Hospitals	53,192	58,853	57,458	(1,395)	-2.4%
MedStar Washington	8,642	9,551	8,557	(994)	-10.4%
Georgetown University	2,684	2,902	2,554	(348)	-12.0%
George Washington University	1,896	1,975	1,790	(185)	-9.4%
Provident	1,786	1,890	1,799	(91)	-4.8%
Total All D.C. Hospitals	20,288	21,423	19,572	(1,851)	-8.6%

Source: January 16, 2015 Replacement Application (DI #30, p. 224)

As for the impact on the costs and charges of other Maryland providers, the applicants stated that:

> as the inpatient utilization of Maryland hospitals is reduced, the inpatient revenue at these hospitals will be proportionately reduced. This reduction in revenue is expected to be limited to a 50% reduction in each hospital's GBR or TPR revenue in relation to the specific service line that is affected. This reduction is expected to occur in the year following the change in volumes as a market share adjustment. Any reduction in volumes and related revenue at Maryland hospitals is expected to be partially offset by a reduction in variable expenses. Applying an assumption of 50% variability of expenses with changes in volumes suggests that for every 1% reduction in volumes, the 0.5% reduction in revenue will be offset by a 0.5% reduction in variable expenses.[93]

Regarding the impact on the costs and charges of out-of-state hospitals and Medicare, the applicants referenced the 1,947[94] admissions projected to be recaptured from the District of

[93] January 16, 2015 replacement application (DI #30, p. 225)

[94] 1,947 is the number of discharges that the applicants' project will be recaptured by PGRMC from the

Columbia and 263 admissions from Virginia. Applying PGHC's approved FY 2013 charge per case of $14,029 would result in gross revenue of approximately $31 million in current dollars. The applicants stated further that they were not able to estimate the current net patient revenue associated with specific hospitals in the District of Columbia or Virginia because each hospital negotiates its own rates with payors. (DI #30, p. 225)

With respect to payors, the applicants observed that Medicare paid more in Maryland than it does under the national payment system (PPS and OPPS). They stated that, while no recent computations have been developed, based on analyses done a few years ago, the Medicare inpatient payment differential was approximately 21%. They also stated that, although payment levels outside the State of Maryland are difficult to estimate, insight comes from studies completed by both the American Hospital Association and the State of Maryland. These studies comparing regulated versus national payment levels generally showed that commercial payors nationally pay approximately 135% of costs, while in Maryland commercial payors pay between 110% and 115% of costs. This suggests that commercial payors are likely paying 20% less in Maryland. (DI #30, p. 225)

Regarding the impact of the Mount Washington Pediatric Hospital unit at PGHC, the applicants stated that the unit already is a statewide resource and that its patients live in all regions of Maryland. They note that MWPH at PGHC provides a more geographically proximate alternative for pediatric patients' families than being admitted to MWPH in Baltimore City and that PGHC improves access for many of these families. (DI #30, p. 226)

The applicants stated that the proposed project will have positive effects on the health care system as a whole, particularly regarding the following:

- The project will address and resolve considerable deficiencies in the current site.
- The existing PGHC has 73 semi-private rooms. The new PGRMC will have all private rooms, which will produce higher occupancy rates than are achievable with semi-private rooms. Private rooms also enhance patient satisfaction and family involvement, reduce the risk of infection, and reduce the need for transfers due to patient incompatibility.
- The new hospital will improve recruitment and retention of physicians, which presents a challenge in PGHC's current service area.

Interested Party Comments

Anne Arundel Medical Center and the Prince George's County Health Department did not submit specific comments regarding this criterion.

D.C. hospitals. The 1,851 in the table above is the net change in discharges from D.C. hospitals that includes both the market recapture from D.C. hospitals and the relocation effect, which add discharges to the D.C. hospitals as PGHC moves further away.

Doctors Community Hospital

According to Doctors Community Hospital, PGHC professes to want to be a regional referral center, but its history says otherwise. DCH characterized Dimensions' response to all questions on this issue as simply "trust us, it will be different in the new hospital." Nevertheless, DCH believes that if PGRMC becomes a regional referral center, it would have a profound effect on other hospitals in the region. DCH stated that, while "the Applicant does not predict significant impacts, our analysis says otherwise."[95] (DI #46, p. 22)

DCH analysis projects a likely loss of at least 393 admissions if the project goes forward, assuming that the replacement hospital realizes its projections (which DCH characterizes as "unsupported") of recapturing a large proportion of the County residents who have consistently chosen to receive care in hospitals in the District of Columbia and Virginia. DCH believes the impact on it would be greater if such a recapture does not occur. (DI #46, p. 22)

DCH then projected the impact of the loss of 400 MSGA admissions on its revenues and expenses. The following table sets forth the interested party's projection of the impact of such a reduction on DCH's revenues. DCH inflated its FY 2014 inpatient charge per case of $13,364 to FY 2020, 2021, and 2022, assuming an annual inflation rate of 2.3% and a demographic adjustment of 0.53% (DCH's FY 2015 GBR Demographic Adjustment). Based on the inflated charge per case and a 50% reduction in associated revenue, the following table sets forth DCH's view of the impact of such a reduction on its revenues.

Table IV-35: Doctors Community Hospital: Impact of Projected MSGA Volume Loss On Projected Patient Service Revenue

Fiscal Year	Inpatient Charge Per Case	Gross Patient Services Revenue Lost at 100%	Gross Patient Service Revenue Lost at 50%[96]
2020	$15,811	$6,300,000	$3,160,000
2021	$16,261	$6,500,000	$3,250,000
2022	$16,723	$6,700,000	$3,350,000

Source: DCH May 4, 2016 comments on Replacement Application (DI #46, p. 23)

DCH stated that it had not yet done a detailed computation of the cost reductions that it could achieve associated with these lost cases, but, relying on past experience, it estimated that there would be no more than 25% expense variability, and that even that is questionable for several reasons, writing that:

> although the loss of revenue is great, the actual impact on an operational level is small. The loss of less than 8 patients a week is not the type of impact that can realistically lead to reduced personnel costs, and DCH's high capital costs are

[95] Doctors Community Hospital May 4, 2015 comments on the application, p. 22

[96] DCH cited "Limitations on Payments for Recaptured Market Share" regarding discussion of probable GBR adjustment amounts associated with Market Shift Adjustment. DCH noted that its analysis assumes that all cases lost by Doctors result in an HSCRC-approved 50% market share adjustment. As noted, the HSCRC has not yet finalized its treatment of MSA, which will affect this dollar loss. (DI #46, p. 23)

[96] DCH May 4, 2015 comments on replacement application (DI #46, p. 23).

completely unaffected.[97]

Assuming 25% expense variability, DCH estimated that the impact could be more than $1,000,000 per year. It pointed out that its consolidated margin for 2014 was $652,000, while in 2013, it was negative, a loss of $1,415,000. DCH stated that a reduction to its consolidated margin of $1,000,000 per year could lead to a bond rating downgrade, thereby impeding its ability to incur debt needed to maintain competitiveness in the market. And if the impact were greater, DCH stated that its viability would be threatened.

In conclusion, DCH stated that, if the replacement hospital cannot reverse decades of losing market share to Washington D.C. and other Maryland hospitals outside of Prince George's County, it must either fail or attract patients that would otherwise use nearby hospitals like DCH. DCH observed that, in an unregulated environment, it could take actions to combat this potential erosion of market share, but in Maryland, its GBR revenue will go down and its rates will go up, reducing DCH's cost competitiveness. This could lead to potentially greater losses of volume from cost conscious purchasers. Further, DCH is concerned that it could lose staffing to the new hospital, located approximately six miles away. DCH stated that, while the impact on maintaining needed personnel when facing a well-funded competitor so close is hard to predict, it is nonetheless very real. (DI #46, p. 24)

Reviewer's Analysis and Findings

This criterion requires an applicant to provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area. The criterion requires that this information include the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

In considering this criterion, I want to first note that I have considered the impact of this project on geographic and demographic accessibility under the related Geographic Accessibility and Adverse Impact standards, COMAR 10.24.10.04B(1) and (4). I concluded that the proposed relocation is consistent with the Geographic Accessibility standard and would not inappropriately diminish either access for the population in the primary service area or the availability of care. I will not repeat that analysis here.

Regarding the impact of the proposed project on patient volumes of other hospitals, as discussed in the Need criterion, COMAR 10.24.01.08(G)(b), I concluded that the volumes projected by the applicants for the relocated hospital were most likely too high because they were based on the assumption that use rates would level off and what I view as aggressive assumptions of market share recapture. There is room for further reduction in hospital use rates based on Maryland's historic experience and the need to reduce avoidable hospitalizations. Therefore, I have done my own projections of possible volume impact based on my expectation that use rates will continue to decline and market recapture is likely to occur at more moderate levels.

One would expect such an analysis to indicate a reduction in volume impact when

[97] DCH May 4, 2015 comments on replacement application (DI #46, p. 23).

compared with the analysis done by the applicants. However, I share DCH's concern with the applicants' assumption that almost 70% of the incremental volume growth will occur by attracting service area residents who are currently migrating to D.C. and Virginia hospitals. While the most recent evidence clearly indicates that a significant but decreasing percentage of Prince George's County residents receive care out-of-state, particularly from D.C. hospitals, the evidence does not support the high allocation assumed in the applicants' impact analysis.

In terms of total discharges, the applicants report that, in FY 2013, 72.9% of the discharges from the area identified as the replacement hospital's likely service area were discharged from Maryland hospitals, with 24.1% coming from D.C. hospitals and 2.9 % coming from Virginia hospitals. Narrowing that analysis to secondary and tertiary discharges, I see that 68.1% were Maryland hospital discharges, 2.1% were discharged from Virginia hospitals, and 29.7% were discharged from D.C. hospitals. (DI #49, p. 4)

Projecting future consumer behavior is highly uncertain. While the applicants accurately describe Prince George's County residents who use hospitals in D.C. as "leaving the state for hospital care," I do not believe that the vast majority of these patients view this as an inconvenience. The movement of persons seeking medical care from one urban/suburban jurisdiction to an adjacent urban jurisdiction in the same metropolitan area is something that happens with great frequency in metropolitan areas throughout the country every day.

Thus travel for medical services mirrors a pattern of movement between Prince George's County and D.C. that occurs every day for work, education, recreation, and retail activity. I am hopeful that the applicants will see improvement in the market share commanded by the replacement hospital in its service area when compared to the relatively low market share that PGHC has achieved in its service area. This will enhance the ability of the replacement hospital to reach financial stability and a more competitive price position and will provide the residents and medical community of Prince George's County with a more attractive alternative than the existing PGHC. However, I think it is important to acknowledge that Washington, D.C. and other Maryland hospitals will continue to be used by Prince George's County residents and to take a more temperate view of how much and how quickly a project of this type will alter patterns of use that have gradually been established over many years and, for the most part, are not extraordinary or unusual. Therefore, my impact analysis employs more conservative assumptions about market shifts, and assumes that market shifts will be distributed proportionally based on each affected hospital's 2014 market share.

My analysis suggests that the project can be expected to have the largest potential negative impact on three Maryland hospitals: Doctors Community Hospital; Anne Arundel Medical Center; and MedStar Southern Maryland Hospital Center. A fourth hospital that could be expected to experience a comparable impact in absolute terms (with a projected loss of 294 discharges) is MedStar Washington Hospital Center, which is located in Washington, D.C.

For DCH, the projected loss of 482 discharges represents 5.3% of its total 2015 discharges. For MedStar Southern Maryland Hospital Center, the projected loss of 361 discharges is equivalent to 3.0% of its 2015 discharges and, for Anne Arundel Medical Center, the projected loss of 300 discharges is equivalent to 1.2% of its 24,940 discharges in 2015. The loss of 294 discharges by

Washington Hospital Center is equal to 0.9% of its 34,015 discharges in 2015.

As pointed out by both the applicants and DCH, Doctors Community Hospital could avoid a negative impact on its financial condition if it could reduce the expenses associated with the lost volume by 50%. However, DCH maintains that that it will not be able to reduce expenses associated with the lost volume by more than 25% because the number of discharges lost is not large enough to make major cost-reducing changes (such as closing a patient care unit). DCH estimates that the loss of these discharges will mean a $1 million increase in the loss it has recently experienced. While I understand that such an impact could be a challenge for DCH, given its tepid financial performance in recent years, its 2015 operating profit of approximately $6 million, suggests that it will survive. In addition, the recent analysis of the impact of the approved relocation of Washington Adventist Hospital (Docket Number 13-15-2349) projected the potential for a positive impact on DCH, in excess of 100 discharges, which would help offset a significant portion of the losses that could be expected to result from the relocation of PGHC.

Regarding any negative impact on MedStar Southern Maryland Hospital Center, I note that the hospital did not request interested party status. I also note that while MedStar reported an operating loss of $7.5 million in its FY 2015 audited financial statement, it reported operating profits of $160.8 million for all of its operating entities combined. Any negative impact on the volume of AAMC would be relatively small because it is a much larger hospital. Further, according to its audited financial statement, AAMC had operating profits of over $14 million in FY 2014 and over $25 million in FY 2015. Any volume loss by Washington Hospital Center would also be relatively small, given its size. . I also note that the future relocation of Washington Adventist is expected to result in additional discharges for Washington Hospital Center, providing an offset to volume that might be lost to a new PGRMC. Thus I do not consider the potential impacts to require adjustments that will be particularly difficult for the affected hospitals

In summary, I conclude that the projected impact of this project is, on balance, positive. The replacement hospital's likely impact on other hospitals does not provide a basis for its denial. The project can be expected to produce benefits for patient safety and, potentially, the quality of patient care. I am firmly convinced that the project will substantially improve the availability of and accessibility to medical services provided by a modernized hospital for the residents of Prince George's County and that these benefits greatly outweigh the adverse impact of the project on the charges and financial condition of existing providers. Though I cannot report that this project is likely to close the pricing gap that exists between PGHC and comparable hospitals, HSCRC has concluded that this gap is not likely to widen substantially and may be narrowed in the future if UMMS, the new owner and operator of Dimensions, can make good on its commitment to productivity improvements, which can only be helped by stabilizing further erosion of the hospital's market position. I find that the proposed project, as modified, is likely to have a positive impact on the health care delivery system.

V. REVIEWER'S RECOMMENDATION

Based on my review and analysis of the application for Certificate of Need filed by Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mount Washington Pediatric Hospital, Inc. and the full record in this review, I recommend that the Commission issue a Certificate of Need for the relocation and replacement of PGHC, as described in the redesigned

project plan filed by the applicants on August 31, 2016.

The ability of PGHC to fulfill its potential as the primary general hospital serving the residents of Prince George's County and southern Maryland has been a challenge for its parent, Dimensions, for Prince George's County, and for the State of Maryland for over two decades. Previous attempts at a long-term solution to arrest the decline and fragility of this hospital, which were essentially variations on finding another entity to take over the Dimensions operation in exchange for commitments of financial support, were tried and failed. Lacking a long-term solution to the problem, short-term, stop-gap, government funding measures were implemented, but they did not provide the resources necessary for the modernization of PGHC nor for the improvements in its performance or reputation necessary for a turnaround. In fact, they have instead maintained a poorly performing hospital with an eroding patient base, starkly evident in the outmigration of patients to hospitals in Washington D.C. and Virginia. The result was that the people of Prince George's County were underserved by an institution with substandard facilities and the provision of services at a relatively high price. Altogether, this was a poor return on value for patients and a poor return on the investment of Maryland taxpayers, who provided such generous funding for many years.

The Commission can now take a major step toward a long-term solution. Maryland and Prince George's County have been successful in engaging the University of Maryland Medical System, the state's largest hospital system, in a planning and project development process aimed at providing PGHC with a new facility and a new location. The people of Maryland, through their elected representatives at the State and County level, have committed over $400 million dollars in capital funding and what is hoped to be a final commitment of operating expense subsidies to reach these goals. UMMS has already become directly involved in management of the hospital and medical direction of important hospital services. And, on August 30, 2016, UMMS committed itself to become owner and operator of the Dimensions Health System, with the required regulatory approvals for the hospital relocation and replacement.

In the course of this review, two important developments with bearing on this project have occurred. A new payment model for hospitals was introduced in Maryland with charges based on global budgets for individual hospitals and systems and limits on growth of hospital spending. In addition, Dimensions outlined a strategic change in direction for its health system that will reshape it as a single hospital health care system, that hospital being the new PGHC in Largo, with at least two major ambulatory care campuses, in Bowie and Laurel. These developments create the potential for implementation of the replacement hospital project without expansion of the Dimensions global budget beyond its current level and the routine updates for inflation and other non-extraordinary budget adjustments that would be occurring as the project is built and opened.

As a Reviewer, I was sharply critical of the size and scope of the project initially planned by Dimensions. I fully understand the applicants desire to bring back higher levels of service at the replacement hospital and hope that the new management is successful in attracting the critical mass of users needed to make it a self-sustaining institution capable of handling most of the hospitalization needs of its community. I have not required that PGHC eliminate any services that it currently provides, despite the fact that, in some cases, services had withered away to negligibility at the point in time that the CON application was filed. But my review of this project

has taken place at a time in which all hospitals, broadly, have experienced reduced demand for their inpatient services and moderating to declining demand in some of the outpatient services they provide as well. For this reason, I determined that some reductions in the size and cost of this project were warranted. I instructed the applicant to make changes that I believe were realistic, in light of the changes occurring in hospital demand and the further changes desired in the use of hospitals for the delivery of services. I also believe these changes did not alter the service capabilities of the hospital in any substantial way. In fact, they will allow the project to go forward with less risk of excess capacity and excessive debt obligations. While Dimensions did not alter every specific facet of project change I outlined at the Project Status Conference on May 17, 2016, it did adopt my proposed major modifications. These were substantial and achieved my main objectives -- to reduce the size and cost of the project, to reduce the financial risk and thus ensure sound stewardship of the Maryland taxpayers' generous investment in this major project.

Unfortunately, as I have noted in this Recommended Decision and as HSCRC has pointed out, it is still not clear that the hospital can be price competitive with similar hospitals in its region. While I do not believe that this problem is a basis for denying the project, I want to stress once again, to the leadership of UMMS that every effort should be made to complete this project within the approved budget and reduce the expense of operating this new hospital wherever possible. I appreciate HSCRC's perspective that there are limits to our existing ability to accurately compare costs among hospitals serving patient populations with widely varying socio-economic characteristics. That is indisputable. However, if higher service volumes are the only approach to reducing unit costs, it places the objective of creating a high value replacement hospital at odds with our objective of reaching optimal levels of hospital use, which are broadly perceived as being well below what Maryland is currently achieving.

Nonetheless, as I have said, it is time to move forward with meeting the crucial need at issue, a modern general hospital to replace PGHC. But I strongly urge UMMS, working closely with HSCRC, to reduce the gap between charge levels at PGHC and those at similar community hospitals. I want to emphasize that it is essential that UMMS management devote the appropriate resources and exercise prudent leadership on the project and ongoing management of the existing hospital. I have every reason to believe that they will do so.

Therefore, I am pleased to recommend that this project, as modified be approved. I have found that the proposed project complies with each applicable State Health Plan standard and that the applicants have adequately addressed each of the other five review criteria considered in the review of CON applications. I find that the relocation and replacement of PGHC is a cost-effective approach to meeting the applicants' objectives and conclude that development of the replacement medical center in Largo will have the ability to play a major role in supporting and revitalizing the health care system in Prince George's County

Accordingly, I recommend that the Commission **APPROVE** the application for a Certificate of Need to relocate Prince George's Hospital Center and replace it with a general hospital in Largo, Maryland to be known as Prince George's Regional Medical Center.

IN THE MATTER OF	*	**BEFORE THE**
	*	
DIMENSIONS HEALTH	*	**MARYLAND**
CORPORATION d/b/a PRINCE	*	
GEORGE'S HOSPITAL CENTER	*	**HEALTH CARE**
and	*	
MT. WASHINGTON PEDIATRIC	*	**COMMISSION**
HOSPITAL, INC.		*
Docket No.: 13-16-2351	*	
	*	

* *

FINAL ORDER

Based on the analysis and findings in the Recommended Decision, it is this 20th day of October 2016:

ORDERED, by a majority of the Maryland Health Care Commission, that the application of Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mt. Washington Pediatric Hospital, Inc. for a Certificate of Need to relocate and replace Prince George's Hospital Center through construction of a new general hospital to be known as Prince George's Regional Medical Center in Largo, Maryland, containing the 15-bed Prince George's County unit of Mt. Washington Pediatric Hospital, 154 MSGA beds, 22 obstetric beds, 28 acute psychiatric beds, one pediatric bed, eight operating rooms, and 45 emergency department treatment bays, at a total project cost of $543,000,000 (exclusive of the value of donated land), be, and hereby is, **APPROVED**.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1

RECORD OF THE REVIEW

APPENDIX 1: Review of Record

Prince George's Regional Medical Center
Docket No. 13-16-2351

Docket Item #	Description	Date
1	Commission staff acknowledged receipt of Letters of Intent to file CON applications.	10/6/13
2	The applicants submitted a copy of solicitation materials for Letters of Support for the proposed project.	9/30/13
3	The applicants submitted letters of support for the project from numerous people on various dates.	09/13
4	The Commission received a Modified Letter of Intent.	10/3/13
5	The applicants filed their Certificate of Need application.	10/4/13
6	Commission staff acknowledged receipt of application for completeness review.	10/7/13
7	Commission staff requested that the *Washington Times* publish notice of receipt of application.	10/7/13
8	Commission staff requested the *Maryland Register* publish notice of receipt of application.	10/7/13
9	Notice of receipt of application was published in the *Washington Times.*	10/21/13
10	Following completeness review, Commission staff requested additional information before a formal review of the CON application could begin.	10/21/13
11	There is no document 11 for this project due to mis-numbering.	
12	Commission staff acknowledged a request for notification of review from MedStar Health.	11/4/13
13	Commission staff received responses to additional questions from the applicants' counsel.	11/4/13
14	Commission staff received additional completeness responses from the applicants' counsel.	11/12/13
15	Commission staff requested additional information from the applicants.	11/20/13
16	Commission staff acknowledged a request for notification of review from Howard Sollins.	12/5/13
17	Commission staff acknowledged request for notification of review from Doctor's Hospital.	12/5/13
18	The applicants filed responses to completeness questions dated 11/20/13.	12/10/13
19	Commission staff requested additional information in response to the applicants'12/10/13 submission.	12/23/13
20	Commission staff received the applicants' response to completeness questions dated 12/23/13.	1/16/14
21	Commission staff requested additional information from the applicants.	1/30/14
22	E-mail correspondence between commission staff & the applicants' counsel regarding extension to file additional completeness information until 2/27/14.	2/11/14
23	E-mail correspondence between commission staff and the applicants' counsel regarding additional extension to file completeness information until 3/7/14.	2/27/14
24	Commission staff received the applicants' response to completeness questions dated 01/30/14.	3/7/14
25	E-mail correspondence among commission staff and the applicants'	3/20/14

	counsel concerning charts on Page 25 and 26 of the completeness information.	
26	Commission staff sent additional completeness questions to the applicants regarding information from their 3/7/14 submission.	3/21/14
27	The applicants presented on Transformation of Prince George's County's Healthcare System to the Health Services Cost Review Commission.	8/26/14
28	MHCC Project Review description of Prince George's Regional Medical Center.	10/10/14
29	The applicants presented on Transformation of Prince George's County's Healthcare System to the Maryland Health Care Commission.	10/10/14
30	The applicants filed a modified Certificate of Need Application (3 Volumes).	1/16/15
31	E-mail correspondence between Commission staff and applicants' counsel regarding draft of completeness questions for the modified application.	2/4/15
32	Commission staff requested additional information regarding the modified CON application.	2/10/15
33	E-mail correspondence between Commission staff and applicants' counsel regarding extension to file completeness information on modification until 3/5/15.	2/25/15
34	E-mail correspondence between Commission staff and applicants' counsel regarding changing the completeness extension due date to 3/6/15.	3/4/15
35	E-mail correspondence between Commission staff and applicants' counsel regarding changing the completeness extension due date to 3/13/15.	3/6/15
36	Commission staff received completeness information.	3/13/15
37	Commission staff received a disc containing completeness information.	3/13/15
38	Commission staff requested that the *Washington Times* to publish notice of the formal start of the review.	3/20/15
39	Commission staff requested that the *Maryland Register* to publish notice of the formal start of review.	3/20/15
40	The applicants filed large construction design documents.	3/18/15
41	E-mail correspondence between Commission staff and applicants' counsel regarding application docketing on 4/3/15 & request for additional information.	3/23/15
42	Notice of formal start of review of application as published in the *Washington Times.*	4/3/15
43	Email correspondence between Commission staff and applicants' counsel regarding the formal start of the review of the application on 4/3/15 and request for additional completeness information.	4/24/15
44	The Commission received comments from Anne Arundel Medical Center.	5/4/15
45	The Commission received comments from Prince George's County Health Dept.	5/4/15
46	The Commission received comments from Doctor's Community Hospital.	5/4/15
47	The Commission received a request for an Evidentiary Hearing from Doctor's Community Hospital.	5/4/15
48	E-mail correspondence between Commission staff and applicants' counsel regarding error in calculating the due date for additional information questions; submission date: 5/11/15.	5/8/15
49	Commission staff received applicants' response to additional information questions from the applicants' counsel.	5/11/15
50	Commission staff received response to additional information from the	5/19/15

	applicants' counsel.	
51	The applicants filed Motion to Strike Exhibit O from the Comments of Doctor's Community Hospital.	5/19/15
52	Interested Party Counsel filed opposition to Motion to Strike Exhibit "O" on behalf of Doctor's Community Hospital and a renewed Request for a Hearing on the Modified Application.	6/3/15
53	Interested Party Counsel filed a Renewed Request for a Hearing on the Modified Application for Certificate of Need for PGRMC and all information provided after the Deadline to Comment on behalf of Doctor's Community Hospital.	6/3/15
54	The applicants filed a Response to Request for Hearing and Renewed Request for Hearing.	6/9/15
55	The applicants filed Dimensions' Reply in Further Support of its Motion to Strike Exhibit O to the Comments of Doctor's Hospital.	6/23/15
56	Interested Party Counsel filed a supplement to written comments on behalf of Anne Arundel Medical Center.	7/10/15
57	Interested Party Counsel for Doctor's Community Hospital filed a Reply to Dimension's Response to Request for a Hearing.	7/14/15
58	Commissioner Moffit notified the parties of his appointment as Reviewer in this matter and sent his ruling on interested party status for AAMC, DHC, and Prince George's County Health Department to counsel for the parties and Pamela Creekmur, the Prince George's County Health Officer.	8/4/15
59	Commission Chair Tanio received a letter written in support of the project from Senator Douglas J.J Peters, Chair of the Prince George's Senate Delegation, and Delegate Jay Walker, Chair of the Prince George's House Delegation.	8/5/15
60	Commissioner Moffit sent a request for a site visit to counsel for the parties and Ms. Creekmur.	8/21/15
61	The Commission received availability details for a site visit of Prince George's Hospital Center from Mr. Montgomery on behalf of AAMC.	8/27/15
62	The Commission received availability details for a site visit of Prince George's Hospital Center from the applicants' counsel on behalf of the applicants.	8/28/15
63	The Commission received availability details for a site visit of Prince George's Hospital Center from the applicants' counsel on behalf of Doctor's Community Hospital.	8/28/15
64	AAG for the Commission, sent notification of the scheduling of the site visit to be held on September 25, 2015 at 9:30 a.m. to counsel for the parties and Ms. Creekmur.	9/1/15
65	Commissioner Moffit sent a request to the Health Services Cost Review Commission (HSCRC) for comments on the proposed project.	9/11/15
66	Commission staff received an additional response by Dimension on the site visit from the applicants' counsel.	9/14/15
67	Commissioner Moffit sent information to Dame/Montgomery/ Parvis/Creekmur regarding the itinerary for the site visits on September 25, 2015.	9/17/15
68	Commission staff received an additional response from Dimensions on the site visit from the applicants' counsel.	9/17/15

69	AAG for the Commission sent a revised Itinerary for the site visits by e-mail to Dame/Montgomery/Parvis/Creekmur.	9/21/15
70	The applicants' counsel filed a Motion to Strike the Supplemental Comments of Anne Arundel Medical Center on behalf of the applicants.	10/9/15
71	Commissioner Moffit received HSCRC Comments on the application.	10/23/15
72	Commissioner Moffit shared the HSCRC comments with counsel for the parties.	10/28/15
73	Commissioner Moffit received the applicants' response to request for response on HSCRC comments from Mr. Dame.	12/4/15
74	Interested Party Counsel for AAMC filed a response to Dimension's Motion to Strike Supplemental Comments.	1/12/16
75	The applicants filed a reply in Further Support of Dimensions Motion to Strike the Supplemental Comments of AAMC.	1/29/16
76	Commissioner Moffit requested an update from Dimensions regarding the status of its partial rate application and potential MOU with UMMS and the State of Maryland.	3/7/16
77	Commissioner Moffit received a response to his March 7, 2016 requested update from the applicants' counsel.	3/23/16
78	Commissioner Moffit notified the parties that he would hold a project status conference.	4/13/16
79	E-mail correspondence from Interested Party Counsel regarding availability of DCH for the project status conference.	4/18/16
80	Commissioner Moffit received a letter from the Applicants' Counsel regarding availability of PGRMC for the project status conference.	4/18/16
81	E-mail correspondence from the Commissions' AAG that the project status conference would be held on 5/17/16 to the parties' counsel and Ms. Creekmur.	4/18/16
81A	E-mail correspondence regarding the parties' attendees for the project status conference.	5/16/16
82	Sign-in Sheet for the project status conference.	5/17/16
83	Commissioner Moffit sent counsel for the parties and Ms. Creekmur his project status conference summary.	5/17/16
84	Commissioner Moffit received correspondence from the Applicants' Counsel that the applicants would modify their application and applicants' response to concerns expressed at the project status conference.	5/23/16
85	Commissioner Moffit sent clarification on the project status conference recommendations to the applicants by letter to the Applicants' Counsel.	5/26/16
86	Commissioner Moffit received a request from the Applicants' Counsel on behalf of the applicants that MHCC make certain materials part of the project record.	6/2/16
87	Commissioner Moffit received a request for additional clarification regarding the project status conference recommendations from the Applicants' Counsel.	6/2/16
88	Commissioner Moffit sent the reviewer's Clarification of Budget, Record of Review (with DVD) to the Applicants' counsel.	6/17/16
89	Commissioner Moffit sent rulings on pending motions and requests to counsel for the parties and Ms. Creekmur.	7/8/16
90	E-mail correspondence from the Applicants' Counsel to the Commissions' AAG requesting the Commission's advice on format for the modification.	7/15/16
91	Anonymous Filing of Documents concerning PGRMC project.	8/15/16

92	The Commission received applicants' Modified CON Application.	8/31/16
93	Commissioner Moffit sent the HSCRC a request for comments on the modified application.	9/8/16
94	Commissioner Moffit sent a request for additional completeness information on the modified application to the Applicants' Counsel.	9/8/16
95	E-mail correspondence between the Commissions' AAG and Counsel for the applicants' regarding clarification on the submission date for completeness information.	9/8/16
96	The applicants filed Response to Additional Information Questions Received September 8, 2016.	9/13/16
97	Commissioner Moffit received HSCRC's comments on the modified application	9/21/16

APPENDIX 2

POPULATION DATA

- **Population Change, Prince George's County - 2010 to 2040**
- **Population Change, Maryland - 2010 to 2040**

Population Change, Prince George's County 2010 to 2040

PG County Population by Age Group, 2010 - 2040						
Year	**0-14**	**15-44**	**45-64**	**65-74**	**75+**	**Total**
2010	168,969	387,755	225,183	50,100	31,413	863,420
2015	168,319	395,623	233,042	65,336	38,028	900,348
2020	165,230	397,322	228,136	77,281	46,526	914,495
2025	163,112	401,849	220,046	85,386	59,256	929,649
2030	163,868	403,207	214,858	91,252	71,363	944,548
2035	162,513	405,260	217,837	89,845	82,192	957,647
2040	160,364	404,717	228,660	83,760	90,347	967,848
Projected Change, PG County Population by Age Group, 2010 - 2040						
Year	0-14	15-44	45-64	65-74	75+	Total
2010-2015	0.38%	-2.03%	-3.49%	-30.41%	-21.06%	-4.28%
2015-2020	1.84%	-0.43%	2.11%	-18.28%	-22.35%	-1.57%
2020-2025	1.28%	-1.14%	3.55%	-10.49%	-27.36%	-1.66%
2025-2030	-0.46%	-0.34%	2.36%	-6.87%	-20.43%	-1.60%
2030-2035	0.83%	-0.51%	-1.39%	1.54%	-15.17%	-1.39%
2035-2040	1.32%	0.13%	-4.97%	6.77%	-9.92%	-1.07%
2010-2020	2.21%	-2.47%	-1.31%	-54.25%	-48.11%	-5.92%
2020-2030	3.09%	-1.57%	5.58%	-30.69%	-55.82%	-3.25%
2030-2040	0.82%	-1.48%	5.82%	-18.08%	-53.38%	-3.29%
2010-2040	0.37%	-0.85%	1.00%	-5.22%	-38.71%	-3.01%

Source: Maryland Department of Planning, 2014 Total Population Projections by Age, Sex and Race (Revised January 2015)

Population Change, Maryland 2010 – 2040

Maryland Population by Age Group, 2010 - 2040						
Year	**0-14**	**15-44**	**45-64**	**65-74**	**75+**	**Total**
2010	1,110,385	2,357,553	1,597,972	386,357	321,285	5,773,552
2015	1,106,568	2,409,248	1,655,351	493,826	345,148	6,010,141
2020	1,119,381	2,490,172	1,630,621	584,116	400,221	6,224,511
2025	1,143,279	2,571,215	1,565,281	658,770	491,204	6,429,749
2030	1,184,538	2,600,959	1,526,682	715,532	584,480	6,612,191
2035	1,200,660	2,624,928	1,555,264	698,164	683,287	6,762,303
2040	1,201,604	2,644,554	1,636,879	637,546	769,109	6,889,692

Projected Change, Maryland Population by Age Group, 2010 - 2040						
Year	0-14	15-44	45-64	65-74	75+	Total
2010-2015	0.34%	-2.19%	-3.59%	-27.82%	-7.43%	-4.10%
2015-2020	-1.16%	-3.36%	1.49%	-18.28%	-15.96%	-3.57%
2020-2025	-2.13%	-3.25%	4.01%	-12.78%	-22.73%	-3.30%
2025-2030	-3.61%	-1.16%	2.47%	-8.62%	-18.99%	-2.84%
2030-2035	-1.36%	-0.92%	-1.87%	2.43%	-16.91%	-2.27%
2035-2040	-0.08%	-0.75%	-5.25%	8.68%	-12.56%	-1.88%
2010-2020	-0.81%	-5.63%	-2.04%	-51.19%	-24.57%	-7.81%
2020-2030	-3.32%	-6.72%	5.44%	-33.40%	-42.32%	-6.98%
2030-2040	-5.82%	-4.45%	6.37%	-22.50%	-46.04%	-6.23%
2010-2040	-5.02%	-2.09%	0.64%	-5.98%	-39.10%	-5.17%

APPENDIX 3

Acute Care Hospital Data for Prince George's County,

CY 2009-2015:

MSGA, OBSTETRICS, PEDIATRICS, and PSYCHIATRY

- **DISCHARGES**
- **DISCHARGE DAYS**
- **AVERAGE LENGTH OF STAY**

Table MSGA 1: Prince George's County General Hospitals MSGA Discharges, CY 2009 - 2015

MEDICAL/SURGICAL/GYNECOLOGICAL/ADDICTIONS (MSGA) DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY	12,010	13,005	12,468	11,074	10,537	8,807	9,064
FORT WASHINGTON	3,007	2,980	2,254	2,030	2,264	2,150	2,224
LAUREL REGIONAL	4,391	3,831	3,206	3,437	3,695	2,920	3,053
PRINCE GEORGE'S	9,520	9,133	8,069	7,218	6,951	7,855	8,431
MEDSTAR SOUTHERN MARYLAND	13,379	13,178	12,748	12,111	10,682	10,065	9,375
Total	42,307	42,127	38,745	35,870	34,129	31,797	32,147
ALL Maryland Hospitals	552,772	532,380	508,914	486,273	465,441	442,633	428,984

Table MSGA 2: Prince George's County General Hospitals MSGA Discharge Days, CY 2009 - 2015

MSGA DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY	48,560	55,178	54,130	51,598	49,071	42,311	46,835
FORT WASHINGTON	10,934	10,845	8,755	7,727	8,489	8,195	8,504
LAUREL REGIONAL	18,379	16,681	14,009	14,475	14,089	11,968	11,857
PRINCE GEORGE'S	46,809	47,853	43,132	42,312	40,759	45,978	46,282
MEDSTAR SOUTHERN MARYLAND	49,575	48,828	50,623	49,985	45,747	44,486	42,273
Total	174,257	179,385	170,649	166,097	158,155	152,938	155,751
All Maryland Hospitals	2,312,078	2,241,818	2,234,630	2,173,796	2,110,391	2,078,304	2,048,936

Table MSGA 3: Prince George's County General Hospitals MSGA Discharge Average Length of Stay, CY 2009 - 2015

MSGA AVERAGE LENGTH OF STAY (ALOS) (DAYS)							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY	4.04	4.24	4.34	4.66	4.66	4.80	5.17
FORT WASHINGTON	3.64	3.64	3.88	3.81	3.75	3.81	3.82
LAUREL REGIONAL	4.19	4.35	4.37	4.21	3.81	4.10	3.88
PRINCE GEORGE'S	4.92	5.24	5.35	5.86	5.86	5.85	5.49
MEDSTAR SOUTHERN MARYLAND	3.71	3.71	3.97	4.13	4.28	4.42	4.51
Total	4.12	4.26	4.40	4.63	4.63	4.81	4.84
All Maryland Hospitals	4.18	4.21	4.39	4.47	4.53	4.70	4.78

Source: HSCRC Discharge Database.

Table OB 1: Prince George's County General Hospitals Obstetric Discharges, CY 2009 - 2015

OBSTETRIC ("OB") DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY*	88	110	81	43	55	32	35
FORT WASHINGTON*	22	21	17	14	17	3	15
LAUREL REGIONAL	778	954	1,074	1,045	960	700	640
PRINCE GEORGE'S	2,763	2,816	2,430	2,366	2,275	2,395	2,338
MEDSTAR SOUTHERN MARYLAND	2,033	2,138	2,386	2,236	1,843	1,603	1,405
Total	5,684	6,039	5,988	5,704	5,150	4,733	4,433
All Maryland Hospitals	78,199	77,064	75,189	74,013	71,830	72,427	71,614

Source: HSCRC Discharge Database.
*Hospital does not operate an organized obstetric service or have licensed OB beds.

Table OB 2: Prince George's County General Hospitals Obstetric Discharge Days, CY 2009 - 2015

OB DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY*	137	189	143	84	112	73	99
FORT WASHINGTON*	31	23	30	16	30	6	25
LAUREL REGIONAL	1,848	2,403	2,684	2,450	2,148	1,591	1,447
PRINCE GEORGE'S	8,180	8,152	7,117	6,531	5,936	6,393	5,879
MEDSTAR SOUTHERN MARYLAND	5,169	5,498	6,323	6,064	4,972	3,943	3,546
Total	15,365	16,265	16,297	15,145	13,198	12,006	10,996
All Maryland Hospitals	220,599	213,066	206,325	195,078	185,896	184,797	180,884

Source: HSCRC Discharge Database.
* Hospital does not operate an organized obstetric service or have licensed OB beds.

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Table OB 3: Prince George's County General Hospitals Obstetric Discharge Average Length of Stay, CY 2009 - 2015

OB ALOS (DAYS)							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY*	1.56	1.72	1.77	1.95	2.04	2.28	2.83
FORT WASHINGTON*	1.41	1.10	1.76	1.14	1.76	2.00	1.67
LAUREL REGIONAL	2.38	2.52	2.50	2.34	2.24	2.27	2.26
PRINCE GEORGE'S	2.96	2.89	2.93	2.76	2.61	2.67	2.51
MEDSTAR SOUTHERN MARYLAND	2.54	2.57	2.65	2.71	2.70	2.46	2.52
Total	2.70	2.69	2.72	2.66	2.56	2.54	2.48
All Maryland Hospitals	2.82	2.76	2.74	2.64	2.59	2.55	2.53

Source: HSCRC Discharge Database. * Hospital does not operate an organized obstetric service or have licensed OB beds.

Table Peds 1: Prince George's County General Hospitals Pediatric Discharges, CY 2009 - 2015

PEDIATRICS DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY	---	4	---	2	2	2	2
FORT WASHINGTON *	---	---	---	---	----	---	---
LAUREL REGIONAL *	---	---	1	1	---	---	---
PRINCE GEORGE'S	150	48	45	23	23	3	2
MEDSTAR SOUTHERN MARYLAND	186	151	93	92	35	33	2
Total	336	203	139	118	60	38	6
All Maryland Hospitals	24,432	20,782	19,710	18,797	16,922	15,372	14,166

Source: HSCRC Discharge Database.
* Hospital does not operate an organized pediatric service or have a licensed pediatric bed.

Table Peds 2: Prince George's County General Hospitals Pediatric Discharge Days, CY 2009 - 2015

PEDIATRIC DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY*	---	9	---	5	4	11	7
FORT WASHINGTON*	---	---	---	---	---	---	---
LAUREL REGIONAL*	---	---	2	2	---	---	---
PRINCE GEORGE'S	354	130	123	38	42	8	7
MEDSTAR SOUTHERN MARYLAND	377	363	234	215	90	86	5
Total	731	502	359	260	136	105	19
All Maryland Hospitals	76,925	67,188	65,118	61,891	61,871	55,323	54,787

Source: HSCRC Discharge Database.
* Hospital does not operate an organized pediatric service or have a licensed pediatric bed.

Table Peds 3: Prince George's County General Hospitals Pediatric Discharge Average Length of Stay, CY 2009 - 2015

PEDIATRIC ALOS (DAYS)							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY*	---	2.25	---	2.50	2.00	5.50	3.50
FORT WASHINGTON*	---	---	---	---	---	---	---
LAUREL REGIONAL*	---	---	2.00	2.00	---	---	---
PRINCE GEORGE'S	2.36	2.71	2.73	1.65	1.83	2.67	3.50
MEDSTAR SOUTHERN MARYLAND	2.03	2.40	2.52	2.34	2.57	2.61	2.50
Total	2.03	2.47	2.58	2.20	2.27	2.76	3.17
All Maryland Hospitals	3.15	3.23	3.30	3.29	3.66	3.60	3.87

Source: HSCRC Discharge Database.
* Hospital does not operate an organized pediatric service or have a licensed pediatric bed.

Table Psych 1: Prince George's County General Hospitals
Psychiatric Discharges, CY 2009 - 2015

PSYCHIATRIC DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY	39	41	25	30	24	10	17
FORT WASHINGTON	8	7	13	15	12	16	16
LAUREL REGIONAL	765	807	898	723	801	725	729
PRINCE GEORGE'S	1,269	1,348	1,421	1,363	1,321	1,395	1,387
MEDSTAR SOUTHERN MARYLAND	1,331	1,349	1,278	1,085	918	1,166	1,156
Total	3,428	3,552	3,635	3,216	3,076	3,312	3,305
All Maryland Hospitals	33,583	35,265	36,134	34,990	34,428	34,183	32,705

Source: HSCRC Discharge Database.
* Doctors Community Hospital and Fort Washington Hospital do not operate an organized psychiatric service or have a licensed psychiatric bed.

Table Psych 2: Prince George's County General Hospitals
Psychiatric Discharge Days, FY 2009 - 2015

PSYCHIATRIC DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
DOCTORS COMMUNITY	178	127	81	104	115	43	73
FORT WASHINGTON	16	20	39	42	50	56	76
LAUREL REGIONAL	3,104	2,571	3,654	3,320	3,445	2,795	3,315
PRINCE GEORGE'S	7,008	7,901	7,866	7,402	7,464	8,897	9,209
MEDSTAR SOUTHERN MARYLAND	6,450	5,965	6,446	4,965	4,330	5,486	6,172
Total	16,756	16,584	18,086	15,833	15,404	17,277	18,845
All Maryland Hospitals	192,191	197,565	205,348	203,971	200,374	207,881	205,460

Source: HSCRC Discharge Database.
*Doctors Community Hospital and Fort Washington Medical Center do not operate an organized psychiatric service or have a licensed psychiatric bed.

Table Psych 3: Prince George's County General Hospitals
Psychiatric Discharges - Average Length of Stay, FY 2009 - 2015

PSYCHIATRIC ALOS (DAYS)							
	2009	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
DOCTORS COMMUNITY	4.56	3.10	3.24	3.47	4.79	4.30	4.29
FORT WASHINGTON	2.00	2.86	3.00	2.80	4.17	3.50	4.75
LAUREL REGIONAL	4.01	3.19	4.07	4.59	4.30	3.86	4.55
PRINCE GEORGE'S	5.49	5.86	5.54	5.43	5.65	6.38	6.64
MEDSTAR SOUTHERN MARYLAND	4.85	4.42	5.04	4.58	4.72	4.70	5.34
Total	4.89	4.67	4.98	4.92	5.01	5.22	5.70
All Maryland Hospitals	5.56	5.60	5.68	5.83	5.82	6.08	6.28

Source: HSCRC Discharge Database.
* Doctors Community Hospital and Fort Washington Medical Center do not operate an organized psychiatric service or have a licensed psychiatric bed.

APPENDIX 4

Dimensions' Assessment of Alternatives

Dimensions' Assessment of Alternatives (Di#30, pp. 102-113)

Objectives	Maintain PGHC's role as a regional medical center	Address public perceptions of PGHC	Improve the ability to recruit physicians	Maintain or improve access for its service area population	Enable collaboration with the University of Maryland System and School of Medicine	Site and cost considerations including: adequate size; site acquisition and development costs, engineering and traffic considerations; timing of site availability; and future expansion and development potential	
1: Option Replace on current campus	Would marginally improve PGHC's ability to remain a regional medical center. (But)…the continued association with the historical campus would limit the benefits of perception. ***Score: 7***	The continued association with the existing site would limit the improvements in perception. ***Score: 7***	Because the improvements in perception would be limited, (so)… Option 1 would only marginally improve the ability to recruit hysicians. ***Score: 7***	Would maintain, but not improve, access. ***Score:5***	Would enable collaboration (but)…marginal improvements in perception would limit the synergistic value of UMMS collaboration. ***Score: 7***	Moderate engineering issues. No improvement in traffic issues. ***Score: 5***	Costs would be comparable to building a new facility at a different site. ***Score: 7*** **TOTAL SCORE= 47**
Option 2: Additions/renovations on existing site	Would marginally improve PGHC's ability to remain a regional medical center. (But)…continued association with the historical campus and use of existing buildings would significantly limit the benefits of perception. ***Score: 6***	The continued association with the existing site and buildings would significantly limit the improvements in perception. ***Score: 6***	Because the improvements in perception would be limited, Option 2 would only marginally improve the ability to recruit physicians. ***Score: 6***	Option 2 would maintain, but not improve, access. ***Score:5***	Would enable collaboration. (But)…the marginal improvements in perception would limit the synergistic value of UMMS collaboration. ***Score: 6***	Significant engineering issues. No improvement in traffic issues. ***Score: 4***	Because of the 10 year phasing, costs could actually be higher than building a new facility at a different site. $**389,667,500** ***Score: 5*** **TOTAL SCORE= 38**
Option 3: Relocate to Woodmore Town Center	Would significantly improve PGHC's ability to remain a regional medical center. ***Score: 10***	The fresh start at a new site will significantly improve perception. ***Score: 10***	Would significantly improve the ability to recruit physicians. ***Score: 10***	Would improve access, though the traffic issues would limit the improvements. ***Score:8***	Would enable collaboration with UMMS. ***Score: 10***	Moderate engineering issues. Significant traffic issues. ***Score: 7***	Costs…comparable to building a new facility at a different site. Most expensive site costs of the new sites. ***Score: 7*** **TOTAL SCORE= 62**

Note: These costs do not include financing costs, permits, A&E fees, moveable equipment, or escalation premiums

Table continues on next page….

Objectives	Maintain PGHC's role as a regional medical center	Address public perceptions of PGHC	Improve the ability to recruit physicians	Maintain or improve access for its service area population	Enable collaboration with the University of Maryland System and School of Medicine	Site and cost considerations including: adequate size; site acquisition and development costs, engineering and traffic considerations; timing of site availability; and future expansion and development potential	
Option 4: Relocate to Landover Mall site	Would significantly improve PGHC's ability to remain a regional medical center. ***Score: 10***	The fresh start at a new site will significantly improve perception. ***Score: 10***	Dimensions believes Option 4 would significantly improve the ability to recruit physicians. ***Score: 10***	Would improve access, though the traffic issues would limit the improvements. ***Score:8***	Would enable collaboration with UMMS. ***Score: 10***	Significant engineering issues. Significant traffic issues. ***Score: 6***	Costs would be comparable to building a new facility at a different site. Second most expensive site costs of the new sites. ***Score: 8*** **TOTAL SCORE= 62**
Option 5: Relocate to Boulevard at the Capital Centre (Powell Property);	Would significantly improve PGHC's ability to remain a regional medical center. ***Score: 10***	The fresh start at a new site will significantly improve perception. ***Score: 10***	Would significantly improve the ability to recruit physicians. ***Score: 10***	Option 5 would improve access. Adjacent Metro station is an advantage. ***Score: 10***	Option 5 would enable collaboration. ***Score: 10***	Moderate engineering issues. No traffic issues. Less site development restrictions than Option 6. ***Score: 9***	Costs would be comparable to building a new facility at a different site. Second least expensive site costs of the new sites. (Only $225,000 more than Option 6.) ***Score: 9*** **TOTAL SCORE= 68**
Option 6: Relocate to Boulevard at the Capital Centre (Schwartz Property)	Would significantly improve PGHC's ability to remain a regional medical center. ***Score: 10***	The fresh start at a new site will significantly improve perception. ***Score: 10***	Would significantly improve the ability to recruit physicians. ***Score: 10***	Would improve access. Adjacent Metro station is an advantage. ***Score: 10***	Would enable collaboration. ***Score: 10***	The road to the Metro Station. traverses the middle of the property (and)… severely limits the site's use. No traffic issues. ***Score: 6***	Costs would be comparable to building a new facility at a different site. Least expensive site costs of the new sites. ***Score: 10*** **TOTAL SCORE= 66**

APPENDIX 5

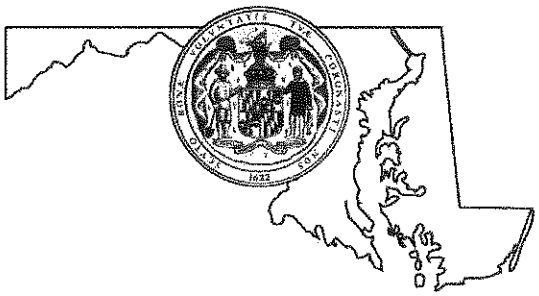
Excerpted CON standards for General Surgical Services From State Health Plan Chapter 10.24.11

Excerpted CON standards for General Surgical Services
From State Health Plan Chapter 10.24.11

Each of these standards prescribes policies, services, staffing, or facility features necessary for CON approval that MHCC staff have determined the applicant has met. Bolding added for emphasis. Also included are references to where in the application or completeness correspondence the documentation can be found.

STANDARD	**APPLICATION REFERENCE (Docket Item #)**
(4) Transfer Agreements. (a) Each ASF and hospital **shall have written transfer and referral agreements** with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital. (b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.	DI#36, Exhibit 52
(4) Design Requirements. Floor plans submitted by an applicant **must be consistent with the current FGI Guidelines.** (a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines. (c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.	DI. #30, Exhibit 41
(5) Support Services. Each applicant **shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services**.	DI #30, p. 181

APPENDIX 6: HSCRC Comments



Health Services Cost Review Commission
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Toll Free: 1-888-287-3229
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Memorandum

Date: September 21, 2016

To: Robert E. Moffit, Ph.D.
Commissioner/Reviewer, MHCC

From: Donna Kinzer, Executive Director
Gerard J. Schmith, Deputy Director, Hospital Rate Setting, HSCRC

Subject: Modification of Application for Certificate of Need to Relocate Prince George's Hospital Center (Docket No. 13-16-2351)

On September 8, 2016, you requested that we review and comment on certain aspects of the financial feasibility and underlying assumptions of the modified Certificate of Need ("CON") application submitted by Dimensions Health System ("Dimensions," or "DHS") on August 31, 2016. The application concerns the proposed relocation of Prince George's Hospital Center ("PGHC").

Per your request we will address each of the five specific questions outlined in your letter.

1. *Are the sources of funds assumed by the applicants appropriate? In your opinion, is the proportion of non-debt and non-grant sources of project funding adequate?*

PGHC has assumed the following sources of funds for their project as reported to the HSCRC:

Source:	Amount
Authorized Bonds	$117,809,717
Interest Income from Bond Proceeds	9,190,283
State Grant	208,000,000
County Grant	208,000,000
Contribution of Land by County	12,350,000
Total Sources of Funds	$555,350,000

The $12,350,000 reported as "Contribution of Land by the County" as a source of funds also appears as a use of funds in the CON modification as "Land Purchase," so no cash is required to be paid. We do not know if the assessed value of $12,350,000 is reasonable.

The sources of funds assumed by the applicants appear appropriate with the understanding that the County and State will provide the funds in the amounts shown above. Beyond the funds granted and the land contributed, DHS must borrow the balance of funds needed, since it has no excess cash reserves to contribute to the project. In fact, DGH will need to borrow money for the short term in order to ensure that an adequate number of Days of Cash on Hand are available, which may be required in the bond documents.

2. *The applicants have assumed that a "redistribution" of the Dimension's Health System's global budget revenue will be a source of revenue needed by PGHC to successfully relocate and transition to operation of a new replacement hospital, in lieu of the partial rate request revenue adjustment for capital that it has been pursuing to date. This would appear to be related to the plan announced by Dimensions in 2015 to convert the Laurel Regional Hospital campus to an outpatient health care facility by 2018. In your opinion, is this a reasonable and acceptable approach to increasing PGHC's revenue in the amount necessary for this project to be feasible and the replaced and relocated PGHC to be financially viable? Is it a preferable option to the current partial rate request revenue adjustment for capital that Dimensions has filed with the HSCRC? If, in your opinion, this redistribution is not necessary for project feasibility and the viability of PGHC, please provide the basis for this opinion.*

We have reviewed DHS's plan to redistribute the System's Global Budget Revenue (GBR) among PGHC, Laurel Hospital, and the Bowie Health Center. The plan proposed by Dimensions would provide PGHC with a greater revenue increase ($30 million) than requested in the partial rate application for additional capital ($25 million) previously submitted by PGHC. As will be discussed in the response to question # 4, PGHC's rates after the redistribution of revenue to PGHC will be 25% to 30% above its neighboring competitor hospitals.

HSCRC staff believes that reallocating resources within a system is a preferable approach and is consistent with the All Payer Model goals. By restructuring resources within a system, funds are freed up to fund transition and ongoing resource needs of the system, inclusive of support of the new facilities. Through this mechanism, the project does not add additional cost to the healthcare system as a whole. We have worked with other healthcare systems over the last few years to allow for the reallocation of resources, as they have moved services and providers from one campus to another. This flexibility promotes the goals of better care and lower costs.

Whether the total $30 million is necessary is questionable given the level of the expenses DHS has built into its projections, and the fact that its rates are currently higher than other competitor and peer hospitals. However, there are some legitimate reasons for its higher rates than

competitors (as we will address in Question 4), and PGHC believes that it will become more competitive over time. There are also transition expenses, infrastructure and population health investments, and other expenses that will need to be funded. Also, DHS will be subject to efficiency measures, and if the level of funding is too high, it will be subject to adjustment.

3. *As with previous iterations of this project, Dimensions assumes that revenue adjustments for market shifts should be recognized immediately in the year of the volume growth resulting from the shift in market share rather than in the year following the volume growth. Will HSCRC agree to this treatment of market share shift-related volume increases?*

As stated above, HSCRC staff has been working with other healthcare systems to ensure that revenues are moved as expenses are incurred for planned moves of services from one facility within a system to another. If services are moved within DHS, the revenue would also be moved as soon as possible. The HSCRC staff has recently begun to implement rate changes for market shifts on a more current basis than we have in the past. Also, HSCRC has made other current market shift adjustments. For example, HSCRC implemented concurrent market shift adjustments when Holy Cross Germantown opened, and several facilities were adversely affected thereby. When HSCRC makes concurrent market shift adjustments, it subsequently corrects for differences between estimated and actual shifts. PGHC understands that if it does not achieve the projected market shift change, then an adjustment will be made during the subsequent year to recover the revenue advanced in anticipation of the market shift.

4. *Based on your analysis and the experience of the HSCRC to date in implementing the new payment model for hospitals, what is the ability of the proposed replacement to be competitively priced, when compared with general hospitals in its region of the State and when compared with similar (peer group) hospitals throughout the State, if the project is implemented as proposed and the applicants' utilization projections are realized?*

We remain concerned that the projected unit rates for PGHC will be well above other general hospitals in its region as well as in similar peer group hospitals throughout the State.. Listed below are the projected inpatient revenue, inpatient discharges, inpatient revenue per discharge, and the annual percentage increase in inpatient revenue per discharge for PGHC for the years ended June 30, 2016 through June 30, 2023 per the inflated projected financial statements included in the CON:

Year Ended June 30	Inpatient Revenue (in 000's)	Inpatient discharges	Inpatient Revenue Per Discharge	Percentage Annual Increase
2016	$214,979	12,306	$17,469	
2017	222,540	12,417	17,922	2.6%

2018	230,168	12,573	18,306	2.1%
2019	263,213	12,730	20,677	13.0%
2020	272,654	12,886	21,159	2.3%
2021	283,965	13,185	21,537	1.8%
2022	294,605	13,484	21,848	1.4%
2023	304,262	13,783	22,075	1.0%
Total				24.2%

On Page 53 of PGHC's request to redistribute GBR revenue submitted to the HSCRC on July 27, 2016, PGHC stated that its rates were on average 19.5% above the other general hospitals within its region. Assuming that the other hospitals in PGHC's region are granted approved increases in revenue of 2.3% annually for the 7 years ending June 30, 2023, their rates would increase by 16.1% compared to the 24.2% projected by PGHC. If we were to add the 8.1% difference between PGHC's projected increases and the other hospitals' projected increases to the existing 19.5% difference in rates, then PGHC's rates would be on average 27.6% higher than the other hospitals in its region by the end of the projection period in the CON. While DHS has projected an increase in volumes at a variable cost rate of 50%, the increase in volume is not sufficient to significantly reduce the PGHC's prices.

The original CON modification submitted January 16, 2015 projected a significantly higher percentage increase in annual volumes than the August 31, 2016 CON modification. Listed below are the projected discharges from the January 16, 2015 CON filing compared to the projected discharges in the August 31, 2016 CON modification:

	Year Ended June 30,				
	2019	2020	2021	2022	2023
January 16, 2015 CON Modification Discharges	12,081	12,993	13,905	14,817	N/A
Annual Percent Increase	1.4%	7.5%	7.0%	6.6%	
August 31, 2016 CON Modification Discharges	12,701	12,886	13,184	13,484	13,783
Annual Percent Increase	1.3%	1.5%	2.3%	2.3%	2.2%

In January 2015, PGHC had projected that it would have 10% more discharges than it is now projecting for 2022. If PGHC had not reduced the projected 2022 volumes between the January 2015 CON submission and the August 31, 2016 CON submission and had held projected revenue constant, PGHC's projected 2022 revenue per discharge would have been 5% to 10% lower than the amount projected in the August 31, 2016 CON submission.

Based on the projected inpatient revenue per discharge included in the current CON modification, PGHC does not appear to be competitively priced compared to the hospitals in region.

The HSCRC is currently developing comparisons of cost per capita to augment comparisons based on unit or per case prices. This may change the relative ranking of the PGHC facility. PGHC's current revenue per equivalent discharge on a calendar year-to-date basis through July 31, 2016 is approximately 12% higher than the average charges of a peer group of similar hospitals including MedStar Harbor Hospital, MedStar Union Memorial Hospital, Sinai Hospital, Mercy Hospital, and Johns Hopkins Bayview. By 2023, PGHC's projected charges per case would be approximately 20% higher than the peer group of hospitals after taking into account the redistributed System revenue and projected future volume changes at PGHC.

PGHC has a trauma service and has had a large share of indigent patients referred to as "Disproportionate Share" patients. Trauma services and higher costs related to health and socioeconomic costs of treating indigent patients serve to increase relative rates. We have not removed these costs from this analysis. These are severity and social costs that must be borne by Dimensions.

HSCRC staff will recommend that PGHC's rate structure be subject to efficiency measures developed by HSCRC staff in the future.

5. *I asked the applicants to provide a complete and detailed analysis of how this project will improve operational efficiency and reduce staffing hours and cost per unit of service. I asked them to quantify the financial impact of the projected operational efficiencies. Pages 17 through 30 of the August 31, 2016 filing responds to this request. I am interested in HSCRC's perspective on the strength of the case made by the applicants.*

We reviewed the performance improvements explained on Pages 17 through 30 of the August 31, 2016 CON modification. The first set of performance improvements relate to improved collection efforts by PGHC which will result in higher collections in the future. We believe that the collection improvements identified by PGHC are achievable and may actually result in even greater improvements in future collections than the amounts estimated by PGHC in the modification.

The second and third performance improvements identified by PGHC relate to reductions in overall length of stays as well as unnecessary admissions. Staff believes that the performance improvements related to reduced utilization are achievable and could potentially be higher. .

The fourth and fifth set of performance improvements identified by PGHC relate to reductions in salaries through improvements in recruiting efforts, management of staff, and improvements in supply chain management and drug and contract service cost reductions. In order to evaluate the estimated performance improvements in operational expense areas, we calculated the average annual percentage change in uninflated operating expenses per Equivalent Inpatient Admission. In our calculation of annual changes in operating expenses, we excluded from our analysis

changes in capital expenses and physician support expenses because these two items are not impacted by changes in volumes. The results of our analysis are presented below:

Projected Year Ended June 30,	Average Operating Expenses Per EIPA (Uninflated)	Percent Change from Prior Year
2016	$13,240	2.7%
2017	$13,163	-.6%
2018	$12,895	-2.0%
2019	$12,348	-4.2%
2020	$12,017	-2.7%
2021	$11,880	-1.1%
2022	$11,748	-1.1%
2023	$11,649	-.8%

Beginning in FY 2017, PGHC projected that the average operating cost per EIPA would decrease each year as expense performance improvements were implemented and volumes increased. Again, we believe that these operational expense performance improvements projected by PGHC are reasonable, and that actual improvements could be greater than anticipated.

In summary, we believe that the performance improvements identified by PGHC in their CON modification are achievable. Furthermore, we believe that PGHC will exceed the savings estimated from performance improvements, which will have a positive impact on the projected income statements.

Please contact us if you have further questions.