

IN THE MATTER OF THE * **BEFORE THE**
*
CONVERSION OF THE * **MARYLAND**
*
UNIVERSITY OF MARYLAND * **HEALTH CARE**
*
SHORE MEDICAL CENTER AT * **COMMISSION**
*
DORCHESTER TO A *
*
FREESTANDING MEDICAL FACILITY *
*
Docket No. 18-09-EX006 *
*

STAFF REPORT & RECOMMENDATION
(corrected)

EXEMPTION FROM CERTIFICATE OF NEED REVIEW
CONVERSION OF THE UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER
AT DORCHESTER TO A FREESTANDING MEDICAL FACILITY

April 18, 2019

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I. INTRODUCTION

A. Background

In June 2017, the Maryland Health Care Commission (“MHCC”) adopted COMAR 10.24.19 (“FMF Chapter”), a chapter of the State Health Plan for Facilities and Services (“SHP”) that governs the establishment of an Freestanding Medical Facility (“FMF”) and certain other actions by an FMF through Certificate of Need (“CON”) approval. The FMF Chapter also governs the establishment of an FMF through the conversion of a general hospital to an FMF, using the exemption from CON review process. This type of health care facility was first established in Maryland in 2005 and four FMFs are currently operating in Maryland. For the first ten years following creation of this category of health care facility, FMFs operated as pilot programs, subject to study by MHCC and subsequent legislative action. Since Fiscal Year (“FY”) 2016, the establishment of an FMF has been subject to regulation by the Commission. This staff report addresses the second FMF project submitted for review by MHCC that involves the conversion of a general hospital to an FMF.

A freestanding medical facility is an outpatient health care facility that: (a) provides medical and health care services; (b) is an administrative part of an acute care general hospital; (c) Is physically separated from the hospital or hospital grounds; (d) operates 24 hours a day, seven days a week; (e) complies with the provisions of the Emergency Medical Treatment and Active Labor Act¹ and Medicare Conditions of Participation; (f) has the ability to rapidly transfer complex cases to an acute care general hospital after the patient has been stabilized; (g) maintains adequate and appropriate delivery of emergency medical care within the statewide emergency medical services system as determined by the Maryland State Emergency Medical Services Board; and (h) may provide observation services. COMAR 10.24.19.05B(8). The FMF model created in Maryland is one that is commonly referenced as a “freestanding emergency center” in other states.

Establishment of a new FMF by a general hospital, the relocation of an FMF, or a capital expenditure made by or on behalf of an FMF that exceeds the applicable capital expenditure threshold requires CON approval. Maryland’s first three FMFs were established as satellites of their parent general hospitals,² extending a level of care similar to the full-time and specialist-directed emergency services found in the parent hospital’s emergency department to alternative locations within the parent’s service area. MHCC has found that these three FMFs have lower patient acuity and produce lower numbers of inpatient admissions than their parent hospitals. (*Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities*, MHCC, February 4, 2015)

In 2016, Maryland law was amended to permit a general hospital that is part of a multi-hospital system to transition from an inpatient facility to an FMF through an exemption from

¹ Also known as EMTALA, 42 U.S.C. §1395.

² Bowie Health Center was established before the creation of the FMF as a distinct category of health care facility in Maryland. It was initially licensed as a department of the University of Maryland Prince George’s Hospital Center. It was licensed as an FMF after this category of health care facility came into existence.

Certificate of Need review, a review process that requires approval by the Commission but, unlike CON review, does not permit intervention and possible judicial appeal by interested parties. This is similar in some respects to a concept embodied in Maryland law decades ago, creating a facility called a “limited service hospital” as a hospital-successor outpatient campus. No limited service hospitals were ever established in Maryland. In contrast, creating an FMF as a rate-regulated facility within a hospital system to replace a general hospital is an option has been pursued by three general hospitals, all of which are part of the University of Maryland Medical System (“UMMS”). One of those conversions has been authorized to date.

B. The Applicant(s)

The applicants are two general hospitals operated by Shore Health System, Inc. (“Shore” or “SHS”): SHS d/b/a the University of Maryland Shore Medical Center at Dorchester (“SMC-D”); and SHS d/b/a the University of Maryland Shore Medical Center at Easton (“SMC-E”). This staff report will refer to the two applicants collectively as “the applicant,” “SHS,” or “Shore.”

SMC-D is a 42-bed general hospital with 18 licensed medical/surgical/gynecological/addictions (“MSGA”) beds and 24 acute psychiatric beds for adults located in Cambridge. (Dorchester County). SMC-E is a 104-bed general hospital, with 79 MSGA beds, 17 obstetric beds, and eight pediatric beds located in Easton (Talbot County). Each is the only general hospital in its jurisdiction.

In 1996, SMC-E, then known as Memorial Hospital at Easton, and SMC-D, then known as Dorchester General Hospital, merged to form SHS, a network of medical services that combined the resources of community hospitals, physicians, and outpatient centers. Ten years later, in 2006, SHS affiliated with the University of Maryland Medical System (“UMMS”). Finally, on July 1, 2013, Chester River Hospital, which was then part of UMMS and known as University of Maryland Chester River Health System at Chestertown,³ merged with SHS to become the University of Maryland Shore Regional Health, Inc. (“SRH”).⁴

In addition to these three general hospitals, SRH consists of:

- The Requard Rehabilitation Center, a 20-bed special rehabilitation hospital located on the SMC-E campus;
- UM Shore Emergency Center at Queenstown (Queen Anne’s County), a freestanding medical facility, located approximately 19 miles from SMC-E, its parent;
- UM SRH Cancer Center and Requard Radiation Oncology Center, located in Easton, approximately one mile from SMC-E;
- The Diagnostic and Imaging Center and Clark Comprehensive Breast Center located in Easton, approximately one mile from SMC-E;

³ The hospital in Chestertown is currently a 21-bed hospital and known as University of Maryland Shore Medical Center at Chestertown.

⁴ UM SRH is the sole corporate member of SHS. (Shore request for exemption from CON, review, DI #2, p.1).

- A network of diagnostic laboratory and/or imaging facilities located in Denton (Caroline County), Centreville (Queen Anne's County), Cambridge, and Chestertown (Kent County);
- Outpatient rehabilitation centers located in Denton, Cambridge, and Easton; and
- A regional network of employed primary care and specialty physicians and providers, with locations in all five counties of the mid-Shore region served by SRH; Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties.

C. The Project

The subject of this exemption from CON review request is a proposal to convert SMC-D to a freestanding medical facility. It is one of three proposals submitted by Shore to reorganize and modernize its facilities in Dorchester and Talbot Counties. In addition to converting the general hospital in Dorchester County to an FMF, Shore has also submitted a request for an exemption from CON review to consolidate certain inpatient services of SMC-D and SMC-E, primarily to continue the provision of acute psychiatric hospital services within the SRH system after the planned conversion of SMC-D to an FMF, given that the only psychiatric hospital services site within the system is currently operated at SMC-D. Shore has also submitted a CON application to relocate SMC-E to a new site within Easton.

Background

The applicant has described these projects as growing out of a strategic planning process designed to set a course that would address the challenges it faces due to inefficiencies inherent in operating low-volume, resource-intensive hospitals that are aging and costly to maintain, facing declining utilization, and a number of environmental challenges, including: a lack of public transportation resources that limits the population's access to services; difficulty in recruiting and retaining experienced providers; and limited community-based population health resources that are essential for establishing an effective continuum of care. Appendix 1 provides a statement of Shore's assessment of its operating environment, vision, and goals. The document ends with this summary and conclusion:

UM SRH is proposing the reconfiguration of its facilities and services after an in depth and lengthy planning process that evaluated the needs of its service area population and engaged numerous community stakeholders. This ... planning process resulted in recommendations, including the conversion of UM SMC at Dorchester to an FMF and the replacement of UM SMC at Easton. UM SRH is confident that its proposals enjoy widespread community support. The new care delivery model will provide accessible, high-quality care to patients, and it will create substantial cost savings and operational efficiencies. Consolidating acute care at UM SMC at Easton will result in more efficient and effective delivery of care as well as improved quality. It will also improve the long-term financial outlook for UM SRH, securing financial sustainability for the future. Finally, by modernizing its facilities and care delivery model, UM SRH will enhance its ability to recruit and retain needed health care providers to the region. For all of these

reasons, UM SRH is proposing the reconfiguration described in the three applications pending before the Commission.

The Proposed FMF

The proposed FMF would be located on the first floor of a two-story building. The first floor will house the FMF as well as space for three other rate-regulated services, a cardiac rehabilitation suite, an infusion suite, and space for intensive outpatient treatment of behavioral health and substance use disorders, which includes the Bridge Clinic.⁵ The second floor would house a medical office building (“MOB”) with non-rate regulated services (described in more detail below).

The FMF will operate 24 hours per day every day, a requirement for FMFs, and will have the ability to care for patients of all ages categorized in Emergency Medical Services Priority Levels 2 through 4, as well as EMS Priority Level 1 patients who suffer from either an unsecured airway, are in *extremis*, or suffer from a stroke and are brought to the FMF because an accredited primary or comprehensive stroke facility was greater than 15 additional minutes of drive time away. The Maryland Institute for Emergency Medical Services Systems (“MIEMSS”) uses the following classifications for patient priority level:⁶ Priority 1 patients are critically ill or injured person requiring immediate attention and unstable patients with life-threatening injury or illness; Priority 2 patients have less serious conditions not immediately endangering the patient’s life but those conditions are potentially life-threatening injuries or illnesses requiring emergency medical attention; Priority 3 patients have non-emergency conditions, requiring medical attention but not on an emergency basis; Priority 4 patients do not require medical attention.

The FMF, if approved, will operate as UM SMC at Cambridge. It will have the ability to rapidly transfer patients who cannot be cared for at the facility to hospitals and tertiary centers via ambulance or air transport from the FMF’s on-site helipad. It will maintain the MIEMSS-approved EMS Base Station designation currently held by SMC-D to provide necessary communication with EMS providers to direct patients to the appropriate level of service. (DI#21, p.3).

The FMF is proposed to have a capacity of 22 emergency treatment spaces and six observation rooms. Three of the treatment spaces would be dedicated to behavioral health patients. Of the remaining 19 treatment spaces, two would be bariatric spaces and two would be resuscitation/critical care treatment bays. The FMF would also contain: a diagnostic imaging suite including conventional x-ray, ultrasound, and computed tomography, with related support space; a laboratory; and medication stations that are stocked and monitored by the SRH Pharmacy Service

⁵ SRH established the Bridge Clinic in 2016 to improve access to urgent community psychiatric care. The Bridge Clinic currently serves patients discharged from the SMC-D’s acute psychiatric unit who are unable to access psychiatric care from the community due to a shortage of psychiatric providers. The Bridge Clinic will continue to serve patients at the FMF by providing continuity of care, counseling, and other support services to patients until they are able to connect with a behavioral health provider in the community. Source: Exemption request, DI #21, p. 4).

⁶ MIEMSS, The Maryland Medical Protocols for Emergency Medical Services Providers (effective July 1, 2017).

using protocols developed and implemented at the SRH FMF in Queenstown. Space allocation for the FMF is shown in Table I-1.

**Table I-1: Space Allocation
Proposed UM SMC at Cambridge FMF**

Function	Departmental Gross Square Feet
Emergency Treatment – 22 Treatment Spaces	19,512
Observation Unit – Six Rooms	4,861
Laboratory	1,364
Cardiac Rehabilitation Services	2,128
Infusion Services	1,453
Intensive Outpatient Behavioral Health Services/Bridge Clinic	1,461
Total (includes space not specifically allocated as department space for specific functional areas)	43,794

Source: DI #21, Exh. 19, Table B.

The composition of the second floor MOB is still in the planning stages. Its ultimate makeup will depend on a continuing needs assessment and community dialogue, and will also be dependent on the availability and interest of providers. Tentatively, it is slated to include space for primary care, pediatrics, cardiovascular testing, outpatient rehabilitation, imaging, and blood draw. It may also include a physician-owned outpatient surgery center.

The total estimated cost of the building is \$60,394,058. The first floor FMF component has an estimated cost of \$38,497,006. The project budget estimate is included as Appendix 2.

D. Staff Recommendation

MHCC staff recommends that the Commission approve Shore Health System’s request for an exemption from Certificate of Need review to convert UM Shore Medical Center at Dorchester to a freestanding medical facility that will provide rate-regulated emergency and observation services and will be an administrative unit of UM Shore Medical Center at Easton. Staff’s recommendation is based on its conclusion that the exemption request complies with applicable criteria and standards established for such conversions, as discussed in this report.

II. PROCEDURAL HISTORY

The procedural history is shown in Table I-2 below.

Table I-2: Record of the Review

Docket Item #	Description	Date
1	Letters of Support	Various Dates
2	Exemption Request	7/6/18
3	Request to publish notice of the Exemption Request in the Star Democrat	7/12/18
4	Request to publish notice of Exemption Request in the Maryland Register	7/12/18
5	Notice of Exemption Request as published in the Star Democrat	7/19/18

6	Summary of public information hearing held by SHS	8/14/18
7	MIEMSS comments and recommendation on proposed exemption	10/15/18
8	SHS Vision of Health Care Delivery for Maryland's mid Eastern Shore	11/15/18
9	MHCC staff requests additional information	11/15/18
10	SHS response to request to additional information questions of 11/15/18	11/19/18
11	MHCC staff requests HSCRC comments on proposed project	11/20/18
12	Second MHCC staff request for additional completeness information	11/26/18
13	Supplemental MHCC staff second request for additional completeness information	11/29/18
14	SHS requests extension to submit all completeness information	11/29/18
15	SHS requests additional extension to submit completeness information	12/17/18
16	SHS submits completeness information as requested on 11/26/18 and 11/29/18	12/21/18
17	MHCC staff requests responses to questions from HSCRC that need to be answered before HSCRC can render an opinion	1/9/19
18	SHS response to question 7 in MHCC completeness information request of 11/29/18	1/22/19
19	SHS response to questions posed by HSCRC	2/8/19
20	HSCRC Comments on proposed project	2/15/19
21	SHS response to additional information and Modification to proposed request	2/21/19

III. REQUIREMENTS FOR AN EXEMPTION

10.24.19.04C Exemption from Certificate of Need Review to Convert a General Hospital to a Freestanding Medical Facility.

(1) A freestanding medical facility created through conversion from a general hospital shall only retain patients overnight for observation stays.

The applicants state that the proposed freestanding medical facility, to be known as the University of Maryland Shore Medical Center at Cambridge, will not have the capability to admit or retain patients for overnight hospitalization and will only retain patients for overnight observation stays. (DI #8, p.1).

(2) Each notice, documentation, or other information regarding a proposed conversion of a general hospital to a freestanding medical facility that is required by Section C of this regulation or by COMAR 30.08.15.03 shall be provided simultaneously to the Commission and to the Maryland Institute for Emergency Medical Services Systems.

The applicants state that it has and will continue to provide, to the Commission and MIEMSS, all notices, documentations, or other information regarding the proposed conversion that are required by COMAR 10.24.19.04C and/or by COMAR 30.08.15.03. (DI #8, p.1).

(3) A notice of intent to seek an exemption from Certificate of Need review to convert a general hospital to an FMF shall:

(a) Be filed in the form and manner specified by the Commission, which may require a pre-filing meeting with Commission staff to discuss the proposed project, publication requirements, and plans for a public informational hearing.

(b) Be filed with the converting hospital and its parent hospital as joint applicants;

A notice to seek an exemption from CON review to convert SMC-D to an FMF was filed in the form and manner specified by the Commission was filed by Shore doing business as SMC-D, the converting hospital, and by SMC-E, the parent hospital.

Staff concludes that the applicant has satisfied the requirements of Paragraphs (3)(a) and (b) of the standard.

(c) Only be accepted by the Commission for filing after:

(i) The converting hospital publishes on its website and otherwise makes available to the general public and community stakeholders, at least 14 days before holding a public informational hearing, the hospital's proposed transition plan that addresses, at a minimum, job retraining and placement for employees displaced by the hospital conversion, plans for transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.

SMC-D held its public informational meeting on July 31, 2018. It posted its transition plan on its webpage dedicated to the conversion of the Dorchester hospital (<https://www.UMShoreRegional.org/DorchesterVision>) on July 13, 2018. The transition plan addressed job retraining and placement of employees displaced by the conversion, plans for transitioning acute care services previously provided at SMC-D to residents of the service area, and plans for the hospital's physical plant and site. (DI #8, p.2). Staff concludes that the applicant has met this requirement.

(ii) The converting hospital, in consultation with the Commission, and after providing at least 14 days' notice on the homepage of its website and in a newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public informational hearing that addresses the reasons for the conversion, plans for transitioning acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion.

The public informational meeting was held eighteen days after posting notice of the meeting on SMC-D's homepage (<https://www.umms.org/shore>) and a its webpage dedicated to the conversion of Dorchester (<https://www.UMShoreRegional.org/DorchesterVision>).

Beginning on July 13, 2018, UM Shore Regional Health published notice of this public informational meeting in area newspapers, as follows: *Star Democrat* (7/13, 7/20, 7/27, and 7/29); *Dorchester Star* (7/13, 7/20, and 7/27); *Dorchester Banner* (7/18 and 7/25); *Times Record* (7/18 and 7/25); *Bay Times* (7/18 and 7/25); *Kent County News* (7/19 and 7/26); and *Record Observer* (7/20 and 7/27). Staff concludes that the applicant has met the requirement of Subparagraph (c)(iii).

(iii) Within ten working days after the public informational hearing, the converting hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission, and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located;

Staff concludes that the applicant satisfied this subparagraph by documenting its distribution of the required written summary of the public meeting to the required bodies and individuals in a letter dated August 14, 2018. It is attached as Appendix 3.

(iv) The State Emergency Medical Services Board has determined that the proposed conversion of the general hospital to an FMF will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system;

SMC-D submitted a letter from MIEMSS, dated October 15, 2018, documenting that the State EMS Board “unanimously determined that the proposed conversion of the University of Maryland Shore Medical Center at Dorchester to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system.” That letter is attached as Appendix 4. Staff concludes that this action satisfies Subparagraph (c)(iv) of the standard.

(v) The applicants receive a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the proposed FMF for which the applicants seek rate regulation.

(vi) The applicants receive approved rates from HSCRC for each rate-regulated outpatient service at the proposed FMF; and

HSCRC staff stated its

willing[ness] to approve rates for the FMF and a revised GBR (‘global budgeted revenue’) for Easton in the future [although]...further discussions need to occur to ensure that the proposed rates are reasonable. As part of the approval of rates for the FMF and the revised GBR for Easton, staff will require that the portion of the savings related to the closure of Dorchester that Shore is allowed to retain in its revised GBR for Easton and the FMF approved rates will be used to fund the new proposed hospital

in Easton. Staff believes that substantial resources could be available which would allow Shore to complete the FMF and the consolidation of the inpatient service of Dorchester and Easton without an increase to rates or patient charges. (DI#20).

In a subsequent letter, HSCRC staff responded to MHCC staff's questions regarding the reasonableness of the applicant's FMF revenue projections by stating that it compared the rates proposed by Shore with other facilities of a similar nature and believes that the total revenue projected for the Dorchester FMF for Year 3 is reasonable, although HSCRC staff expressed concerns that the projected volumes will not be achieved, since Shore assumes that 100% of its current inpatient and outpatient emergency room visits will be serviced by the FMF, an assumption HSCRC staff believes has not been sufficiently validated.⁷

(vii) The applicants provide any additional information determined by Commission staff as necessary for the notice of intent to seek an exemption to convert to an FMF to be complete.

Shore complied with all staff requests for information and met this requirement.

(4) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

SMC-D is the only general hospital in Dorchester County. The proposed FMF site is approximately one mile away from the existing hospital. Staff concludes that the proposed FMF meets this requirement.

(5) The parent hospital shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A.

There are three applicable general standards in the Acute Hospital Services Chapter of the SHP, at COMAR 10.24.10.04A: (1) Information Regarding Charges; (2) Charity Care Policy; and (3) Quality of Care. They are addressed below.

⁷ Note that at (8)(f)(i) below, this report describes a similar question posed by MHCC staff and Shore's response. In brief, Shore indicated that it did not assume a decline in emergency patient visits based on a potential change of behavior among EMS responders or consumers because patients with certain conditions, including stroke patients, obstetric patients, patients experiencing heart attacks, and complex orthopedic cases, are typically already transported by EMS directly to UM SMC at Easton since it is a Primary Stroke Center, Percutaneous Coronary Intervention Center, and orthopedic center, with the only SRH labor and delivery unit. Thus, these patients are already bypassing the existing hospital in Cambridge.

COMAR 10.24.10.04A(1): Information Regarding Charges

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.***

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.

The applicant submitted Shore Health's Policy and Procedure on Public Disclosure of Charges. The document provides for the provision of information on charges for hospital services to the public and on hospital internet sites; that it be updated quarterly; that Financial Counselors are responsible to provide this information to consumers; and that the Patient Financial Services department is responsible to orient and train individuals who will handle this function.

Responding to Paragraph (a), the applicant provided a link to the information regarding charges for UM SMC at Dorchester on its website: <https://www.umms.org/shore/patients-visitors/for-patients/billing-insurance>; the site provides readily available information on the most frequently accessed inpatient and outpatient procedures by service line, which are updated quarterly based on actual patient charges over the previous 12 months. Responding to Paragraph (b), the policy describes the procedures for providing consumers with this information, and the website includes this guidance:

Estimated Charges

University of Maryland Shore Regional Health provides the information regarding charges for common procedures and services to help patients plan for health care expenses. The links below include the average range of fees associated with common procedures and services. The cost for services is based on a specific patient's condition. The information below can help you estimate your costs which might be higher or lower. For additional help with estimating charges, please contact our Patient Financial Services offices at 1-800-876-3364.

[Estimated Charges for Inpatient Admissions](#) *(Updated quarterly, Updated as of September 1, 2018)*

[Estimated Charges for Common Outpatient Services](#) *(Updated quarterly, Updated as of September 1, 2018)*

Commission staff has verified that SRH complies with this standard.

COMAR 10.24.10.04A(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. COMAR 10.24.10 10

(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.

The applicant provided a copy of the "Financial Assistance" policy of the University of Maryland Medical System, which applies to the SRH hospitals and will be implemented at UM SMC at Cambridge, the FMF, when it opens. The policy states that SMC-E and SMC-D 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 #2, p. 13, and Exh. 5). Staff concludes that the proposed FMF meets this requirement.

(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.***

The UMMS policy provides that its related entities will publish notice of the availability of financial assistance on a yearly basis in their local newspapers; post notices of its availability at appropriate intake locations as well as in the billing office; and be sent to patients with their bills. The applicant stated that notices regarding the availability of financial assistance are posted in the admissions offices, the business offices, and emergency departments of the two hospitals, and notice of financial assistance are provided at admission or preadmission to each person who seeks services in the hospitals (the applicant provided a copy of that notice). (DI #2, p. 14 and Exh. 6). Staff concludes that the proposed FMF provides the notices required by this standard.

(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.

The applicant provided data from the HSCRC Community Benefit Report for FY 2017 that showed SMC-E with a level of charity care that fell within the third quartile for all Maryland hospitals and SMC-D with a level of charity care that fell within second quartile for all Maryland

hospitals. Staff confirmed the accuracy of this information and concludes that the applicant satisfies this standard.

10.24.10.04A(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.

SMC-E and SMC-D are licensed by the State of Maryland and accredited by The Joint Commission. (DI#2, p.16 and Exh. 8). Each is also in compliance with the Conditions of Participation of the Medicare and Medicaid programs. The applicant states that SMC at Cambridge will comply with requirements issued by the Maryland Department of Health for licensure as an FMF, be accredited by the Joint Commission, and comply with all conditions of participation in the Medicare and Medicaid programs. Based on this assurance, staff concludes that the proposed FMF meets this requirement.

(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.

Staff notes that Paragraph (b) of this standard has become outdated in recent years, as currently written. There is still a Maryland Hospital Performance Evaluation Guide ("HPEG"), which is the hospital consumer guide component of the MHCC website. Quality measures are included as a component of that guide. However, since this standard was adopted, the HPEG has been substantially expanded to include many more measures of hospital quality and performance. Moreover, the specific format of the quality measure component of the HPEG no longer consists of a set of measure values that conform with the format of this standard in which each measure is scored as a compliance percentage that can be ranked by quartile. The performance for most of the expanded number of quality measures is now in a comparative context, expressed as "Below Average," "Average," or "Better than Average".

The applicant stated that UM SMC at Cambridge will be a provider-based department of SMC-E and provided a summary showing that this hospital scored "better than average" or "average" on 49 of the 72 quality measures and "below average" on 10 quality measures. There were 13 quality measures for which there was insufficient data to report a performance level. The applicant identified the quality measures for which SMC-E scored "below average" and provided a summary of its corrective action plans for these measures. (DI#2, p. 17 and Exh. 9). Staff concludes that the applicant meets this requirement.

(6) The applicants shall document that the proposed FMF will meet licensure standards established by DHMH.

The applicant states that UM SMC at Cambridge will meet or exceed licensure standards established by the Department of Health. Staff concludes that this statement satisfies this requirement.

(7) The applicants shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital’s policies and that are in compliance with COMAR 10.24.10.

The applicant confirmed that it will implement the same financial assistance and charity care policies at the proposed freestanding medical facility as are in effect at both the Easton and Cambridge hospitals. The applicant’s compliance with the charity care standard was discussed under compliance with COMAR 10.24.10.04A(2) of the Acute Hospital Services Chapter, *supra*, pp. 11-12.

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital’s service area for at least the most recent five years;

Shore described the service area of the proposed FMF (i.e., the zip code areas from which 85% of its emergency department patients are anticipated to originate) to be eight zip code areas located in Dorchester, Caroline, and Talbot Counties. They include zip code areas designated as Cambridge, Hurlock, East New Market, Federalsburg, Linkwood, Easton, Vienna, and Trappe. Between 2013 and 2017, the population of these zip code areas generated an average of 39,270 Maryland hospital emergency department (“ED”) visits per year (ranging from a high of 40,907 in 2013 to a low of 36,920 in 2017). Maryland hospital ED visit volume generated from this service area declined by almost 10% from 2013 to 2017. The Maryland hospital ED visits were divided between three hospitals, SMC-E, SMC-D, and Peninsula Regional Medical Center. Visit volumes generated from this service area population and the hospital shares of this volume for this service area over the last five years are shown in Table III-1 below.

Table III-1: Maryland Hospital ED Visits Originating from the Defined SMC at Cambridge Service Area, FY2013 – FY2017

Hospital	Historical ED Service Area Visits					2017 % of Total	2013-2017 % Change
	2013	2014	2015	2016	2017		
UM SMC at Easton	19,276	18,458	18,627	18,567	16,815	45.5%	-12.8%
UM SMC at Dorchester	18,494	17,234	18,111	17,396	16,596	45.0%	-10.3%
PRMC	1,195	1,220	1,335	1,351	1,253	3.4%	4.9%
Hospitals with <1000 visits	1,942	2,032	2,121	2,073	2,256	6.1%	16.2%
Total Service Area ED visits	40,907	38,944	40,194	39,387	36,920	100.0%	-9.7%

Source: St. Paul statewide non-confidential utilization data tapes (DI#2, p. 20)

The ED at SMC-D serviced an average of 44.7% of all Maryland hospital ED visits for this population over the five-year period shown in the table.

Staff concludes that the applicant satisfies Paragraph (8)(a) of the standard.

(b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

Shore provided the information shown in Table III-2, below, regarding the availability of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

Table III-2: Hospitals, FMFs, and Urgent Care Centers in the SMC-D Service Area or Near the Service Area

Facility	Type	Location and Distance from UM SMC at Cambridge
UM SMC at Easton	Hospital	Easton - 15 miles
Peninsula Regional Medical Center	Hospital	Salisbury - 31 miles
Nanticoke Memorial Hospital	Hospital	Seaford, DE - 27 miles
Atlantic General Hospital	Hospital	Berlin - 54 miles
<hr/>		
UM Shore Emergency Center	FMF	Queenstown - 35 miles
<hr/>		
Your Doc's In	Urgent Care	Cambridge
Your Doc's In	Urgent Care	Easton – 16 miles
Choice One Urgent Care	Urgent Care	Easton – 17 miles
Choice One Urgent Care	Urgent Care	Denton – 31 miles

Source: DI #2, pp. 21, 22.

Shore states that the establishment of UM SMC at Cambridge is necessary to ensure that access to emergency services for this service area population continues, because other area hospitals, especially SMC at Easton, would be “overwhelmed if UM SMC at Cambridge were not developed to the proposed size and with the proposed capabilities to meet the needs of the service area population.” (DI #2, p. 20).

Staff concludes that the applicant satisfies the information requirements of Paragraph (b) of the standard.

(c) Demonstrate that the proposed conversion is consistent with the converting hospital’s most recent community health needs assessment;

Shore states that the findings of the most recent Community Health Needs Assessment centered on improving the availability and accessibility of chronic disease management services, behavioral health services, cancer services, and outreach and education.

Shore points out that the design of the emergency treatment unit of the FMF includes a dedicated behavioral health suite with three secure behavioral health treatment spaces. The FMF also includes almost 1,500 SF to house intensive outpatient behavioral health services under the auspices of the Behavioral Health Bridge Clinic.

With respect to cancer services, the FMF is also proposed to house an infusion therapy suite. In addition, while not a regulated health care facility that is part of the exemption from CON review request to convert SMC-D to an FMF, the co-located MOB will also house resources that will help to address needs identified in the Community Health Needs Assessment. (DI #2, p. 24).

Regarding chronic disease management, Shore states that it has fully implemented population health measures to resolve patients' acute issues in the ED to avoid unnecessarily hospitalizing the patient, either as an inpatient or in observation status. It states that these measures have resulted in increased ED length of stay, and SRH anticipates that “with these initiatives and others aimed at population health management the ED length of stay may continue to increase.” (DI #16, p.5).

Staff recommends that the Commission find that the proposed project is consistent with and will contribute to addressing the needs identified in the Community Health Needs Assessment.

(d) Demonstrate that the number of treatment spaces and the size of the FMF proposed by the applicant are consistent with the applicable guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume.

(i) Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces.

(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

Subparagraphs (d)(i) and (ii) of this standard require that the number of emergency treatment spaces and space proposed for an FMF be consistent with the guidance set forth in *Emergency Department Design: A Practical Guide to Planning for the Future*, published by the American College of Emergency Physicians (“ACEP”) and commonly referred to as the “ACEP Guidelines.” Its two iterations have been incorporated by reference in the State Health Plan since 2009. MHCC referenced these ED planning guidelines in the FMF Chapter in order to provide applicants and the Commission with a basis for evaluating the appropriate space and service capacity needs for an FMF, even though the guidelines were specifically developed as guidelines for hospital ED planning and not for freestanding emergency centers.

Essentially, the ACEP Guidelines prescribe the optimal amount of treatment spaces and square feet that an ED should have based on the number of annual visits and certain characteristics of the facility and the population to be served. The Guidelines set forth estimates of the number of treatment spaces and the departmental space appropriate for a range of projected annual ED visit volumes for EDs with low to high range operating characteristics. The position of an ED on the low to high range operational spectrum is determined on the basis of 16 factors such as percentage of admitted patients, length of stay in the ED, location of observation space, percentage of behavioral health patients, percentage of non-urgent patients, and age of patients, as well as the presence of specialty units within the ED. If an ED ranks high on more of the factors, space and treatment capacity should be planned for the number of treatment spaces and square footage called for in the high range estimate for a given volume. If an ED ranks on the low range for more factors, the low range guidance should apply. The Guidelines also identify medium measures for each factor but not space and the number of treatment spaces. If a facility ranks in the mid-range for more factors the number of treatment space and the amount of space should fall in between the low and high range. In this taxonomy, a facility whose characteristics and population served defined it as “high range” would require more treatment rooms and building space than a “mid range” or “low range” facility, as illustrated in Table III-3 below.

Table III-3: ACEP Guide Recommendations: Number of ED Treatment Spaces Needed at Various Visit Volume Levels

Annual Emergency Department Visits	Low Range ED		High Range ED	
	Total Treatment Spaces	Annual Visits per Treatment Space	Total Treatment Spaces	Annual Visits per Treatment Space
15,000	11	1,364	13	1,154
20,000	14	1,429	16	1,250
25,000	18	1,389	20	1,250
30,000	21	1,429	25	1,200

Source: ACEP Guidelines

Although this table shows both low range and high range values, staff notes that the FMF Chapter specifies that FMFs be outfitted according to the ACEP Guidelines for low range unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces or the need for additional building space.

In responding to this section of the standards, the applicant provided historic and projected ED visit volume for the existing hospital in Dorchester as well as projected volume for the FMF. Shore also presented an analysis that adjusted its volume projections based on an eight-hour peak “to ensure there will be available examination space 80%-90% of the time a patient walks into the FMF for emergency services.”

It also characterized the future operations of the proposed FMF in terms of the ACEP Guidelines by assessing the operations of SMC-D, using the 16 factors in those Guidelines to classify the ED operations as low, medium, or high range. Shore assumed that the operations of the FMF would be similar to that of the current hospital ED (DI#2, p.27). Appendix 5, *UM SMC-Dorchester ED Comparison to ACEP Guidelines*, displays the current characteristics of the ED at SMC-D. Based on this analysis, showing nine factors rated as “mid range,” five as “low range,”

and two as “high range,” Shore maintained that the ACEP Guidelines would classify the SMC-D ED operation, and thus the proposed FMF operation, as mid-range.⁸

Need for ED Treatment Spaces

In order to project the number of treatment spaces that would be required, Shore provided historic and projected ED visit volume for the existing hospital in Dorchester, and projected volume for the FMF (Table III-4). Shore noted that after declines of about 3% in 2016 and 5% in 2017, visits grew by about 0.5% in 2018. Shore used 2018 as a base year and projected annual growth of 0.2% annually based on the projected population growth in the service area.

Table III-4: Actual and Projected ED Visits, UM SMC at Dorchester and Successor FMF

	Actual at UM SMC-Dorchester ED					Projected at UM SMC-Dorchester ED			Projected at FMF		
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Total Visits	20,162	21,146	20,531	19,453	19,543	19,574	19,605	19,636	19,668	19,699	19,730

Source: (DI #2, p. 26 and DI #16, p.12).

In translating the projected visit volumes into a calculation of the number of ED treatment spaces that will be needed, Shore stated that using the ACEP Guidelines to define the optimal number of treatment spaces is “problematic” because “it addresses only the *average* number of patients in the emergency department in a year to determine the number of emergency department treatment spaces...[and] does not address surge issues or account for the peak number of patients in an emergency department, each of which will require a treatment space.” (DI #2, p.30).

To address this alleged shortcoming, and stating a desire “to ensure there will be available examination space 80%-90% of the time a patient walks into the FMF for emergency services,” Shore presented an analysis that calculated the number of rooms that would be needed during the period of peak demand, defined as the eight-hour period from 12 Noon to 8 p.m. (13.8 patients, on average), with the average hourly need (9.6 patients, on average). That calculation and resulting conclusion appears in Table III-5, below.

Table III-5 Shore’s Projection of Emergency Treatment Spaces Needed at Proposed FMF

		Actual SMC-D ED	Projected for FMF		
		2018	2022	2023	2024
1	ED and FMF emergency visits	19,543	19,668	19,699	19,730
2	24-hour average number of patients in a treatment space	9.6	9.6		
3	8 hour peak average number of patients in a treatment space	13.8	13.8		
4	Adjustment for 8 hour peak utilization	144%	144%		
5	Adjusted ED or FMF emergency visits	28,096	28,275	28,320	28,365
6	Annual visits per treatment space @ low range	1,409	1,409	1,409	1,409

⁸ Staff notes that the review standard does not call for an evaluation of the “range” status of a proposed FMF, instead specifying that planning for it should use the low range values, leaving room for the applicant to make a case for an exception, based on the particular characteristics of the population to be served as described above.

7	Annual visits per treatment space @ high range	1,225	1,225	1,225	1,225
8	Annual visits per treatment space @ weighted average	1,308	1,308	1,308	1,308
9	Treatment space need based on adjusted visits and assuming the weighted average range	21.5	21.6	21.7	21.7

Notes:

- Information in Rows 1, 2, and 3 were submitted by Shore.
- Row 4 = ratio of treatment spaces occupied at peak hours to average treatment space occupancy (Row 3 divided by Row 2, or 13.8 / 9.6).
- Row 5: actual or projected visits (Row 1) x 144% (Row 4) = “Adjusted” emergency visits
- Row 6: arrived at by averaging ACEP’s calculation of annual visits per space at “low range” for 25,000 visits (1,389) and 30,000 visits (1,429)
- Row 7: arrived at by averaging ACEP’s calculation of annual visits per space at “high range” for 25,000 visits (1,250) and 30,000 visits (1,200)
- Row 8: described by Shore as the “weighted average of the high and low averages, calculated based on the distribution of the peak period adjusted projected emergency department visits between 25,000 and 30,000 visits.”
- Row 9: Row 1 (ED visits) divided by Row 8 (annual visits/treatment space)

Source: DI #16, p. 13.

Shore maintains that planning treatment space capacity for peak volumes is “essential to size the FMF to accommodate peak utilization rather than average number of patients” in order to meet “daily/weekly surge volumes which can vary significantly from the average daily census.”

Staff Analysis

Staff is skeptical of a number of the assumptions and judgments built into Shore’s analysis and conclusions, and thus looking at the same data and assumptions leads us to a different conclusion regarding the number of ED treatment spaces likely to be needed at the proposed FMF.

First, staff sees no reason to calculate the number of spaces needed at any other than the parameters ACEP suggests for a “low range” ED, as defined in the SHP. Shore did not really base its reason for deviating from that other than its belief that it needed to plan for peak rather than average demand.

Second, contrary to what Shore maintains, the ACEP Guidelines take peak into account in its guidance regarding the number of rooms needed at a variety of volumes, as described in this passage from the ACEP Guidelines (emphasis added).

Volume Spikes

The sizable variations that can occur in hourly utilization can include spikes of 25% to 30% on certain days or during certain hours of the day. *For example, a department that accommodates 40,000 annual visits can experience a day or certain hours during which the volume spikes 30% and would calculate out to an annual volume of 52,000 visits if this spike continued for a year. This doesn’t mean an emergency department expected to accommodate 40,000 visits should be designed for 52,000 visits to accommodate all spikes, but it does mean that there should be some cushion in the programming numbers for surge capacity.* The formulas I present in this chapter include flexibility and some capacity for volume spikes. And, if calculated correctly based on future examination space use times, your emergency department should have an available examination space 80% to 90% of the time a patient walks into the emergency department. - *Emergency Department Design: ACEP Guidelines, Second Edition, at 108.*

Thus, staff believes that Shore’s calculation of Adjusted ED Visits and resulting treatment space need is overstated. Table III-6 below applies the ACEP Guidelines at both low and high range to the actual projected number of visits, uninflated by substituting peak for average. It shows that at the 19,640 visits Shore projects for 2024, the 22 ED treatment spaces exceeds the 14 that ACEP prescribes at the low range and the 16 that ACEP prescribes at the high range by a healthy margin.

Turning to Subparagraph (d)(ii) – “demonstrate that the building gross square footage is consistent with the low range guidance, unless...the applicant demonstrates the need for additional building gross square footage” – shows that Shore measured its compliance with the building gross square feet standard based on a number of visits and treatment rooms inflated by calculating need at peak, stating:

With 23 treatment spaces in the UM SMC at Cambridge, the ACEP guide provides for 19,274 departmental gross square feet. With a 1.25 multiplier for building gross square feet, the ACEP guide for 23 treatment spaces equals 24,092 square feet. The proposed project is within the ACEP Guide’s “low range” and “high range” guidelines as it proposes 23 emergency department treatment spaces, all housed within 18,673 departmental gross square feet. (DI#2, p. 33).⁹

Table III-6: ED Treatment Capacity and Space Needed, as per ACEP Guidelines, for a Range of Visit Volumes

		Low Range		High Range	
		Total Spaces	Bldg. Gross SF	Total Spaces	Bldg. Gross SF
1	15,000 ED Visits	11	11,344	13	14,219
2	20,000 ED Visits	14	14,438	16	17,500
3	25,000 ED Visits	18	18,563	20	21,875
4	30,000 ED Visits	21	21,000	25	27,344
5	ED treatment spaces and building gross square feet needed, according to ACEP Guidelines, for the number of visits projected for the FMF (19,640 by 2024).	14	14,438	16	17,500

Source: Emergency Department Design - A Practical Guide to Planning for the Future (2nd edition) pp.116-117 and Shore’s Modified Exemption Request (DI#21)

Table III-6, above, shows that for 20,000 visits at a low range ED operation, the ACEP guidelines call for 14 treatment spaces and 14,438 building gross square feet. Both of those specifications are exceeded by Shore’s proposal. Staff notes that even for a high range ED operation, the number of rooms and BGSF proposed appear excessive.

⁹ Staff notes that since the initial exemption request quoted above, Shore submitted a modified request that eliminated one ED treatment space and four observation spaces, changing the amount of square footage. Thus the proposed project would include 22 ED treatment spaces within 19,512 BGSF.

Summary

Despite staff's conclusion that the number of treatment spaces and the building square footage for emergency treatment are inconsistent with the ACEP Guidelines for a low range hospital ED, which the SHP assumes to be an appropriate level for an FMF operation, there are mitigating factors to be considered when evaluating the proposal. Shore presented several, including:

- Unlike inpatient bed capacity, there is no concern that potential excess FMF emergency treatment capacity would produce overutilization of services, because under Maryland's All-Payer Model, there are no financial incentives for hospitals and their affiliated FMFs to increase ED or FMF utilization. Thus more capacity at the FMF would not induce additional emergency visits, but rather improve throughput at peak times.
- Alternatives are few. There are only four urgent care centers in the UM SMC at Cambridge service area and only one is within 15 miles of Cambridge. The closest EDs are located at SMC-E, approximately 15 miles away, and at Nanticoke Memorial Hospital in Seaford, Delaware, approximately 30 miles away;
- The capital cost of adding ED treatment spaces is minimal, approximately \$25,000 to \$30,000 per treatment space. It is more cost effective to build appropriate surge capacity at the new FMF at the outset then to have to expand the ED spaces at SMC-E or other local hospital EDs to accommodate additional patient visits due to overflow at the FMF. (DI #16, pp.8-10);
- As discussed earlier when assessing the proposal's consistency with SMC-D's most recent community health needs assessment, prioritizing chronic disease management, Shore stated that population health measures it has implemented to resolve patients' acute issues in the ED have resulted in increased ED length of stay, and anticipates that "with these initiatives and others aimed at population health management the ED length of stay may continue to increase." (DI #16, p.5); and
- Two of the proposed FMF treatment spaces are dedicated to a self-contained behavioral health suite. In fiscal year 2017, 1,036 or 5.3% of SMC-D emergency department visits were diagnosed with a behavioral health condition. These patients "experienced a peak average length of stay of 12.6 hours." With an average length of stay of 12.6 hours per visit, there is an expected average daily census of 1.5 patients with behavioral health diagnoses. (DI #2, p.33). This dedicated unit would take two treatment spaces "out of circulation" for non-behavioral health patients, reducing the effective capacity for emergency treatment.

In addition, Shore pointed out that a recent decision by the MHCC allowed what it saw as potential excess emergency treatment space in the conversion of University of Maryland Laurel Regional Hospital to an FMF (Docket No. 18-16-EX002). That decision stated that,

[d]espite the apparent excess capacity that staff believes has been planned for the project ... [s]taff is mindful that a project of this type, in which a freestanding emergency center is replacing a general hospital, has not been implemented in Maryland before. The capital cost savings achievable by marginally reducing the number of treatment spaces in a project such as that proposed would not be great. And a deviation from the ACEP guidance that the applicant used to account for peak levels of demand, which was a significant factor in raising the number of treatment spaces programmed for the FMF above the ACEP guidelines target, may have some merit ... CMS has reported that Maryland has some of the longest ED wait times in the nation and staff believes it is rational...to seek to assure a successful launch of an alternative emergency venue ... that will not regularly frustrate patients with long waits for evaluation and treatment. Thus, staff recommends finding that the proposed capacity of the FMF is acceptable, in view of the analysis presented by the applicants in the request for exemption from CON review.¹⁰

Thus, despite the fact that the possibility that the proposal includes excess ED treatment spaces and excess building space, staff recommends that Shore be allowed to go forward with its project plan for the following reasons.

First, Shore's contention that potential excess ED capacity will not induce overuse, given Maryland's hospital payment model, has some credibility. Second, the rural nature of the community served, with few nearby alternatives, merits consideration, as does the fact that some of the space is dedicated to behavioral health patients, removing those spaces from general use. Finally, the initial capital outlay for the potentially excess treatment spaces represents a small proportion of the project's cost, especially when compared to the costs and inconvenience of a future project that might be needed to add space.

Staff recommends that the Commission find that the proposed facility is consistent with this part of the standard, based on the case presented by the applicant for exceeding the ACEP guidance on treatment space and program space.

(e) Demonstrate that the proposed number and size of observation spaces for the FMF are consistent with applicable guidance included in the most current edition of Emergency Department Design: A Practical Guide to Planning for the Future, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume and average patient time in observation spaces.

¹⁰ MHCC staff notes that the excess space identified in the case of the Laurel FMF was, in relative terms, more modest than the excess proposed for Cambridge, based on the ACEP Guidelines. MHCC authorized development of 25 spaces in Laurel, just under 39% more than the 18 spaces ACEP would recommend for the visit volume projected. Shore is proposing 22 spaces in Cambridge, only three spaces fewer than Laurel, an area with a much higher population density than that of Cambridge, and a number of treatment spaces that is almost 60% higher than ACEP's low range need guidance.

(i) Demonstrate that the FMF will achieve at least 1,100 visits per year per observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of observation spaces;

(ii) Demonstrate that the size of each observation space does not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for larger observation spaces.

To provide context for the discussion under these subparts of the standard, the ACEP Guidelines make the following statement regarding the annual capacity, and appropriate sizing of, an observation space:

- “[G]enerally program[s] [clinical decision unit or observation] spaces in the range of 900 to 1,100 patients per space annually. Use the lower number if your patients use the [clinical decision unit] for 12+ hours, and use the higher number if your patients use the space for 8 to 12 hours. (ACEP Guidelines, p. 272).
- The ACEP Guide generally recommends a square footage range of 135 to 150 for each observation room (ACEP Guide, p. 157), but also states that, “if you decide to equip the [observation] rooms with standard inpatient hospital beds, you’ll need larger rooms – 150 to 160 [square feet].” (ACEP Guidelines, p. 271).

Shore provided the historical and projected utilization data shown in Table III-7 below for observation patients. Shore used the projected number of observation patients in FY2019 as its baseline, and forecasts a 2% annual growth through 2024. Shore attributed the growth rate to a 0.2% annual population growth, and “the expectation that the number of patients placed in observation status will continue to rise as the criteria for inpatient care continues to evolve and more and more care is rendered in alternative settings to decrease cost.” (DI #21, p.4). Shore also projects a decrease in the average length of stay (“ALOS”) for observation patients, based on its experience at SMC-E, where the ALOS for such patients decreased from 41.4 hours in 2017 to 26.7 hours in 2018 through the establishment of a dedicated observation unit with dedicated case management, nursing, and hospitalist staffing to facilitate the discharge of the observation patients. (DI #21, p. 2).

Shore projects that the observation patient ALOS will decline from 49.3 hours at SMC-D to 38.4 hours at the FMF’s observation unit.¹¹

¹¹ Shore stated that the ALOS of 38.4 hours varies based on the disposition of the patient. Those who are discharged to home (74% at Dorchester in 2018) had an ALOS of 24 hours. Those discharged to a skilled nursing facility or assisted living facility (9.4%) had an ALOS of 115 hours, while those discharged to a hospital or other type of health care facility (12.2%) had an ALOS of 70 hours.

Shore projects that the FMF’s observation beds will need to accommodate almost 34,000 total observation hours, and proposed six observation beds.

Regarding room size, Shore cites: a length of stay that is “significantly longer than the ACEP Guide considers,” and might extend up to 48 hours. Obviously, the FMF will have no inpatient beds in which to admit patients. For these reasons, it proposes observation rooms sized at 159 SF, exclusive of in room toilet and bathing areas. The bariatric room will be sized at 200 SF, exclusive of toilet and bathing areas.

Table III-7: Historical and Projected Observation Utilization

	Historical			Projected at Dorchester			Projected at FMF		
	2016	2017	2018	2019	2020	2021	2022	2023	2024
Observation Cases	597	737	781	799	815	831	847	864	881
% Change	-1.0%	21.6%	6.0%	2.4%	2.0%	2.0%	2.0%	2.0%	2.0%
OBV Cases % of ED Visits	2.91%	3.79%	4.00%	4.08%	4.16%	4.23%	4.31%	4.39%	4.46%
Avg Hours Per Case	38.9	47.1	49.3	49.3	49.3	49.3	38.4	38.4	38.4
Total Observation Hours	23,221	34,696	38,469	39,374	40,145	40,932	32,518	33,155	33,804
Observation Days	968	1,446	1,603	1,641	1,673	1,705	1,355	1,381	1,409
Average Daily Census	2.7	4.0	4.4	4.5	4.6	4.7	3.7	3.8	3.9
Occupancy Target	70%	70%	70%	70%	70%	70%	70%	70%	70%
Bed Need	3.8	5.7	6.3	6.4	6.5	6.7	5.3	5.4	5.5
Requested Beds							6	6	6

Source: Historical observation cases and hours are based on UM SMC at Dorchester Internal Observation patient level data set (DI#21, p. 5)

Staff Analysis

The six observation rooms proposed are significantly out of harmony with Subparagraph (e)(i) of this standard, requiring that the FMF achieve at least 1,100 visits per year per space. Clearly, the ACEP guidance presumes that, on average, the type of observation patient it is assuming to be progressing from the hospital ED setting, has a much lower observation stay, on average, than is the case with Maryland hospital use of rate-regulated observation beds. Thus Shore relies on the exception language in the standard which permits a larger number of observation spaces if the applicant demonstrates need “based on the particular characteristics of the population to be served”

Shore presented data for SMC-D’s current observation patients that shows an actual ALOS for these patients that far exceeds what is implicit in the ACEP prescription of 1,100 visits per year per space. In projecting forward, Shore’s growth rate of 2% per year may be somewhat overstated, but it has assumed a declining ALOS based on moving to what is, if effect, a dedicated observation space and the institution of protocols to hasten diagnosis and disposition. The target occupancy rate it used to project the number of beds needed., at 70%, does not appear unreasonable. Staff concludes that deviation from the ACEP guidance in considering the need for observation beds at the proposed FMF is logical.

As for the disharmony of this projection with the standard, staff observes that the “grafting” of the ACEP prescription for the use of observation space in a hospital-based emergency room onto an FMF, may not be a good match. Thus staff has analyzed the proposal based on SMC-D’s historical observation usage and the validity of Shore’s assumptions and projections, and concludes that the request for six observation spaces is reasonable. Staff also notes that the applicant reduced its proposed capacity from 10 observation rooms to six after being questioned by staff on some of the underlying assumptions and projection methodology.

Staff recommends that the Commission find that Shore’s proposed number and size of observation spaces is consistent with this standard, based on its demonstration that more beds are needed than can be derived through use of the ACEP Guidelines.

(f) Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF’s projected service area;

Shore presented the data shown in Table III-8, below. As described earlier in this staff report, the growth in ED visits is attributable to assumed population growth of 0.2%. Observation census was projected at a more robust 2% based on recent trends and what Shore described as ongoing efforts to avoid hospitalizing patients.

Table III-8: Actual and Projected ED and Observation Patient Volume, UM SMC at Dorchester and Projected Emergency Visits and Observation Patient Volume, UM SMC at Cambridge FMF

	2016	2017	2018	2019	2020	2021	2022	2023	2024
	Actual SMC-D		Projected SMC-D				Projected FMF		
ED visits	20,531	19,453	19,543	19,574	19,605	19,636	19,668	19,699	19,730
Observation	597	737	781	799	815	831	847	864	881

Source: ED data from DI #16, p. 12; Observation data from DI #21, p. 5.

Staff questioned the reasonableness of the applicant’s utilization projections, given that they merely extend a trend of projected growth in demand for service at the converting general hospital. MHCC staff also questioned the likelihood of emergency visits trending upward for two reasons: (1) demand at the hospital’s ED has been declining in recent years; and (2) the FMF will not be a hospital ED. The change from a hospital to a purely outpatient facility could, in staff’s view, result in a different perception by the service area population that might influence demand in a negative way and shift higher acuity demand to alternative hospital EDs.

In response, Shore confirmed that it anticipates that the FMF will continue to serve the same patient population that currently seeks service at SMC-D and did not assume that a transition from a hospital ED to an FMF would affect the demand for emergency care in Cambridge or change the care-seeking behavior of EMS responders or consumers. With respect to EMS responders, Shore states that patients with certain conditions, including stroke patients, obstetric patients, heart attacks, and complex orthopedic cases, are already transported by EMS directly to SMC-E. Thus, these patients are already bypassing the existing hospital in Cambridge. This

protocol will remain when the hospital converts to an FMF. Further, Shore has also informed the community that it expects the FMF will continue to serve the same patient population for emergency and observation services as are provided by the hospital today. Shore apparently believes this assurance will prevent any change in care-seeking behavior by patients transporting themselves for service. (DI #16, p. 14). Staff recommends that the Commission find that the applicant satisfies Subparagraph (f)(i) of the standard.

(ii) The utilization projections for rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are consistent with the observed historic trends by the population in the FMF's projected service area.

Shore's projected volumes for the rate-regulated outpatient services included in this project, including infusion services and cardiac rehabilitation, are consistent with historic trends. In fact, there is virtually no growth projected in those services. Staff concludes that the application meets this standard.

(iii) The revenue estimates for emergency services and other outpatient services specified by the HSCRC under Health-General Article §19-201(d)(iv) and COMAR 10.37.10.07-2 are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

HSCRC's review of the proposal resulted in a staff opinion that the FMF revenue estimates are reasonable based on Shore's projected volumes. HSCRC staff did, however, express "concerns that the projected volumes will not be achieved, since Shore Hospital assumes that 100% of its current inpatient and outpatient emergency room visits will be serviced by the FMF. HSCRC staff believes this assumption has not been sufficiently validated." (DI #22, p. 2). Staff recommends that the Commission find that the applicant satisfies Subparagraph (f)(iii) of the standard.

(iv) The staffing assumptions and expense projections for emergency services and any other rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

Shore states that the projected staffing at the FMF reflects a reduction of 113 FTEs and \$8 million of salaries and benefits in fiscal year 2022 for Shore operations in Cambridge as the staff at SMC-D are transitioned to UM SMC at Cambridge and SMC-E. (DI #2, p. 42). Staff concludes that the applicant meets the requirements of Subparagraph (f)(iv).

(v) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

Shore presented actual and projected financial performance for the system components affected by this project, the two hospitals in Easton and Cambridge, the FMF in Queenstown (a satellite of the Easton hospital), and the future FMF in Cambridge, also parented by SMC-E. It

reported a combined net income in excess of \$52 million for these components in 2017 and 2018, with a positive excess revenue over expense forecast through 2024. In that year, it projects an overall net income of \$15,641,000 for these system components. (DI#21, Table H, Revenue and expenses, Inflated, Entire Facility). Staff concludes that the applicant meets the requirements of Subparagraph (f)(v).

Summary, Subparagraphs (f)(i)-(v)

Staff concludes that the projections of utilization, revenues, and staffing are, in most respects, consistent with historic trends. In the cases where consistency with historic trends would, arguably, not be anticipated, given the ways in which Shore is reconfiguring its system components, the applicant has provided acceptable explanations of its assumptions that have a plausible basis. It is likely that those components of Shore affected by this project will, on a combined basis, be able to generate excess revenue over expenses, if the proposed project is implemented.

(g) Demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in COMAR 10.24.11 for operating room capacity and needs assessment for dedicated outpatient operating rooms and that the design is consistent with requirements in COMAR 10.24.11 for health care facilities with surgical capacity.

This standard is not applicable since there are no operating rooms proposed in this request.

(h) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

The applicant responded to this standard by providing an analysis of the project construction cost estimate with a benchmark cost based on the Marshall Valuation Service guidance on hospital costs, given that the facility will be built to hospital standards. Its analysis yielded an adjusted project cost estimate of \$415.24 per SF, \$0.66 below the calculated MVS benchmark cost. Staff's calculation arrived at a benchmark cost that was about 8% higher. Staff believes that the construction cost estimate is reasonable. For details, see Appendix 6: Evaluating Construction Cost Estimate Using the Marshall Valuation Service Methodology).

Staff concludes that the analysis undertaken by the applicant is reasonable and recommends that the Commission find that the project is consistent with this standard.

(i) Demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs, FMFs, or other health care facilities, and demonstrate why other less expensive models of care delivery cannot meet the needs of the population to be served.

Shore states that the existing hospital in Dorchester is approximately 199,000 square feet in size and is quite oversized relative to its recent utilization levels. When its age is considered

along with the expense required to replace or modernize it, a feasible plan for modernization and right-sizing the hospital is not apparent. In contrast the proposed FMF will be appropriately sized at approximately 42,000 SF and will yield significant operational cost efficiencies. The FMF is not projected to be profitable but Shore does project that its operating losses will be small. The combined parent hospital operation, with it existing and proposed FMF satellite operations is likely to be able generate net positive operating income after this proposed project is implemented. (DI #2, pp. 50, 51).

In assessing whether the care could be provided at other hospital EDs or health care facilities, Shore points out that the facility is located in a rural area and travel time to alternative hospitals providing the emergency treatment and other services proposed for the FMF will substantially increase for much of the SMC-D service area if an FMF is not developed in Cambridge. SMC-E is located approximately 15 miles from the proposed FMF. The next closest general hospitals are Nanticoke Memorial Hospital, approximately 27 miles away, Peninsula Regional Medical Center, approximately 31 miles away, and Atlantic General Hospital, about 54 miles from Cambridge. UM Shore Emergency Center at Queenstown, an FMF, is 35 miles away. As shown earlier in this staff report in Table III-2, there are four urgent care centers in SMC-D's service area; one is within one mile, but the other three are more than 16 miles away. Shore states that developing the FMF

with the proposed level of emergency treatment spaces, observation beds, and ancillary equipment is critical to ensure continued access to emergency and observation services for the service area population ... [and] ensuring it is sized appropriately to handle the projected volumes from its service area is essential to ensure that the next closest facility, UM SMC at Easton's ED, does not become overwhelmed by increased patient volume due to the conversion. (DI#2, p. 22).

Staff concludes that the applicant has demonstrated that the conversion to an FMF will result in the delivery of more efficient and effective health care services. Replacing SMC-D with an FMF will retain important emergency and observation services at a lower cost than maintaining the present hospital.

(j) Demonstrate that the conversion is in the public interest, based on an assessment of the converting hospital's long-term viability as a general hospital through addressing such matters as:

(i) Trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends;

(ii) The financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals;

Shore presented data showing that inpatient admissions at SMC-D declined almost 16% between 2014 and 2018 (to 2,030), almost double the statewide rate of inpatient decline. Shore maintains that this decrease and concomitant declining financial margin has created a financial

hardship for the hospital due to the cost of maintaining the hospital infrastructure. SMC-D generated operating margins ranging from 12.9% in fiscal year 2013 to 1.7% in fiscal year 2017. That 2017 operating margin of 1.7% is below the statewide average of 2.8%. (DI #2, p. 55).¹²

(iii) The age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant;

The oldest section of the existing hospital in Cambridge is over 100 years old. Its average age of physical plant was 14.4 years in fiscal year 2016, compared to the Maryland statewide average of 10.2 years. The investment required to modernize the existing hospital is considerable, and the direct ongoing expense of operating its 199,000 net SF (an estimated \$3.1 million) require almost three times the estimated direct expense involved in operating the proposed FMF physical plant (\$843,000). (DI #2, p. 58).

(iv) The availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; and

Simultaneous with this exemption request, Shore submitted an exemption request to merge and consolidate a portion of SMC-D's inpatient services with SMC-E in order to ensure continued availability and access to inpatient care for the region served by these two hospitals. Shore projects that all of the psychiatric discharges at SMC-D will shift to SMC-E and is proposing to create a 12-bed adult psychiatric unit in the Easton hospital. Shore also projects that the majority of SMC-D's MSGA census that would otherwise use the Dorchester hospital if it stayed in operation will use SMC-E as an alternative, with about 22% moving to other non-SRH hospitals. (DI #2, p. 58).

(v) The adequacy and appropriateness of the hospital's transition plan.

Shore described a methodical process of preparing for this transition, including much community involvement. It cites the findings of its Community Health Needs Assessment, which "shows a consumer-defined need...for access to outpatient services, primary care, and specialists to support prevention and management of chronic disease, including behavioral health and addiction services...[and] safety net needs related to urgent care and emergency medical care," and describes how its plan meets those needs.

Shore's comprehensive plan to transform service delivery in the region is keyed by the conversion of SMC-D to an FMF, and a plan to relocate and modernize its flagship hospital, SMC-E. To ensure continued access during that transition, Shore also has an exemption request before

¹² In response to staff questions, Shore noted that the historical financial performance presented in the FMF application does not represent the true financial performance of SMC-D as certain shared services and other expenses were not fully allocated to the hospital and remained on the financial statements of either SMC-E or SRH. These expenses include, but are not limited to, physician expenses, various purchased services, back office support functions, and corporate allocations. If these expenses had been fully allocated, SMC-D would have had slimmer profit margins. (DI #16, p. 20).

the MHCC to relocate and consolidate some of the acute services (inpatient MSGA and psychiatric bed capacity) to SMC-E as an interim step. Shore also points out that, “Transportation to and from emergency services, both in FMFs and hospitals is a critical component of successful transition planning and ultimately, to the transformation of health care delivery that provides efficient and effective care with optimal outcomes,” especially in a rural area, and describes a longstanding arrangement with “the region’s predominant provider of interfacility ground medical transportation services, Best Care Ambulance, Inc.”

Finally, Shore described its plans for transitioning employees and disposition of the existing hospital. Regarding the former, it convened a Workforce Transition and Development Task Force in 2018 that will assess the needs of the newly-configured delivery system and seek to match existing employees with those needs, while also making alternative placements within SRH and UMMS for any displaced employees, and identify training options to match employees with resources in the event of displacement. As for the existing hospital site, it will be sold for redevelopment. Dorchester County, the City of Cambridge, and SRH have signed a letter of intent to outline the future property sale to the newly incorporated Cambridge Waterfront Development, Inc. so that the hospital property can be included in a waterfront development project that will enhance destination recreation, job creation, and commerce in Cambridge and Dorchester County.

Summary, Subparagraphs (j)(i)-(v)

Staff concludes that the applicant has demonstrated that the conversion is in the public interest, based on an assessment of the converting hospital’s long-term viability as a general hospital and other circumstances.

(k) Demonstrate that the conversion is in the public interest, based on an assessment of the parent hospital’s projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

The proposed FMF is projected to incur small operating losses totaling about \$650,000 in fiscal years 2022 through 2024. These losses will be absorbed by SRH and will be offset by the profitable operation of the FMF parent, SMC-E. The conversion should benefit the Easton hospitals by expanding its revenue base of inpatient care. Shore presented actual and projected financial performance for the entire system, i.e., its two hospitals in Easton and Cambridge, its FMF in Queenstown, and the future FMF in Cambridge. It showed a combined net income in excess of \$52 million for 2017 and 2018, with a positive bottom line forecast through 2024, in which it projects a combined net income of \$15,641,000. (DI #2, p. 69; DI #21, Table H). Staff concludes that the applicant presented the required demonstration of financial performance.

(9) The Commission shall grant a requested exemption from Certificate of Need within 60 days of receipt of a complete notice of intent from a general hospital to convert to a freestanding medical facility if the Commission, in its sole discretion, finds that the action proposed:

(a) Is consistent with the State Health Plan;

Based on the information contained in this staff report, staff recommends that the Commission find that the proposed conversion is consistent with the State Health Plan.

(b) Will result in more efficient and effective delivery of health care services;

Please see the discussion above, at Subparagraph 8(i), *supra*, pp. 26-27, which staff concluded demonstrates conformance with this part of the standard.

(c) Will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board; and

A positive determination on this criterion was made by the State EMS Board. See Appendix 4.

(d) Is in the public interest.

Please see the discussion at 8(j)(i-v), *supra*, pp. 26-27, and (k) *supra*, p. 29, which staff concluded demonstrates that the proposed conversion is in the public interest.

(10) If a general hospital decides that it will close because the Commission denied its request for exemption from Certificate of Need to convert to a freestanding medical facility or because its conversion request was not considered by the Commission as the result of a determination by the State Emergency Medical Services Board that conversion to an FMF would not maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system, the hospital must provide the notice of closure and hold the public informational hearing required by Health-General §19-120 and Commission regulations adopted pursuant to the statute.

This requirement is not applicable in this review unless the request for an exemption from CON is denied.

IV. STAFF RECOMMENDATION

MHCC staff recommends that the Commission approve the request of Shore Health Systems, Inc. for an exemption from Certificate of Need review to convert University of Maryland Shore Medical Center at Dorchester to a freestanding medical facility to be constructed in Cambridge that will provide rate-regulated emergency and observation services; and will be an administrative unit operated by UM SMC at Easton. Staff concludes that the request complies with the applicable criteria and standards established for such conversions.

As required by Maryland law, both the Maryland Institute for Emergency Medical Services Systems and the Health Services Cost Review Commission have provided input to MHCC that is supportive of the proposed hospital transition to an FMF. Thus, the transition of UM SMC at Dorchester to an FMF is not anticipated to cause a disruption in the availability and accessibility

of emergency medical services that poses a threat to public safety or health care delivery. As well, the project was determined by HSCRC to be financially feasible, as a component of UM SRH.

Although MHCC staff concludes that the 22 ED treatment spaces proposed for the facility may exceed what will be needed at the proposed FMF in order to meet the demand for service, in light of the ACEP guidance referenced in the FMF Chapter, the applicant has cited mitigating factors. This FMF will be the second rural area FMF developed in Maryland and the first such FMF developed through conversion of a small general hospital with a predominantly rural service area. Travel time to a hospital will increase for most of the population in and around Cambridge and the long history of a hospital presence in Cambridge may mean that patterns of care-seeking behavior for emergency care may not change significantly, consistent with what SRH predicts.

Reducing the capacity of the proposed FMF to better align with the smaller space recommendations of ACEP would not greatly reduce the capital cost required for the FMF. The same forces that have reduced demand for most hospital EDs in recent years also suggest that an FMF with more treatment spaces than a conservative perspective would suggest will not necessarily induce more demand for service. The greater concern with FMF use is the more costly care it will provide to patients who could use an urgent care center, physician's office, or other less expensive venue for non-emergent care and very low acuity care needs but this concern is not one grounded in oversizing of the FMF treatment capacity or one that can be avoided by developing smaller FMFs.

Shore responded to staff's skepticism regarding the need for the originally-requested 10 observation beds with a re-examination of the proposal that led to a reduction of observation capacity to six beds. While six beds would exceed the number recommended in the ACEP Guidelines, this guidance envisions an observation service that is not in line with what is currently occurring in Maryland hospitals. That experience justifies the proposed six beds.

Finally, MHCC staff concludes that this reconfiguration of services will help establish a more efficient and effective health care delivery system on the mid-Shore. Access to emergency and urgent care will be retained in the SMC-D service area and the proposed consolidation of inpatient care in Easton will be a more cost-effective alternative to the current two-hospital configuration.

MHCC staff recommends that the Maryland Health Care Commission APPROVE the proposed conversion of University of Maryland Shore Medical Center at Dorchester to a freestanding medical facility.

<p>IN THE MATTER OF THE</p> <p>CONVERSION OF THE</p> <p>UNIVERSITY OF MARYLAND</p> <p>SHORE MEDICAL CENTER AT</p> <p>DORCHESTER TO A</p> <p>FREESTANDING MEDICAL FACILITY</p> <p>Docket No. 18-09-EX006</p>	<p>*</p>	<p>BEFORE THE</p> <p>MARYLAND</p> <p>HEALTH CARE</p> <p>COMMISSION</p>
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FINAL ORDER

Based on the Commission staff’s analysis and recommendation, it is this 18th day of April, 2019 **ORDERED:**

That the request by Shore Health System, Inc. doing business as the University of Maryland Shore Medical Center at Dorchester and as the University of Maryland Shore Medical Center at Easton, for an exemption from Certificate of Need review to convert the University of Maryland Shore Medical Center at Dorchester to a freestanding medical facility to be constructed in Cambridge and that will include rate-regulated services consisting of: 22 emergency treatment spaces; six observation beds in single occupancy patient rooms; a diagnostic imaging suite including conventional x-ray, ultrasound, computed tomography; infusion therapy services, cardiac rehabilitation services, and outpatient behavioral health services; as well as related support space, a laboratory, and medication stations, at an approved expenditure of \$38,497,006 is **APPROVED**.

MARYLAND HEALTH CARE COMMISSION

**Appendix 1: UM SRH VISION FOR HEALTH CARE
DELIVERY**

UM SRH VISION FOR HEALTH CARE DELIVERY

Shore Health System, Inc. (“SHS”), doing business as University of Maryland Shore Medical Center at Dorchester (“UM SMC at Dorchester”) and University of Maryland Shore Medical Center at Easton (“UM SMC at Easton”), recently submitted the following requests for regulatory approval to the Commission: (1) Request for Exemption to Convert UM SMC at Dorchester to a Freestanding Medical Facility (“FMF Application”); (2) Request for Exemption for Merger and Consolidation of Certain Beds and Services of UM SMC at Dorchester and UM SMC at Easton (“Merger/Consolidation Application”); and (3) CON for Replacement and Relocation of UM SMC at Easton (“CON Application”). The Commission requested that SHS prepare this summary to fully explain why it is proposing these changes and its overall vision for the proposed reconfigured services and facilities.

This summary first describes the broader objectives and vision of University of Maryland Shore Regional Health (“UM SRH”) and the strategic planning process that led UM SRH to file the pending applications described above. Second, it describes some of the deficiencies in the current SHS facilities and how the vision will solve these issues and create an optimal care delivery system for the future.

I. UM SRH’s “Big Picture” Objectives and Vision

UM SRH is committed to serving Maryland’s mid-Eastern Shore. Its mission is *Creating Healthier Communities Together* and its vision is *to be the region’s leader in patient centered health care*. It is a rural health care delivery system serving approximately 175,000 people spread over nearly 2,000 square miles in Caroline, Dorchester, Kent, Queen Anne’s, and Talbot Counties. UM SRH includes:

- A network of primary care and specialty providers, diagnostic and treatment centers, regional specialty care centers (cancer, breast health, cardiac care, diabetes, joint replacement, behavioral health, stroke, and acute inpatient rehabilitation);
- A continuum of care services including home health, palliative care, transitional care and population health management, screenings, education and support;
- Four emergency departments (including one freestanding emergency center in Queenstown) and a partnership with two urgent care centers; and
- Three inpatient hospitals (UM SMC at Chestertown, UM SMC at Easton, and UM SMC at Dorchester).

Nationally, health care providers are focusing on the triple aim of improving health, reducing costs, and providing better care. Hospital admissions are declining across the nation and in Maryland, due to better care coordination, improvements in early diagnosis and treatment, and evolving clinical practices and technology. In addition, emergency room visits are targeted for reduction, observation stays are helping to avoid unnecessary admissions, and there is an emphasis on improving wellness through expanded access to primary and specialist care.

UM SRH's objectives align with the triple aim and it is seeing similar utilization trends in its service area as those being experienced at the national level and throughout Maryland.

UM SRH is focused on improving patients' health and wellness by enhancing access to care, expanding services to help patients stay healthy, improving its facilities, and investing in population health and disease management. As a rural health system, UM SRH faces challenges that are specific to rural health care delivery, including:

- Limitations on access due to lack of public transportation;
- Inefficiencies with operating low volume, resource intense hospitals;
- Difficulties recruiting and retaining experienced providers; and
- Challenges with limited community-based population health resources which are essential for establishing effective continuums of care.

II. Creating a Regional Vision through Strategic Planning and Community Engagement

UM SRH has taken the objectives discussed above and its rural health care delivery challenges into account in its strategic planning process. Immediately following the adoption of a new strategic plan in 2014, the UM SRH Board of Directors and its planning committee launched a Strategic Services Delivery Workgroup and subsequently, a Strategic Service Delivery Council to evaluate and define the future of UM SRH clinical services. Both groups engaged physicians, providers, leadership, management, community health care partners, and elected officials in a review of regional health care needs as well as national and state trends in health care. The resulting recommendations were compiled by the Service Delivery Council, recommended for adoption by the UM SRH Board Strategic Planning Committee, and approved by the UM SRH Board and the University of Maryland Medical System ("UMMS") Board in 2016. This Strategic Service Delivery Plan, which defines needs and services at appropriate levels and facility types throughout the region, was then widely shared with community leaders, organizations, citizens, and elected officials.

Some of the key recommendations for UM SRH's regional health care transformation plan include:

- Improving access to high-quality, cost-effective care throughout the five counties of Maryland's mid-Eastern Shore and expanding population health management;
- Enhancing ambulatory care services network (primary care, specialty care, telehealth, behavioral health, mobile integrated health care);
- Achieving service delivery plans to address both community health needs and access to care at multiple existing service points in the region, including the location of inpatient services and freestanding medical facilities; and
- Developing a new medical center to replace UM SMC at Easton, which is aging and costly to maintain.

In addition, the Strategic Service Delivery Plan envisioned that the Maryland General Assembly would allow general hospitals to convert to an FMF, and a new statutory and regulatory framework would be implemented to govern hospitals converting to FMFs without a full CON review process. UMMS and UM SRH participated in commenting on the legislation and regulations that would make hospital conversions to FMFs possible in Maryland. As the Strategic Service Delivery Plan was being communicated and legislation was moving ahead, UM SRH continued its ongoing discussions with its physician leaders in Dorchester County regarding the possibility of converting the aged hospital in Cambridge, UM SMC at Dorchester, to an FMF. With physician support for the concept, including the relocation of inpatient beds to UM SMC at Easton, *just 15 miles away*, UM SRH expanded the discussion to include the local public health officer, emergency medical services (“EMS”) providers, local and state elected officials, and ultimately, to the full community in a series of community listening sessions during 2017. With overwhelmingly positive feedback from all of these sources, the Boards of UMMS and UM SRH approved moving forward with the detailed plan development for the conversion of UM SMC at Dorchester to an FMF to be called the “University of Maryland Shore Medical Center at Cambridge” (“UM SMC at Cambridge”) with an adjacent medical pavilion containing a complement of ambulatory services. In sum, before proposing the reconfigurations proposed in the requests for regulatory approval, UM SRH conducted a thorough, thoughtful, and collaborative process with community stakeholders. This process helped to determine the community’s needs and ensured the particular facility and service changes being proposed were vetted and received widespread support from community stakeholders.

UM SRH’s proposed reconfiguration of SHS’s facilities and services through the three pending applications are designed to create an optimal patient care delivery system that will allow SHS to continue providing accessible and high quality care to residents of Dorchester County and the region.

As described below, the existing UM SMC at Dorchester and UM SMC at Easton each have deficiencies due to the age of the facilities. UM SRH’s vision for the future will alleviate these issues and improve the overall care delivery system.

III. The Current State of UM SMC at Dorchester

As set forth more fully in the FMF Application, UM SMC at Dorchester’s inpatient admissions have been declining each year as a result of efforts toward reducing potentially avoidable utilization (“PAU”), avoiding readmissions, and adopting population health strategies. Due to these declines, the hospital facility is oversized based on the number of inpatients it is serving. With low average daily census and surgical procedure volumes at the facility, it is difficult for staff to maintain certain clinical proficiencies. The hospital’s physical plant was constructed between 1906 and 1960, and has undergone numerous renovations and improvements throughout the years. Although SHS has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has outlived its useful life and is too expensive to maintain. The capital expenditures required to modernize the facility would not be

cost-effective and would not address the limitations of the hospital's current location in a residential and tourism area of the city. Continuing to operate UM SMC at Dorchester with reduced volumes and aging infrastructure is expensive, inefficient, and not in the public's best interest.

IV. UM SRH's Vision for the UM Shore Medical Center at Cambridge

UM SRH's vision for the future of health care delivery in Dorchester County is to provide patient-centered health care within a more accessible, state-of-the-art campus for medical services in Cambridge, designed to conveniently serve all residents of Dorchester County and its neighboring counties. UM SRH has planned the future UM SMC at Cambridge campus to be:

- Conveniently located at a highly visible and accessible site
- A modern place of employment for local residents
- A focal point for transportation
- An attractive draw to recruiting new physicians to the community
- A vital center for economic development for Cambridge and Dorchester Counties

In 2017 and early 2018, UM SRH not only engaged in ongoing conversations with providers, the community and elected officials, it performed detailed planning regarding the location of the proposed FMF campus, the facility design and site planning, services identification, budget and financing, and early transition planning for three essential areas: (1) the plan to transition acute care services previously provided at UM SMC at Dorchester and the related transportation impact; (2) the plan to transition, retrain, and place employees of UM SMC at Dorchester; and (3) the plan for the existing UM SMC at Dorchester physical plant and site. These plans are detailed in the FMF Application.

As noted above, the planning process also identified the need to relocate certain beds and services from UM SMC at Dorchester to UM SMC at Easton as part of the conversion to ensure adequate access to these services for residents of the service area. For this reason, SHS is requesting through the Merger/Consolidation Application to relocate 17 medical/surgical and 12 psychiatric beds from UM SMC at Dorchester to the existing UM SMC at Easton facility. SHS is proposing to renovate portions of the existing UM SMC at Easton facility to accommodate these additional beds and transfer operation of these beds upon the projected opening of the new FMF facility in summer of 2021. This will ensure continued access to adequate medical, surgical, and behavioral health services for residents of the service area.

UM SRH envisions that the UM SMC at Cambridge medical campus will continue serving the most important needs of residents by providing emergency, diagnostic, imaging, observation, surgical, and other outpatient services. When patients arrive at the FMF in need of inpatient services, including inpatient behavioral health services, the patients will be transferred to UM SMC at Easton, just 15 miles away (subject to its capacity, capability to serve the patient, and the patient's choice), or to another acute care facility.

V. The Current State of UM SMC at Easton

The existing UM SMC at Easton facility comprises four components from different eras. A small portion of the building was built in 1915. The majority of the building, including most of the inpatient units, was constructed in phases between 1955 and 1975. A four-story inpatient addition was made in 1982, with a fifth floor added in 1990. Lastly, a one-story ambulatory and emergency wing was constructed in 2006. With the majority of the building having been constructed between 1955 and 1982, primarily with semi-private patient rooms, this facility is aged, obsolete, and in need of replacement. It is not designed for modern, family-oriented medicine. It is undersized in various critical areas, such as the operating rooms. The hospital lacks adequate parking. Surrounded by a residential neighborhood in downtown Easton, the hospital footprint cannot be expanded. The location is inconvenient for access by emergency medical vehicles as well as for the many patients from outside Easton who must drive into downtown Easton on local streets to reach the hospital.

Although the outpatient component of the hospital is not the oldest space, it was designed as an addition to the older building components and, therefore, suffers from considerable limitations. The CON Application details many additional physical and operational deficiencies of the existing facility.

Similar to UM SMC at Dorchester, UM SMC at Easton also has experienced declines in utilization of inpatient services and lengths of stay, largely through its efforts in reducing PAU, avoiding readmissions, and enhancing population health management initiatives. UM SRH has carefully evaluated historical data to project its need for future beds and services at the replacement hospital. These projections include the need for the beds and services that UM SRH is proposing to relocate to the existing UM SMC at Easton facility from UM SMC at Dorchester, as a bridge and transition to the Easton replacement hospital. Accordingly, when the replacement hospital is built, it will be configured and sized to continue providing the regional inpatient and outpatient services it provides today for residents of Caroline, Kent, Queen Anne's, Talbot, and Dorchester Counties.

VI. UM SRH's Vision for UM SMC at Easton

UM SRH's vision for UM SMC at Easton is to replace and relocate the facility with a new hospital on U.S. Route 50 near the Easton Airport. This location is approximately 3.5 miles north of its current location in downtown Easton. UM SMC at Easton will continue to provide regional specialty services, including obstetrics, pediatrics, oncology, interventional cardiology, orthopedics, critical care, neurosurgery, and inpatient acute rehabilitation. UM SRH also intends to build a new medical office building on the campus adjacent to the hospital, which will include physician office space. The new campus will continue to provide access to necessary primary care, specialists, diagnostic services, and outpatient services.

The CON Application details the design and configuration of the replacement hospital, which will address many of the deficiencies and inefficiencies inherent in the current design. The new location will be much more accessible and within a 30-minute drive time to a larger and growing proportion of the service area population than the current location. With a 187-acre campus, the new facility will have ample space for parking and possible future expansion. The

new hospital design will offer operational and cost efficiencies and contain features that will enhance patient safety. In addition, the new facility will be composed of all private rooms, a major improvement over the existing facility. As a result of these improvements, UM SRH expects patient satisfaction and the patient experience to increase significantly.

VII. Conclusion

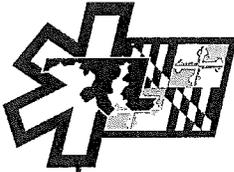
UM SRH is proposing the reconfiguration of its facilities and services after an in-depth and lengthy planning process that evaluated the needs of its service area population and engaged numerous community stakeholders. This thoughtful and collaborative planning process resulted in recommendations, including the conversion of UM SMC at Dorchester to an FMF and the replacement of UM SMC at Easton. UM SRH is confident that its proposals enjoy widespread community support. The new care delivery model will provide accessible, high-quality care to patients, and it will create substantial cost savings and operational efficiencies. Consolidating acute care at UM SMC at Easton will result in more efficient and effective delivery of care as well as improved quality. It will also improve the long-term financial outlook for UM SRH, securing financial sustainability for the future. Finally, by modernizing its facilities and care delivery model, UM SRH will enhance its ability to recruit and retain needed health care providers to the region. For all of these reasons, UM SRH is proposing the reconfiguration described in the three applications pending before the Commission.

Appendix 2: Project Budget

Estimated Project Budget

	FMF (CON project)	MOB	Total
New Construction			
Building	\$13,780,551	\$9,239,812	\$23,020,363
Fixed Equipment	\$220,000		\$220,000
Site and Infrastructure	\$2,900,000	\$2,003,681	\$4,903,681
Architect/Engineering Fees	\$1,320,000	\$1,606,649	\$2,926,649
Permits (Building, Utilities, Etc.)	\$470,000	\$470,000	\$940,000
SUBTOTAL	\$18,690,551	\$13,320,142	\$32,010,693
Renovations			
Building			\$0
Fixed Equipment (not included in construction)			\$0
Architect/Engineering Fees			\$0
Permits (Building, Utilities, Etc.)			\$0
SUBTOTAL	\$0	\$0	\$0
Other Capital Costs			
Movable Equipment	\$6,460,000	\$4,455,000	\$10,915,000
Contingency Allowance	\$2,471,500	\$1,000,000	\$3,471,500
Gross interest during construction period	\$3,410,309	\$2,108,901	\$5,519,210
Other - Owner Enabling	\$75,000	\$193,351	\$268,351
			\$0
SUBTOTAL	\$12,416,809	\$7,757,252	\$20,174,061
TOTAL CURRENT CAPITAL COSTS	\$31,107,360	\$21,077,394	\$52,184,754
Land Purchase	\$6,000,000		\$6,000,000
Inflation Allowance	\$814,049	\$551,574	\$1,365,623
TOTAL CAPITAL COSTS	\$37,921,409	\$21,628,968	\$59,550,377
Financing Cost and Other Cash Requirements			
Loan Placement Fees	\$510,597	\$268,084	\$778,681
Bond Discount			\$0
CON Application Assistance			
<i>c1. Legal Fees</i>	\$45,000		\$45,000
<i>c2. Other (Specify/add rows if needed)</i>	\$20,000		\$20,000
Non-CON Consulting Fees			
<i>d1. Legal Fees</i>			\$0
<i>d2. Other (Specify/add rows if needed)</i>			\$0
Debt Service Reserve Fund			\$0
Other (Specify/add rows if needed)			\$0
SUBTOTAL	\$575,597	\$268,084	\$843,681
			\$0
TOTAL USES OF FUNDS	\$38,497,006	\$21,897,052	\$60,394,058
Sources of Funds			
			\$0
Philanthropy (to date and expected)			\$0
Authorized Bonds	\$38,097,559	\$21,626,985	\$59,724,544
Interest Income from bond proceeds listed in #3	\$399,446	\$270,067	\$669,513
TOTAL SOURCES OF FUNDS	\$38,497,006	\$21,897,052	\$60,394,058

**Appendix 3: Maryland Institute for Emergency Medical
Services Systems Findings**



CHS-8925
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Maryland Health Care Commission

State of Maryland

October 15, 2018

Maryland
Institute for
Emergency Medical
Services Systems

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Donald L. DeVries, Jr., Esq.
Chairman
Emergency Medical
Services Board

410-706-5074
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Dear Mr. Steffen,

As you are know, Shore Health System, Inc., d/b/a University of Maryland Shore Medical Center at Dorchester ("UM SMC Dorchester"), and University of Maryland Shore Medical Center at Easton (UM SMC Easton) (collectively, the "Applicant") are seeking approval from the Maryland Health Care Commission to convert the University of Maryland Shore Medical Center at Dorchester to a freestanding medical facility, as well as for an exemption from Certificate of Need (CON) review for the proposed conversion.

The Maryland Health Care Commission will determine whether to approve the request for exemption from the CON requirement based on a number of factors, including whether the conversion "will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services (EMS) Board." Health General 19-120 (o)(3)(i)5C. In making this determination, the State EMS Board is required to consider eleven (11) factors specified in regulation. COMAR 30.08.15.03.

Please be advised that at its meeting on October 9, 2018, the State EMS Board reviewed the proposed conversion and considered an analysis of the COMAR-enumerated factors. After consideration of these factors, the State EMS Board unanimously determined that the proposed conversion of University of Maryland Shore Medical Center at Dorchester to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. Attached is a copy of the analysis that provided the basis for the Board's determination.

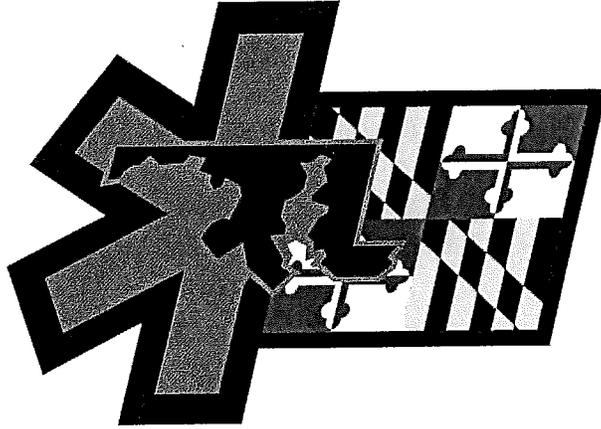
Please let me know if you have any questions or if I may provide any further information.

Sincerely,

Patricia S. Gainer, JD, MPA
Acting Co-Executive Director

Enclosure

Cc: Kenneth D. Kozel, President & CEO Shore Regional Health



**MIEMSS Report and Recommendation to the State
Emergency Medical Services Board Regarding the Proposed
Conversion of University of Maryland Shore Medical Center
at Dorchester to a Freestanding Medical Facility without a
Certificate of Need (CON):**

**Whether the Proposed Conversion Will Maintain Adequate
and Appropriate Delivery of Emergency Care within the
Statewide Emergency Medical Services System**

approximately one mile away from the existing hospital. The proposed new FMF will formally be called the “University of Maryland Shore Medical Center at Cambridge.” Seventeen (17) (of the existing 18) MSGA beds and 12 (of the existing 24) psychiatric beds will be relocated at UM SMC Easton, an existing acute care hospital with 104 licensed acute care beds¹, located approximately 15 miles away at 219 South Washington Street in Easton, Maryland.

Process

Under COMAR 30.08.15.03 (B), the Applicants notified MIEMSS and the MHCC on July 6, 2018, of their intent to convert UM SMC Dorchester to a freestanding medical facility. The Applicants held the required public hearing on July 31, 2018, and provided the required information to MIEMSS within the required timeframe. The Applicants solicited input from the EMS community by publishing a physical address and email address on their website for receipt of comments. Additionally, MIEMSS sought information from the EMS community by soliciting comments on its website as “Opportunity for Comment for University of MD Shore Medical Center Dorchester Hospital Conversion to a Freestanding Medical Facility” from July 18 – August 14, 2018. MIEMSS received comments from one individual during the comment period, generally relating to the conversion of acute care hospitals to FMFs, but not specific to the Dorchester FMF conversion. The Applicant did not receive any comments. Under COMAR 30.08.15.03 (D), the EMS Board is required to issue the determination concerning the proposed hospital conversion under §A of this regulation within 45 days of the required public informational hearing held by the hospital proposing the conversion, in consultation with the MHCC. Accordingly, the deadline for EMS Board to make its determination and to notify the MHCC of its determination was September 14, 2018. By agreement between MIEMSS and the Applicants, however, the 45 day requirement was waived and the date for consideration by the EMS Board was then determined to be October 9, 2018.

Required Factors for EMS Board Consideration under COMAR 30.08.15.03(A)

Each of the eleven (11) factors specified for consideration by the EMS Board is discussed below.

- (1) The EMS resources in the jurisdictions affected by the proposed hospital conversion, including staffing, equipment, and units.*

The primary jurisdiction that will be affected by the conversion is Dorchester County. Talbot County and Caroline County would be expected to be impacted to a lesser extent because transports to UM SMC Dorchester from these jurisdictions are typically only a small portion of their total transports (see infra).

¹ Maryland Health Care Commission, Acute Care Hospital Inventory (ACHI) FY 2019.

average total transport time from UM SMC Dorchester is about 90 minutes to UM SMC Easton and 120 minutes to Peninsula Regional Medical Center (from time of dispatch to return to service time).

Use of public safety resources for these transfers would place an unreasonable burden on the EMS resources in the affected jurisdiction. DCEMS projects any increase in transfer volume would require the addition of a third unit in Cambridge.⁴ In 2017, DCEMS provided approximately 1.5 interfacility transfers per month when BestCare was not immediately available for a total of 18 patients, approximately 7-8 of which were STEMI patients and several other were obstetrics patients. UM SMC projects that the number of transfers requiring admission will be approximately the same from the proposed Dorchester FMF as they are today.⁵

The Applicant provided the following: “...An Ambulance Oversight Committee meets quarterly, which includes management staff from Maryland ExpressCare, Best Care, and UMSRH. The standing agenda includes a report from Best Care on volumes and its On Time Performance. UMSRH will be working with Maryland ExpressCare and Best Care to review the current MOUs and revisit the current metrics in their contracts to ensure they will be able to accommodate any increased transport volumes due to the conversion of UM SMC at Dorchester to an FMF..”⁶

(3) The EMS call volume of affected jurisdictions by priority.

EMS Transports from Caroline, Dorchester, and Talbot					
EMSOPS by Patient Priority and Destination Category					
Calendar Years 2015, 2016, and 2017					
Source: eMEDS®					
Maryland EMSOP	CY 2015	CY 2016	CY 2017	Grand Total	EMSOP Percent
Caroline County					
Priority 1 - Patient Critically Ill or Injured (Immediate / Unstable)	158	189	193	540	5.3%
*Dorchester (UMSRH) - 295	0	1	1	2	
Other Facility	158	188	192	538	
Priority 2 - Patient Less Serious (Urgent / Potentially Life Threatening)	1,540	1,646	1,852	5,038	49.3%
*Dorchester (UMSRH) - 295	17	16	12	45	
Other Facility	1,523	1,630	1,840	4,993	
Priority 3 - Patient Non-Urgent	1,710	1,394	1,497	4,601	45.0%

⁴ Information provided by Dorchester County DES at MIEMSS request.

⁵ Response to MIEMSS request for additional information page 2; October 1, 2018.

⁶ Response to Regulatory Factors, page 6.

County EMS transported approximately 169 Priority 1 and 2 patients to UM SMC Dorchester during the same period, with an additional approximately 130 transported patients to UM SMC Dorchester who were Priorities 3 and 4. Caroline County EMS transported only 47 Priority 1 and 2 patients during the CY15-CY17 period, with an additional 72 patients who were Priorities 3 and 4.

(4) The projected number of patients who could require transport to a general acute hospital rather than the proposed freestanding medical facility for appropriate medical care.

After the conversion, all EMS Priority 1 patients and unstable Priority 2 patients will require transport to an acute general hospital, rather than to the Dorchester FMF, unless the patient requires immediate intervention which Dorchester FMF would provide. As noted above, recent historic data indicates that DCEMS transported an average of 1,340 patients per year to UM SMC Dorchester who were Priority 1 and 2; Talbot County transported an average of 56 patients per year to UM SMC Dorchester who were Priority 1 and 2; and Caroline County transported an average of 21 Priority 1 and 2 patients per year. Thus, EMS transport Priority 1 and 2 patients from all three jurisdictions totaled 4,216 for CY15-CY17; data was not available to indicate which of the transferred Priority 2 patients were unstable.

(5) EMS transport times in the jurisdictions affected by the proposed hospital conversion and the potential for extended transport and out-of-service times resulting from the proposed conversion to a freestanding medical facility, relative to the current pattern of transport times.

Based on the average transport times from CY 2015-CY 2017 in the table below, it is not anticipated that the conversion of UM SMC Dorchester to a FMF will significantly extend transport and out of service times for the three jurisdictions affected by the conversion because of the close proximity of the new Dorchester FMF to the existing UM SMC Dorchester.

EMS Average Transport *Times from Caroline, Dorchester, and Talbot			
EMSOPS by Destination Category			
Calendar Years 2015, 2016, and 2017			
Source: eMEDS®			
	CY 2015	CY 2016	CY 2017
Maryland EMSOP			

**Maryland ExpressCare / Best Care Response Times
CY 2016 to Q1 of CY 2018**

	Request Based on Priority 0800-2000 (within 30 minutes)	Emergent 2000-0800 (within 45 minutes)	Non-Urgent 2000-0800 (within 3 hours)
CY 2016	76%	100%	97%
CY 2017	87%	100%	100%
CY 2018 (through Q1)	91%	100%	100%

UM SRH plans to continue to work with Maryland ExpressCare to expand the capacity and review the efficiency of the service for the coordination of transports and response times within the UMMS facilities.

(7) The number of general hospitals likely to be affected by the proposed hospital conversion and the distance to the closest general hospital ED for appropriate patients if the hospital converts to a freestanding medical facility relative to current patterns of hospital use.

The Applicants provided the following list of the hospitals that may be affected by the conversion of UM SMC Dorchester and the distance from UM SMC Dorchester to these hospitals:⁸

- UM SMC Easton-15 miles
- Peninsula Regional Medical Center-31.3 miles
- Atlantic General Hospital-53.8 miles
- Nanticoke Memorial Hospital-27.4 miles

It should be noted, however, that the Centers for Medicare & Medicaid Services require freestanding medical facilities to transfer patients to the “parent hospital” in order to maintain provider based status and receive reimbursement, in this case the UM SMC Easton. As a result, the hospital that will be most affected by the conversion will be UM SMC Easton.

⁸ Response to Regulatory Factors, page 13.

(9) Recent diversion utilization at the converting hospital and other general hospitals likely to be affected by the proposed hospital conversion and the potential impact of the proposed conversion on diversion utilization.

Hospital	CY15	CY16	CY17	2018	CY2015	CY2016	CY2017	2018	CY2015	CY2016	CY2017	2018
	Yellow	Yellow	Yellow	Yellow	Red	Red	Red	Red	ReRoute	ReRoute	ReRoute	ReRoute
Dorchester	32.25	17.67	18.27	8.96	99	11.48	144.74	15.74	0	0	0	10.61
Easton	317.57	156.69	112.55	100.23	77.31	45.45	180.50	46.28	19.44	11.35	5.34	5.11
PRMC	0	0	0	0	0	0	0	0	0	0	0	0
*1/1/18-9/1/18												

Data Source: MIEMSS County Hospital Alert Tracking System (CHATS)

Alert utilization at UM SMC Dorchester and surrounding hospitals is minimal and continues to decline.¹⁰ DCEMS conveyed that UM SMC Dorchester effectively manages patient volumes and EMS offload times.

(10) The size, scope, configuration, services, and staffing of the proposed project

The proposed Dorchester FMF will include the following features:

- (a) A main public entry and reception/check-in area with four public toilets;
- (b) An emergency department with a total of 23 patient care rooms and related staff and support space, including:
 1. One triage area at 610 square feet;
 2. Sixteen private exam rooms at 158 square feet each;
 3. Two private bariatric exam rooms at 212 square feet each;
 4. Resuscitation/Critical Care suite with two treatment bays, each at 243 square feet;
 5. Seven patient toilets and four staff toilets;
 6. A self-contained behavioral health suite with three exams rooms, all negative pressure/all-hazard rooms, at 165 square feet each and one patient toilet, and related staff and support space;

¹⁰ Yellow Alert: The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care. Yellow alert is initiated because the emergency department is experiencing a temporary overwhelming overload such that priority two and three patients may not be managed safely. Prior to diverting pediatric patient transports, medical consultation is advised for pediatric patient transports when emergency departments are on yellow alert. Red Alert: The hospital has no ECG monitored beds available. These ECG monitored beds will include all in-patient critical care areas and telemetry beds. Re-route: An ALS/BLS unit is being held in the emergency department of a hospital due to lack of an available bed.

electronic medical records, technology, and medication administration for the full range of clinical diagnoses.¹¹

Patients who need inpatient behavioral health services will, if appropriate to the patient's needs and consistent with the patient's preferences, be transferred to UM SMC Easton's inpatient behavioral health unit, if inpatient treatment is required. UM SRH expects that this unit should have sufficient capacity to handle appropriate behavioral health patients transferred from the UM SMC Easton, as it is increasing the number of inpatient psychiatric beds by 12 to accommodate additional admissions.

- (11) *Reasonable changes in the EMS system that are planned or can be made to maintain adequate and appropriate delivery of emergency care within the Statewide emergency medical services system if the hospital converts to a freestanding medical facility.*

No changes to the EMS system are planned as a result of the conversion.

Summary and Discussion

The EMS Board is charged with determining whether the proposed conversion will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. This determination is to be made on 11 specified factors. Each factor and MIEMSS findings are briefly summarized below:

- (1) *The EMS resources in the jurisdictions affected by the proposed hospital conversion, including staffing, equipment, and units.*

The primarily affected EMS jurisdiction is Dorchester County. Talbot and Caroline Counties will be minimally impacted. MIEMSS received no information that would indicate the need for additional EMS resources in these jurisdictions (staffing, equipment, and units) because of the proposed conversion, unless the conversion results in an increase of interfacility transfers for DCEMS, as mentioned earlier. The three jurisdictions all participated in three meetings conducted by UM SRH regarding the conversion of UM SMC Dorchester to a freestanding medical facility held on May 14, 15, and 21, 2018.

¹¹ Response to Regulatory Factors pages 16-18

Securing timely transfer of patients from the Dorchester FMF to other facilities is key to ensuring high quality patient care; however, as stated earlier, such transfers must not place a burden on the jurisdictional EMS Operational Programs for such interfacility transfers. The Applicants have stated their commitment to continue with their existing commercial service, Maryland ExpressCare/Best Care, including quality metrics and a process for ongoing review and resolution of any issues. The timeliness of interfacility transports will need to be closely monitored, and the Applicants will have to be prepared to commit additional resources, if needed, to ensure timely transfer of patients.

(7) The number of general hospitals likely to be affected by the proposed hospital conversion and the distance to the closest general hospital ED for appropriate patients if the hospital converts to a freestanding medical facility relative to current patterns of hospital use.

Although there are three hospitals that could be affected by the conversion, because of CMS payment constraints, in reality, the primary hospital to be affected is UM SMC Easton which currently is 15 miles away.

(8) The expected additional ED visit volume and associated increases in admission and observation patient volumes for the general hospitals likely to be affected by the proposed hospital conversion.

Based on information provided by the MHCC, an additional ED volume of patients requiring admission will be approximately 1,900/year.

(9) Recent diversion utilization at the converting hospital and other general hospitals likely to be affected by the proposed hospital conversion and the potential impact of the proposed conversion on diversion utilization.

The ability of receiving hospitals to accept and timely treat transferred patients from Dorchester FMF is critical. UM SMC Easton will receive most of the transferred patients. UM SMC Easton's yellow alert and red alert diversions as well as reroute by EMS are relatively low and should not significantly impact timely transfer of patients.

**Appendix 4: UM SMC-Dorchester ED Comparison to ACEP
Guidelines**

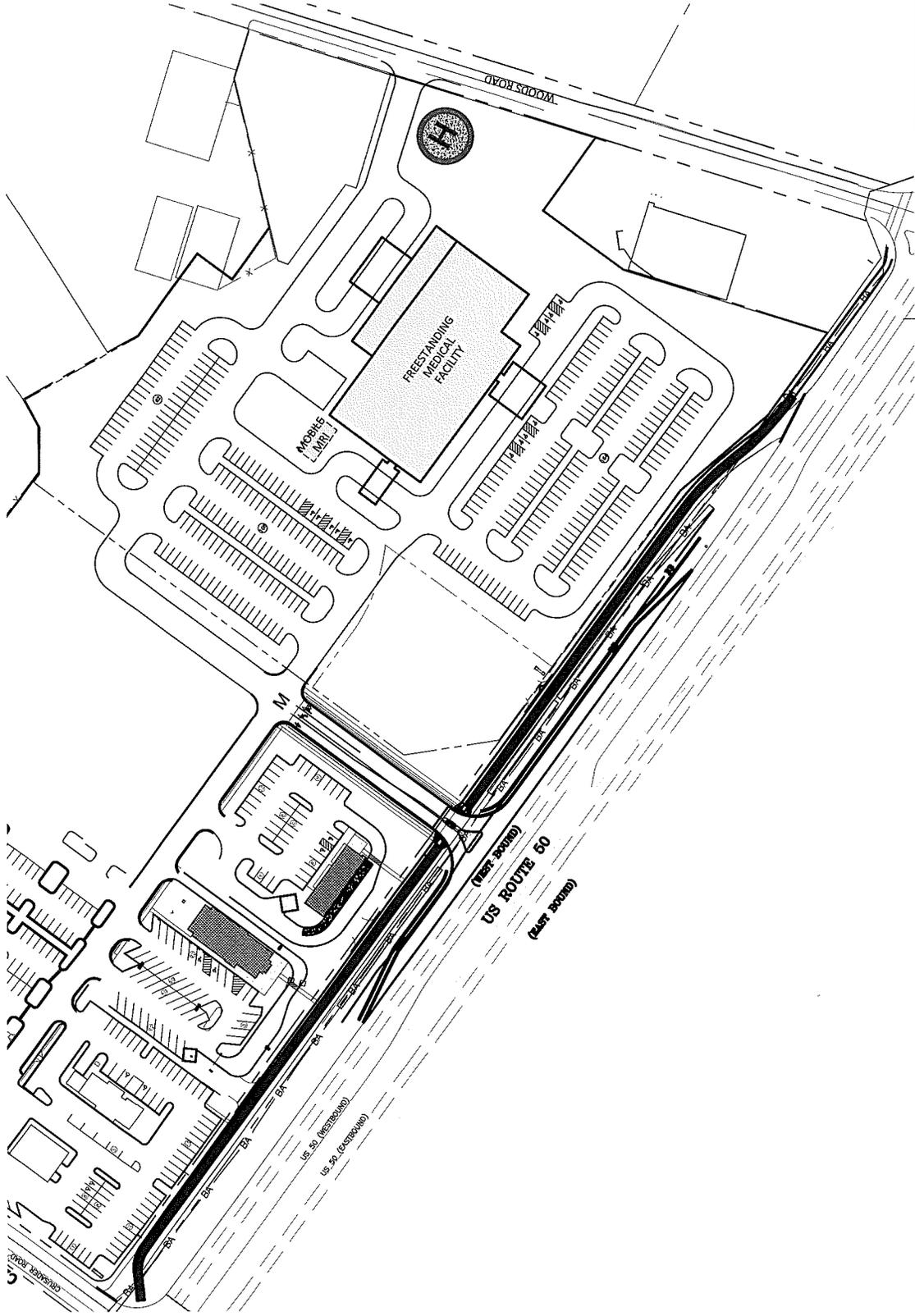
Characteristics of the UM SMC-Dorchester ED, as Rated Against the ACEP Guidelines

Indicators for Adult ED	ACEP Guidance			UM SMC-Dorchester ED	Range Rating for FMF
	Low Range	Mid-Range	High Range		
% Admitted Patients	<8%	12% to 20%	>25%	13.8%	Mid
Average length of stay	<2.25 hours	2.5 to 3.75 hrs	>4 hours	3.01	Mid
Private rooms	Fewer	Majority	All	All	High
Inner waiting & result waiting areas	Available	Limited	Patients stay in bay	Patients stay	High
Location of observation beds	Outside ED	Limited # within	Inside ED	Outside ED	Low
Boarding of admitted patients	Stay < 60 Min.	Stay 90 to 120 Minutes	> 150 Minutes	Stay < 60 min.	Low
Turnaround time Dx tests	<45 Minutes	60 Minutes	>90 minutes	60 min.	Mid
Percentage of behavioral health patients	< 3%	4% to 6%	> 7%	5.3%	Mid
% non-urgent patients	>45%	25% to 45%	<25%	25%	Mid
Age of patients	<10% Age 65+	10 to 20% 65+	>20% Age 65+	17.4%	Mid
Imaging within ED	No	General & CT	Extensive	General and CT	Mid
Family amenities	None	Limited	Multiple	Limited consult	Mid
Specialty components: geriatrics	None	Designated Area	Module with Support	None	Low
Specialty components: pediatrics	None	Designated Area	Module with Support	None	Low
Specialty Components: detention	None	Designated Area	Module with Support	None	Low
Admin or Teaching Space	Minimal	Moderate	Extensive	Moderate	Mid

Source: *Emergency Department Design: A Practical Guide to Planning for the Future* Published by the American College of Emergency Physicians and Applicants Request for Exemption, p.28 (DI#2, p. 30).

Appendix 5: Site and Floor Plans

CONCEPT SITE PLAN

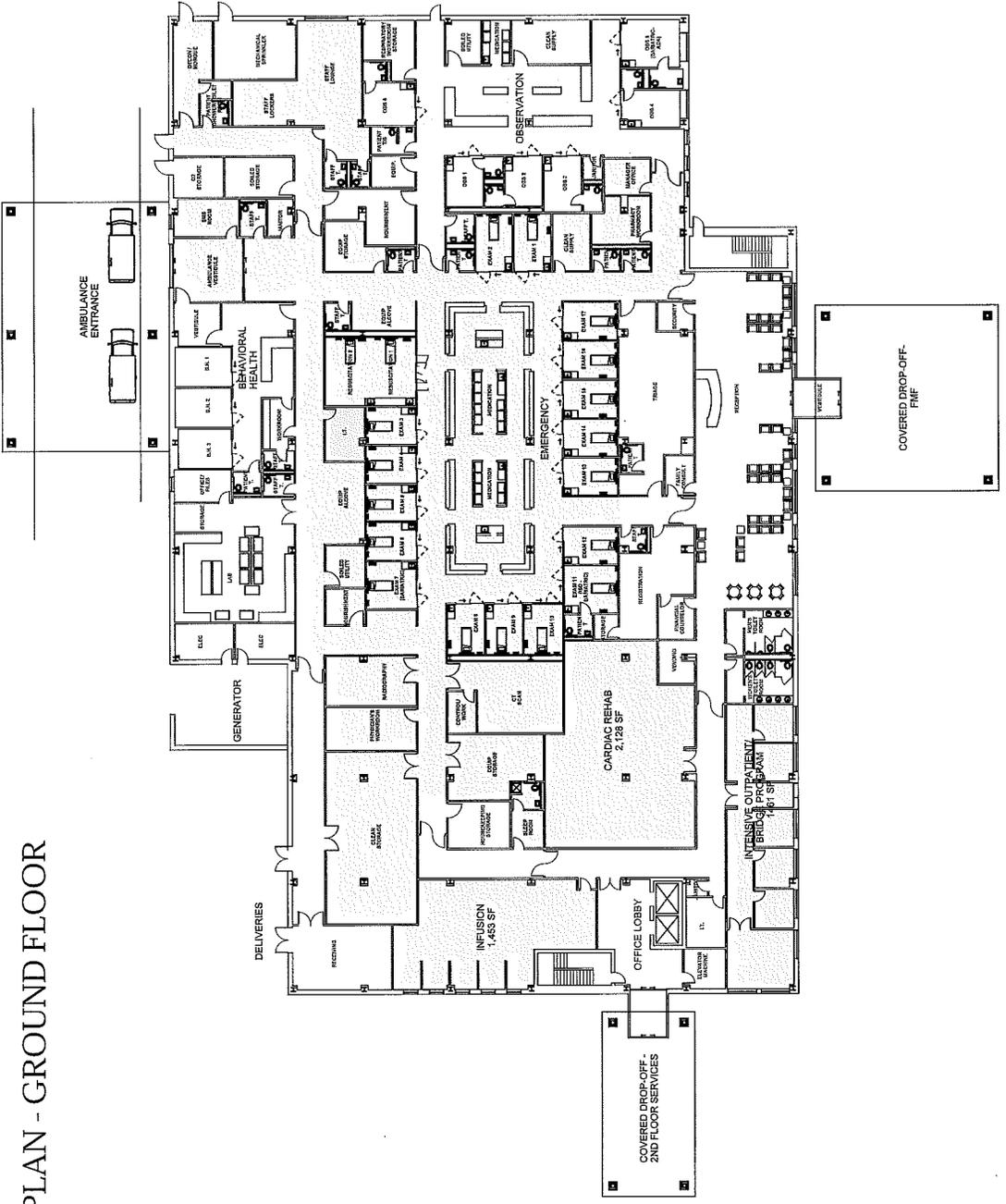


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NOT TO SCALE
JANUARY 17, 2019

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH
CAMBRIDGE, MD

CONCEPT PLAN - GROUND FLOOR



KEY

- EMERGENCY DEPARTMENT
- OBSERVATION
- BEHAVIORAL HEALTH EMERGENCY DEPARTMENT
- LABORATORY
- ENTRY/INTAKE
- OUTPATIENT SERVICES
- BUILDING SUPPORT

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 FEBRUARY 12, 2019

UNIVERSITY OF MARYLAND SHORE REGIONAL HEALTH
 FREESTANDING MEDICAL FACILITY, CAMBRIDGE, MD

**Appendix 6: Evaluating Construction Cost Estimate Using the
Marshall Valuation Service Methodology**

Marshall Valuation Service Review

The Marshall Valuation System – what it is, how it works

In order to compare the cost of a proposed construction project to that of similar projects a benchmark cost is typically developed using the Marshall Valuation Service (“MVS”). 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.

The base cost reported in the MVS guide is 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, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, 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.

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs, the base costs are adjusted for a variety of factors (e.g., an add-on for sprinkler systems, the presence or absence of elevators, number of building stories, the height per story, and the shape of the building. The base cost is also adjusted to the latest month and the locality of the construction project.)

Calculating the Adjusted Project Cost in this Application

Shore states that the proposed FMF will be located on the ground floor of a newly constructed two-story building. The second floor will contain medical office building (“MOB”) space. Only the construction of the 43,794 SF FMF is examined in this MVS review.

Shore and MHCC staff calculated the adjusted project cost per SF based on the actual costs of constructing 43,794 SF for the FMF only. Table A below shows the calculations of the adjusted project cost made by the applicant and by MHCC.

**Table A: Respective Adjusted Project Cost
Developed by SHORE and MHCC Staff**

Cost of New Addition		
New Construction	SHORE	MHCC
Building	\$ 13,780,551	\$ 13,780,551
Fixed Equipment	220,000	220,000
Site and Infrastructure	2,900,000	2,900,000
Architect/Engineering	1,320,000	1,320,000
Financing Fees	0	0
Total Project Costs	\$ 18,690,551	\$ 18,690,551
Cost Adjustments - Off-site and On-site Costs*		
Demolition	368,254	368,254
Storm Drains	230,159	230,159
Rough Grading	184,127	184,127
Paving	276,190	276,190
Signs	46,032	46,032
Landscaping	92,063	92,063
Helipad	460,317	460,317
Covered Walkway	230,159	230,159
Unsuitable Material Allowance	46,032	46,032
Premium for Minority Business Enterprise Requirement	29,460	29,460
LEED Silver Green Building Premium	551,222	551,222
MBE Participation Cost Premium	551,222	551,222
Utility Connection Fees	100,000	100,000
Total Adjustments	\$ 3,165,237	\$ 3,165,237
Net Project Costs	\$ 15,525,314	\$ 15,525,314
Allocated Financing Exp.	2,659,615	2,197,826
Project Costs for MVS Comparison	\$ 18,184,928	\$ 17,723,140
Square Feet of Construction	43,794	43,794
Adjusted Project Cost per SF	\$ 415.24	\$ 404.69
MVS BENCHMARK Cost/SF	\$ 415.90	\$ 439.56
Over(Under)	\$ (0.66)	\$ (34.87)

Source: 2/21/2019 Modification p. 9.

As mentioned in the introduction to this section, the off-site and on-site costs are not included in developing the MVS benchmark for Shore's proposed FMF. In calculating the adjusted project cost per SF, both the applicant and MHCC staff used the same costs reported for Total Project Costs and for cost adjustments, the off-site and on-site costs.

The only difference between Shore and MHCC staff was in the method used to calculate the Allocated Financing Expense, which includes Gross Interest during the construction period and Loan Placement Fees (a total of \$3,920,906). Marshall & Swift includes these two costs in calculating the MVS benchmark value. Shore and MHCC employed different factors in calculating the amount of gross interest and loan placement fees that would be included in the calculations to determine the allowable project costs for MVS comparison. Shore arrived at an allocated financing expense of \$2,659,615 while MHC staff calculated this amount to be \$2,197,826, a difference accounted for by MHCC's decision that a lower percentage of project costs merited inclusion under the MVS instructions. This results in MHCC defining total project cost as \$17,723,140,

compared to Shore's total of \$18,184,928, resulting in Shore calculating a cost per SF of \$415.24, while MHCC staff arrived at a cost of \$404.69 per SF (see Table A above).

Developing an MVS Benchmark for This Project

Shore calculated the MVS benchmark to be \$415.90 SF, whereas MHCC staff's MVS benchmark is \$439.56 SF. These calculations are in Table B below.

The difference between the two MVS benchmark values is \$23.66, or about 5.7%. In both cases, the applicant and MHCC staff used the same values with two exceptions for the construction of a Good Quality, Class A for a general hospital. These values are the following:

1. Both parties used a base cost for a Good Quality, Type A construction for a general hospital as \$374.00 SF. The general hospital base value was used since the Marshall & Swift guide is limited, and does not provide a building category that would be more comparable to a freestanding medical facility than a general hospital.
2. Similarly, both parties used the same values for the Departmental Cost Differential, Perimeter Multiplier, Story Height Multiplier, and for the Sprinkler Add-on Costs.
3. The major cause for the difference in the MVS benchmark values is that SHORE used values for the Current Cost Modifier and Locality Multiplier for the Eastern Shore that were lower than the values used by MHCC staff. These differences are due to staff having access to more current and timely values from Marshall & Swift than the applicant was able to obtain and use. Therefore, Shore used a Current Modifier of 1.03 and Local Multiplier of 0.98, while MHCC used values of 1.08 and 0.99, respectively. Besides small differences due to rounding errors, the difference in the MVS benchmark values is due to the values used for the Current Modifier and the Local Modifier.

Table B: Calculating Marshall Valuation Services Benchmark - Shore and MHCC Staff

	SHORE	MHCC
Class	A	A
Type	Good	Good
Ave. Perimeter (ft.)	950'	950'
Ave. Wall Height (ft.)	14'	14'
Stories	1	1
Average Area Per Floor (sq. ft.)	43,794'	43,794'
	SHORE	MHCC
Net Base Cost	\$ 374.00	\$374.00
Elevator Add-on	0	0
Adjusted Base Cost	\$ 374.00	\$ 374.00
Departmental Cost Differential	1.16	1.16
Gross Base Cost	\$ 432.97	\$ 432.00
Perimeter Multiplier	0.902	0.902
Story Height Multiplier	1.046	1.046
Multi-story Multiplier	1	1
Multipliers	0.943	0.944
Refined Square Foot Cost	\$ 408.55	\$ 407.64
Sprinkler Add-on (wet)	3.48	3.48
Adjusted Refined Square Foot Cost	\$ 412.03	\$ 411.11
Current Cost Modifier	1.03	1.08
Local Multiplier – Eastern Shore	0.98	0.99
CC & Local Multipliers	1.009	1.069
MVS Building Cost Per Square Foot	\$ 415.90	\$ 439.56

Source: 2/21/2019 Modification, Table I, pp. 5-6.

Comparing Estimated Project to the MVS Benchmark

MHCC staff's analysis yielded a difference of \$34.87 per sq. ft. /SF between the adjusted project cost and the benchmark cost (about 7.9%), while Shore calculated the differential to be \$0.66/SF (about 0.2%) below the MVS benchmark. Therefore, the cost of establishing Shore's FMF complies with this standard.

Table C: Comparison of Adjusted Project Cost as Calculated with the MVS Benchmark

	FMF Calculation	MHCC Staff Calculation
Calculated Project Cost	\$18,184,928	\$17,723,140
Adjusted Project Cost per SF	\$415.24	\$ 404.69
SHORE and MHCC calculated MVS Benchmark Cost per SF	\$ 415.90	\$ 439.56
Total Over (Under) MVS Benchmark	(\$0.66)	(\$34.87)
Over(Under) %	-0.2%	-7.9%

Source: 02/21/2019 Modification and MHCC Staff calculations.