Andrew N. Pollak, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

March 22, 2019

VIA E-MAIL AND REGULAR MAIL

James C. Buck, Esquire
Gallagher, Evelius & Jones, L.L.P.
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: Modified Request for Exemption from Certificate of Need Review Conversion of University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility

Dear Mr. Buck:

Maryland Health Care Commission staff has reviewed your modified request of University of Maryland Upper Chesapeake Medical Center ("UCMC") and University of Maryland Harford Memorial Hospital ("HMH") for an exemption from Certificate of Need ("CON") request for the proposed conversion of HMH, a general hospital, to a freestanding medical facility ("FMF"). Based on its review of the information contained in this request, staff has the following questions and requests for additional information or clarification.

Project Description

1. In your project description (p. 12) you refer to the project schedule being incorporated by reference. Please provide the information that you intended to incorporate by reference. Such information should be included in the body of the application documents so that reviewers don't have to spend time cross-referencing other documents, and instead have the necessary information readily available.

State Health Plan Standards

COMAR 10.24.19.04.A

2. We note that we have already informed you that your submission did not provide responses for standards C. (1) through C. (3), and that you have since provided that.

Charity Care Policy

3. Based on the information submitted, it is not possible to determine whether your charity care policy is in compliance with the "Determination of Probable Eligibility" subpart of this standard (COMAR 10.24.19.04(C)(5)(a)(i)). Describe how this determination is made, and what information is required in order to convey probable eligibility (as contrasted with what is required to make final determination.[1]

   If your review of your process and application forms do not comply with this standard, please revise it to do so.

4. You did not address the distribution of your charity care public notice (COMAR 10.24.19.04(C)(5)(a)(ii)). Please provide a copy of this public notice and describe how you will disseminate it to your service area population on an annual basis.

Number of Emergency Treatment Spaces

5. The chart below reflects:
   - Rows 1 and 2: ACEP's prescribed number of "Total Main ED"[2] treatment spaces (ACEP, page 116-117) at both low and high range estimates at both the 25,000 and 30,000 visit level;
   - Row 3: the number of rooms ACEP would recommend at your projected level of 27,000 visits in 2022;
   - Row 4: the number of rooms proposed for the FMF;
   - Row 5: the excess number of ED treatment spaces; a scaled number of "Total Main ED" treatment spaces; and
   - Row 6: staff also calculated, for illustration, the number of visits that would be needed to justify the number of treatment spaces proposed.

[1] Note that the standard requires a two-day turnaround for a determination of probable eligibility, which allows a patient to know their likely eligibility for charity care without having to retrieve documentation that might not be readily available. As long as there is a simple procedure to assess probable eligibility, it is acceptable for the facility to require documentation prior to granting a final determination of eligibility.

[2] You base your number of requested ED treatment spaces on ACEP's "Total Spaces", which includes "Extended Stay" treatment spaces. There's no need for "Extended Stay" treatment spaces to be included in your total requested ED treatment spaces because you are also requesting to have a dedicated observation unit adjacent to your ED. As a result, ACEP "Total Main ED" low and high range estimates should dictate how many ED spaces are requested (ACEP, p. 116 and 117).

		Low Range Estimate	High Range Estimate
		Total Main ED	Total Main ED
1	25,000 ED Visits	15 Spaces	15 Spaces
2	30,000 ED Visits	17 Spaces	19 Spaces
3	Projected 27,000 ED Visits for FMF	16 Spaces	17 Spaces
4	Proposed # of Total ED Spaces	25 Spaces	25
5	Excess ED Treatment Spaces	9	8
6	ED Visits Required to Justify 25 Total ED Spaces[3]	50,000 ED Visits	40,000 ED Visits

This standard – COMAR 10.24.19.(8)(d) -- requires an applicant to "...Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance [included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future*], unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces."

Staff suggests that you reduce the number of rooms proposed, or make a compelling case for why "the particular characteristics of the population to be served...demonstrates the need for a greater number of treatment spaces." In doing so, note that the planning guidelines embodied in the ACEP publication treatment spaces intended for behavioral health use as a general treatment space, not extra rooms to be "carved out" separately; i.e., behavioral health treatment spaces should be included in your proposed total ED spaces, not "add-on" spaces.

6. Your proposed number of behavioral health treatment spaces is based on visit data from one peak hour (5:00 pm) and extrapolates that for 20 hours (p. 36 and 37). Similarly, the methodology uses the average length of stay (LOS) for this cohort and assumes that LOS for all behavioral health patients. This methodology obviously inflates the number of psychiatric/behavioral health visits that the FMF will need to accommodate. The justification and rationale for this assumption is not clear to staff reviewers.

    a) Please explain and justify this approach.
    b) Please provide the actual number and average length of stay (LOS) of emergency psychiatric visits at HMH for the last three fiscal years (FYs 2016-2018).
    c) Recalculate the needed number of behavioral health treatment spaces based on the data provided by this broader sampling of behavioral health ED visits.

[3] ACEP designates behavioral health treatment spaces as general treatment spaces (ACEP, p. 114). As a result, a carve-out for behavioral health treatment spaces is not necessary. Behavioral health treatment spaces should be included in your requested total ED spaces

Projected Percentage of Admitted Patients at UC FMF

7. Your exemption request states that "UC FMF projects to be in the mid-range of the ACEP guide based on historic emergency department visits at HMH and projected visits to UC FMF" (p. 39 and 40) and on Table F you project that UC FMF will have approximately the same number of ED visits in its first year (FY 2022) of operation as HMH had in the last year of its operation (FY 2021). When calculating your projections, did you consider the possibility that ED volume at an FMF, which replaces an acute care hospital, might experience a decline in ED visits because both consumers and EMS personnel – expecting that a certain level of acuity would likely require admission to a hospital – might bypass an FMF and go straight to an acute care hospital?

Number of Observation Treatment Spaces Consistent with the Needs of the Population

8. How did you arrive at your "peak utilization" levels for observation (p. 60)? What hours of the day were used? What period of time or months were used? Please provide a full explanation of your calculation of "peak utilization" and explain how it was utilized to make other projections and calculations within your request.

9. The length of the observation stays projected in this proposal seems excessive. Please justify and put into context.

10. On Table F you project an almost 25% increase in observation discharges and an almost 45% increase in observation patient days from the last year of HMH's operation (FY 2021) to the first year (FY 2022) of UC FMF's operation.

    Please provide an explanation for these abrupt increases, which deviate from both the relatively modest increases in observation discharges and patient days HMH historically experienced and the minimal increases projected at HMH in the years prior to the FMF opening. It is also unusual that after that initial "bump" occurs, there are no projected increases. Please explain.

11. The proposed number of 24 observation beds at this new FMF seems excessive considering that: a) the hospital it is replacing functions with 17 observation beds; b) the increases that you project for your observation discharges and patient days appear to be excessive; and c) your companion proposal would add a large number of observation beds at UCMC. Justify this number and discuss it in context with the UCMC project proposed in its exemption request.

Size of Observation Treatment Spaces Consistent with Licensing Standards

12. ACEP Guidelines state that [observation] rooms, furnished with standard inpatient hospital beds as you propose, will need to be larger-- 150-160 square feet (ACEP, p. 271). However, your plan would build these rooms to be between 188 and 265 square feet – 25% to 76% larger than the ACEP Guidelines specify. Please explain why.

Utilization, Revenue, and Expense Projections

13. Table I (p. 65) appears to include utilization projections for UC FMF only, contrary to your statement that: "Table I includes utilization projections that reflect both the inpatient and outpatient utilization of UCMC and outpatient emergency department visits, observation cases, and related outpatient ancillary services at UC FMF." Please provide a revised Table I that reflects the information described in your request.

14. Similarly, Table L (p. 35) appears to just include UC FMF workforce figures for FY 2024 and does not appear to include workforce figures from HMH's emergency department in FY 2017, contrary to your statement that Table L "incorporates the workforce for HMH's emergency department in fiscal year 2017 and UC FMF in fiscal year 2024." Please provide a revised Table L that reflects the information described in your request.

15. Please demonstrate that your utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area.

16. Please demonstrate that your utilization projections for rate-regulated outpatient services are consistent with observed historic trends use by the population in the FMF's projected service area.

17. Please demonstrate that the revenue estimates for emergency services and other outpatient services are consistent with utilization projections and the most recent HSCRC payment policies for FMFs. Are your revenue estimates consistent with the trends observed by other FMFs statewide and providers of emergency services and outpatient services (hospitals) in your service area? If not, explain why your projections are different and provide justification.

18. Please describe where UM UCH is in the process of negotiations with HSCRC regarding its GBR proposal.

Delivery of More Efficient and Effective Health Care Services

19. In your request (p. 74) you say, "As an initial matter, in addressing the efficiency and cost effectiveness of health care service delivery, the applicants incorporate by reference UM UCH's response to COMAR 10.24.01.08G(3)(c)…". Please provide the information that you intended to incorporate by reference. Such information should be included in the body of the application documents so that reviewers don't have to spend time cross-referencing other documents, and instead have the necessary information readily available.

Exhibits and Tables

20. On Table F you do not project an increase in "Same-Day Surgery Cases" at UCMC after the merger with HMH. Is that an oversight or do you expect that overall same day surgery across the merged facilities will decline?

21. On Table B "Departmental Gross Square Feet Affected by Proposed Project" you list and total all of the square footage for ED, Observation, and Imaging units together. So that the space allocation of each of these departments can be assessed individually and footages more closely, please provide a separate Table B for each of:
    - the ED section of the FMF (including all supporting services and spaces);
    - the Observation unit (including all supporting services and spaces);
    - the Imaging unit (including all supporting services and spaces); and
    - the shared spaces that support all of these units.

Please submit four copies of the responses to above questions and requests for additional information within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov) and Laura Hare (laura.hare1@maryland.gov). If additional time is needed to prepare a response, please let me know at your earliest convenience.

As with the request itself, all information supplementing the request must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, please contact me at (410) 764-5596.

Sincerely,

Laura H. Hare, Program Manager
Health Care Facilities Planning & Development

cc: Lyle E. Sheldon, President and CEO, UM Upper Chesapeake Health System
Kevin McDonald
Russell Moy, M.D., Acting Health Officer, Harford County