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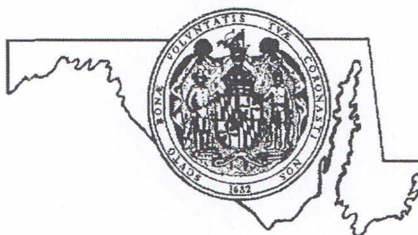


MARYLAND HEALTH CARE COMMISSION

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

November 16, 2012

VIA Email & U.S. MAIL

Michael Silgen, Vice President
Memorial Hospital at Easton
219 South Washington St.
Easton, Maryland 21601

Re: Memorial Hospital at Easton
Hospital Replacement and Relocation
Matter No. 12-20-2339

Dear Mr. Silgen:

Thank you for your October 24, 2012 response to MHCC's request for completeness information on the above-referenced application. The Maryland Health Care Commission staff has reviewed the information you provided and find that the following responses are incomplete. If responses to these questions are received by December 3, 2012, the Application will be docketed for review by December 28, 2012.

Acute Care Hospital Services State Health Plan Chapter Standards

1. As you will note, Question 1b requested that Memorial Hospital of Easton ("MHE") complete a spreadsheet detailing the actual physical bed capacity before and after project completion. The October 24, 2012 response does not appear to include this spreadsheet. The spreadsheet details the existing and proposed private and semi-private rooms and bed capacity by location and service. Please complete the spreadsheet, which is attached to this letter.

2. The response to Question 2f provided the departmental square footage for each clinical service in the existing building and in the proposed facility in Exhibit 24. Thank you for providing this information that should prove helpful. Please provide the following clarifications:

a. Question 2f asked for the total square footage of the existing physical plant comparable to the total square footage of the new facility as reported on Chart 1 (300,678 sq. ft. for Tower 1 and 58,250 for Tower 2). Please try to provide total square footage information for the existing facility(s) that is comparable to these numbers or the sum of these numbers.
b. In addition, in Exhibit 24, three departments are followed by "footnote" like numbers that are not explained. Please explain these numbers.
c. For a number of departments the area square footage is reported with a dash line in the existing column or the proposed column. Please explain what these dashes mean and in the case of the proposed facility, if they mean that such spaces (clinics) will not exist, explain what will happen to the services currently provided in these areas.

3. The response to Question 5 states that "interest income was inadvertently excluded as a source of funds in the Application and is now included in a revised project budget". The response also explains that interest income is calculated assuming a 1.0% interest earned on the investment of funds from the sale of bonds during construction over an 18-month draw, the majority of which will occur within 12 months. Please explain how these assumptions were applied to arrive at the estimated interest income of $1.4 million. Submit all calculations.

4. Regarding the response to Question 8, the policy on the Information Regarding Charges (Exhibit 26) still does not make it clear that the charge information will be updated at least quarterly as required by part (b) of the definition. The policy states that the charges will be updated on a regular basis. Please revise the policy accordingly.

5. Regarding the response to Question 10a (table on page 15), reconcile the total square footage reported for the existing site (300,390) and the proposed site (321,990) with the total existing DGSF (276,701) and proposed DGSF (280,935) reported in Exhibit 24, provided in response to completeness question 2f. For the proposed total square footage, also reconcile it with Application Chart 1 total of 352,928 square feet (300,678 for Tower 1 and 58,250 for Tower 2).

6. In responding to Question 10c, MHE states that there is currently nowhere in the existing facility to clean and store large pieces of equipment, to store beds, and to store vendor deliveries and that such space would typically be co-located with Materials Management or Environmental Services. However, Exhibit 24 does not report Environmental Services space and indicates that Materials Management space will decrease from 6,530 to 5,606 DGSF. Please explain this apparent inconsistency.

7. The response to Question 10d indicates that the on-site alternative cost estimate was generated in 2005 while the costs of the proposed project and the other relocation

alternative were estimated in 2007. The response also indicates that the estimated cost of the on-site alternative does not include the cost of renovating Dorchester General Hospital ("DGH"), implying that the cost estimates of the two relocation alternatives (i.e., the proposed project and the Northern Talbot County site) do include such renovation costs. Please update the cost of the on-site alternative and the relocation alternative to be comparable to the project cost estimate included in the Application, specifying the inflation assumptions and the reasons for making such assumptions. In other words, if the cost estimates for the proposed project and the Northern Talbot County site alternative include renovation costs for DGH, please exclude such costs from the updated cost estimates. Also include separate cost estimates for the development of the desired off-campus ambulatory care facilities under the proposed project and each alternative. If MHE considers the desirability of each off-campus ambulatory care facilities to differ for each alternative, please explain the reasons.

8. Regarding the response to Question 10f, please provide a copy of the questions asked of the physicians and a summary of the responses to each question. In addition, specify the number of physicians interviewed and the number of physicians that care for patients at the hospital.

Obstetric ("OB") Services State Health Plan Chapter Standards

9. With respect to the responses to Standard (2), Demonstration of Compliance with all Essential Requirements of the Maryland Perinatal System Standard, please provide the following additional information and clarifications with respect to the Hospital's self assessment of MHE's Level I perinatal service, performed in October 2011:
   a. Regarding standard 1.1 the assessment indicates no Board of Directors resolution but full Board support. Please explain how the Board of Directors expresses its full support and submit available documentary evidence of such support.
   b. The Hospital's response indicated that the service did not meet three of the essential standards for a Level 1 program at the time of the self assessment. The response also identified the corrective actions taken. While the corrective actions taken with regard to standards 6.8 and 6.13 appear to establish compliance, it is not clear how the corrective action described with respect to standard 4.4 satisfies the standard. Standard 4.4 requires a hospital without a physician board-certified in maternal-fetal medicine on the medical staff to have a written agreement with a consultant who is board certified or an active candidate for board-certification to be available 24 hours a day. Your response clearly states that there is no formal written contract, but that SHS is a member of UMMS, which now provides consultation. Please explain how this arrangement satisfies the requirement that such a physician is available 24 hours a day and submit documentation of any agreement covering the provision of such services.

c. Note that the Commission's OB plan standard refers to the most current version of the Maryland Perinatal System Standard, which was revised in July 2012. This revision has one essential standard for Level 1 programs not included in the Hospital's self assessment. Standard 13.7 has been added. Standard 13.7 states that "the hospital shall have a policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. The hospital shall have a systematic internal review process to evaluate any occurrences and a plan for corrective action." Does MHE have such a policy and review process?

10. The response to Obstetric Plan chapter Standard (6), Physical Plant Design and New Technology, refers to the response to Standard (12) of the Acute Care Hospital Services chapter, Patient Safety, included in the original application. Please specify what portions of the response to the Patient Safety standard of the Acute Care Hospital Services chapter also apply to the proposed relocated OB service and identify any unique aspects of the physical plant design and technology of the OB service not addressed in response to the Patient Safety standard.

Other Review Criteria

11. Regarding the response to Question 21g, explain the difference in the projected gross patient services revenues between the original Table 3 and Exhibit 32 for years 2014 ($188,470,949 vs. $187,024,249) and 2015 ($190,748,565 vs. $187,831,440).

In addition to the completeness questions above, MHCC staff requests the following clarifications and additional information:

1. The Cost Effectiveness standard requires applicants to identify the primary objectives of the proposed project and to consider at least two alternatives for achieving the objectives. The application identified four primary objectives (pages 57 to 58) and the proposed project and two alternatives for achieving these objectives, one involving changes on the existing site and one involving an alternative site for relocation. The application reported how each alternative was ranked against each objective. While this analysis indicates that all three alternatives received a top ranking in terms of meeting the primary objectives of the space needs of a growing population and of the space needs of senior citizens, the response to completeness Question 10, especially parts (c) and (d), indicates that many of the existing physical plant deficiencies would not be corrected by the on-site alternative. Commission staff is uncertain if an on-site alternative could be described that maximizes the correction of these deficiencies, especially the lack of adequate private rooms. If so, that is the alternative that should be analyzed in responding to this Standard. Commission staff suggests that such an alternative could include construction of parking garage space and significant new hospital space either on top of an existing building, if possible, or in place of existing surface parking. The new hospital space

should be able to accommodate significant portions of the patient care space, especially inpatient bed space. If MHE has concluded that such an alternative is not physically possible or approvable by local government, supporting facts and documentation must be provided. (Please review Additional Completeness Question 7 above, which asks for an updated cost estimate of the on-site alternative that is more comparable to the proposed project budget estimate in the Application. This Additional Information question asks MHE to reconsider the scope of the on-site alternative to assure that that best alternative can be considered in this review. If, in responding to this question, the scope of the on-site alternative is expanded, please provide a cost estimate for this expanded on-site alternative as well.)

2. Clearly identify any differences in the expected time for project construction of the proposed project and the two alternative projects, including phasing of the current campus alternative requested in #1 above and the time required to obtain local approvals such as land use and site plan approval and account for the impact of such time frame differences on project cost.

3. Prepare revised revenue and expense projections for each alternative (update Application Tables 10, 12, and 14 and add projected revenues and expenses). Clearly specify all assumptions, especially differences in revenue assumptions and fixed/variable expense assumptions. Patient volume assumptions including changes in market share that support the expense assumptions and revenue assumptions, if appropriate, must be clearly identified and explained.

4. Prepare a ranking of the alternatives that more completely accounts for desired project objectives such as percentage of private rooms, improvements in location, layout, and adequacy of departmental space, etc. Consider including cost and financial feasibility in such rankings.

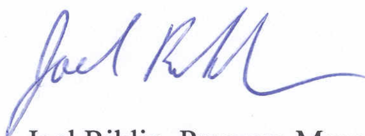
5. The Financial Feasibility standard of the Acute Care Hospital Services chapter of the SHP states that "a hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital." It requires, among other things, that revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital. It also requires that "staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital …" It finally requires that "the hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations …" Your response to this standard in the application pointed to Table 3 and the projected excess of revenues and expenses in both the first year (2016) and 2017 (first full year after

initiating operations). While this would appear to demonstrate consistency with the standard, the revenue projections included both a rate adjustment for capital yet to be approved by HSCRC and an estimate for the population adjustment to be given to MHE as a TPR hospital in lieu of increases for volume and inflation. Since these revenue projections are not based on current charge levels, Commission staff requested that you submit an alternative Table 3 with no revenue increase associated with the proposed project (completeness Question 21g), which you did as Exhibit 32 of the responses to the completeness questions. However, this forecast, which continues to include the population adjustment but not the rate adjustment for capital, did not show that the Hospital will generate excess revenues over expenses for the years included in the forecast. Therefore, please expand the projections to as much as five years after the project is scheduled to be completed to determine if the standard could be met under such revenue assumptions and submit the projections along with assumptions. In addition, explain why you think the original Table 3 was the appropriate test of financial feasibility with respect to this standard given that the standard specifies that revenues and expenses be based on current levels experienced by the hospital.

Please submit ten copies of the responses to completeness questions in this letter within ten working days of receipt and submit response to the requests for additional information at your earliest convenience. All information supplementing the application 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 call me at (410) 764-5596.

Sincerely,



Joel Riklin, Program Manager
Certificate of Need

Attachment

cc: Jack C. Tranter, Esq.
Thomas C. Dame, Esq.
Andrew L. Solberg
Kathleen H. Foster, R.N., Talbot County Health Department
(internal distribution)

ATTACHMENT 1: Actual Physical Bed Capacity Before And After The Project

Hospital: ______________________ Date:

Location (Floor/Wing)	Before the Project						After Project Completion				
			Room Count			Bed Count		Room Count			Bed Count
	Hospital Service	Licensed July 1, 2012	Total Rooms	Semi-Private	Private	Physical Capacity	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity
			0			0		0			0
			0			0		0			0
			0					0			0
			0			0		0			0
			0			0		0			0
SUBTOTAL	Gen. MSGA		0	0	0	0	Gen. MSGA	0	0	0	0
	ICU/CCU		0			0	ICU/CCU	0			0
TOTAL	MSGA	0	0	0	0	0	MSGA	0	0	0	0
	Obstetrics		0			0	Obstetrics	0			0
	Pediatrics		0			0	Pediatrics	0			0
	Psychiatric		0			0	Psychiatric	0			0
ACUTE TOTAL	Acute Care	0	0	0	0	0	Total Acute	0	0	0	0
Non-Acute Beds											
	Rehabilitation										
Hospital Total											

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough, from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall, but are used to accommodate more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms is semi-private, and the bed capacity is as applicable.

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