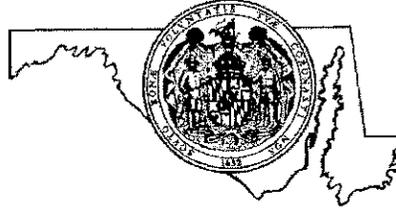


STATE OF MARYLAND

Craig P. Tanio, M.D.  
CHAIR



Ben Steffen  
EXECUTIVE DIRECTOR

**MARYLAND HEALTH CARE COMMISSION**

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

October 21, 2013

John A. O'Brien, Chief Operating Officer  
Dimensions Healthcare System  
Prince George's Hospital Center  
3001 Hospital Drive  
Cheverly, Maryland 20785

Mary Miller  
Chief Financial Officer and Vice President of Finance and Business Development  
Mount Washington Pediatric Hospital  
1708 West Rogers Avenue  
Baltimore, Maryland

Re: Dimensions Health Corporation d/b/a  
Prince George's Hospital Center  
Mount Washington Pediatric Hospital, Inc.  
Relocation of a General Acute Care Hospital  
and a Special Hospital-Pediatric  
Matter No. 13-16-2351

**VIA E-MAIL AND REGULAR MAIL**

Dear Ms. Miller and Mr. O'Brien

Staff of the Maryland Health Care Commission ("MHCC") has reviewed the Certificate of Need application filed on October 4, 2013. We have the following questions and requests for additional information concerning this application. Please respond to this request, following the rules at COMAR 10.24.01.07. The application will be docketed if the response is complete.

**PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION**

1. In June of this year, Prince George's Hospital Center ("PGHC") reported to MHCC that it had physical capacity for 367 acute care beds. Why is it now reported that the hospital only has physical capacity for 311 beds (page 3)?

2. Provide a brief description of the outcome of the first four site zoning and approval process steps listed on page 4. Also report on any other progress or problems arising to date in the required sector plan and zoning map amendment, or the drafting of legislation making the hospital a permitted use at the site.
3. The site plan (third page of Exhibit 2) refers to 261 beds (Hospital and Behavioral Health) and "future patient units" with 136 beds. Please clarify and reconcile with the table on page 3.
4. Is there any below-grade space planned for this project?
5. What is the time frame for a decision by Prince George's County to build and operate a parking garage on the proposed hospital campus? Is the project feasible without this garage? If not, what assurances can be provided that a plan for funding and development of this resource will be implemented?
6. Please provide a table that compares the room and equipment capacity of the current PGHC and the proposed Prince George's Regional Medical Center ("PGRMC"), for the following departments/service lines:
  - A. Cancer Treatment (both medical and radiation oncology)
  - B. Diagnostic Imaging
  - C. Cardiac Catheterization and other Angiography
  - D. Dialysis (acute and chronic)
  - E. Neonatal Intensive Care
  - F. Endoscopy
7. Provide a brief description of the program and patient population served by the PGHC "Transcare" unit and the "Short Stay Center." Are this programs/units being replicated in the proposed PGMC
8. Provide a brief description of the program and patient population to be served by the PGRMC "Cardio/Neuro Diagnostics" department on the Concourse Floor.
9. Provide a brief description of how the "Pediatric ED area" will function as both an inpatient unit and an observation unit. How many patients can be accommodated in this proposed unit at any given time? How will it be staffed?
10. Provide a brief description of the service programs and patient population to be served by the PGRMC "outpatient clinics" in the Ambulatory Care Center.

## **PART II – PROJECT BUDGET**

11. Will any equipment or furnishings be salvaged from the existing PGHC for installation and use at the proposed PGRMC? If so, how is this accounted for in the budget estimate?

12. What is the market value of the PGHC campus?
13. Please provide documentation of the Prince George's County and Maryland commitments to contribute \$416 million for this proposed project.
14. Please provide documentation of the ability to obtain the anticipated debt financing.
15. What are the expected covenants on the long term bond financing and the other financing?
16. Please provide a brief description of the assumptions used in estimating the inflation allowance.
17. Please provide a brief description of the assumptions used in calculating the amount of capitalized construction interest and interest income.
18. Is the purchase of land for the project by Prince George's County included in the \$208 million commitment of the County to the project?
19. Please explain how the contingency estimate was calculated and explain why it is reasonable for a project of this size and scope.

### **PART III - CONSISTENCY WITH REVIEW CRITERIA**

20. Please provide a more legible visual of the hospital's notice of charity care, attached as Exhibit 8.
21. Is PGHC's relatively poor recent performance on the core quality measures (pages 72-76) related to the inadequacy of its physical facilities? If so, please elaborate on this connection. If not, why should MHCC have confidence that performance will improve in a new hospital?
22. Outline the specific steps PGHC took to improve its performance for Pneumococcal Immunization (PPV23) that could help to explain the improvement in performance from 83% in CY 2012 to 91.6% in the first quarter of CY 2013?
23. The Department of Health and Mental Hygiene's "Maryland's All Payer Model," submitted to the Centers for Medicare and Medicaid Innovation on October 11, 2013, anticipates that, "The CON program would support the success of the Maryland All-Payer Model by considering the goals and objectives of the model in its decisions to approve or deny health care facility projects by requiring health care facilities to demonstrate that their projects are viable without reliance on continually growing service volume." Given this expectation:

- A. Can the applicants demonstrate that the proposed project is viable without reliance on continually growing service volume? Page 91 of the application indicates that the project has used an assumption that medical/surgical/gynecological/addictions use rates of the service area population will "stabilize," i.e., remain at 2015 levels, between 2016 and 2021, which, given adult population growth, will result in growing demand for MSGA beds during this period. The pediatric population is also projected to grow with no change in use rates, leading to growing demand for this service. The same is true for adult acute psychiatric services. How can this analysis be squared with Maryland's All Payer Model?
  - B. Can the applicants demonstrate that the proposed project's utilization forecasts are consistent with a future in which demand for hospital admissions by the hospital's service area population (i.e., the acute hospital use rate of the service area population) is trending down, consistent with the Model's expectations?
24. While the applicants state that Standard .04B(3) is not applicable on the basis that the project does not involve development of a new pediatric service, the proposed one bed pediatric unit is clearly inconsistent with the intent of this standard. Why is it necessary for the proposed PGRMC to have any pediatric beds? Why shouldn't pediatric patients be handled, as necessary, in the emergency department, observed if necessary, and, if found to need admission to a hospital, transferred to a hospital with an organized inpatient unit, given the very small number of patients involved?
25. How is the request for a rate increase (page 99) consistent with the Maryland All-Payer model?
26. How will higher rates for the proposed PGRMC affect the competitiveness of this new hospital in the market, given the relatively high rates already authorized for PGHC?
27. With respect to the analysis of hospital construction cost:
- A. Explain the need for the deep foundation, pilings and hillside foundation and how each adjustment was calculated;
  - B. Report the total cost estimate for bringing utilities to the building, broken down by the cost estimate for bringing the utilities from the property line to the building and the cost estimate for bringing the utilities to the property line. Do not include jurisdictional hook-up fees; and
  - C. Explain how the adjustment for the concrete frame construction was calculated.
28. Explain why each of the objectives ranked in the scoring matrix on page 137 appears to have the same value in this decision-making process. Are the objectives essentially given

the same weight or were some objectives more important than others? If the latter, how does this analysis incorporate those different levels of importance for each objective?

29. Please discuss Laurel Regional Hospital in the context of the costs and effectiveness of alternatives. Was consolidation of the two Dimensions' hospitals in Prince George's County considered as an option when replacing and relocating PGHC? If so, why was this option rejected, given the declining demand for inpatient service at LRH in recent years (an average daily census of less than 60 total acute care patients in FYE March 31, 2013)? If not, why not?
30. Please discuss cardiac surgery and PCI in the context of the cost and effectiveness of alternatives. Was elimination of the moribund cardiac surgery program at PGHC considered as an option when replacing and relocating this hospital? If so, why was this option rejected, given the declining demand for this service in recent years and its collapse as a viable service at PGHC? If not, why not?
31. Regarding COMAR 10.24.10.04B(11), Efficiency, as it relates to Policy 3.2 listed in COMAR 10.24.10.03, please address how this project considers smart and sustainable growth policies and green design principles.
32. Regarding COMAR 10.24.12.04(6), Physical Plant Design and New Technology, please provide additional analysis of patient safety features for the proposed obstetric unit, especially to the degree that these features are improvements over the existing obstetric facilities.
33. Regarding COMAR 10.24.07 AP 6, please provide documentation of the hospital's separate written quality assurance programs, program evaluations, and treatment protocols for patients with secondary diagnosis of substance abuse and for geriatric patients.
34. Regarding COMAR 10.24.11.05B(6), please provide additional analysis of patient safety features of the proposed surgical facilities that enhance and improve patient safety, especially to the degree that these features are improvements over the existing surgical facilities.
35. Please provide alternative projections of revenues and expenses for the proposed project that are consistent with a variable cost factor that provides the hospital with 50 percent of revenue for incremental increases in volume above the budgeted amount in the hospital's base for the year, consistent with the Maryland All-Payer Model proposal. Provide this alternative projection in both current year dollars and with inflation assumptions for both revenue and expenses.
36. Provide a service area population-based analysis of the need for surgical capacity at the proposed PGRMC.
37. Please explain the bed occupancy rate projections included in Table 1 that exceed 100%.

38. Do the assumptions at Exhibit 22 cover both the PGRMC and MWPH pro forma schedules of revenues and expenses or just PGRMC? If the latter, please provide a comprehensive set of assumptions for MWPH.
39. Please clarify the revenue deduction assumptions listed in Exhibit 22. What do the declines for contractual allowances, charity care, allowance for bad debt, and UCC pool payment correspond to in Table 3?
40. Supplement the assumptions at Exhibit 22 with a detailed discussion of how the changes likely to occur through implementation of the Affordable Care Act (i.e., more persons eligible for Medicaid and more persons with private insurance) influenced the payor mix projections in Table 3 for PGRMC and in Table 3 for MWPH at PGRMC.
41. What is included and will be included in other operating revenues (line 1h) and why is it projected to remain at the same level for years FY 2015 to 2021?
42. What is included and will be included in other expenses for Table 3 for MWPH at PGRMC.
43. Explain how current depreciation and amortization were calculated, and how project depreciation and amortization were calculated.
44. What is the basis for the increase in bad debt as a percent of gross patient revenues from 5.8% in 2012 to 6.7% in 2013 to more than 8% for the projected years? Shouldn't implementation of the Affordable Care Act reduce bad debt levels?
45. What is the basis for the projection of contractual allowance? As a percent of gross patient revenue, it goes from an actual of 5.1% in 2012 and 2.5% in 2013 to a projected 3.6% in 2014 and a projected range of 2.5 to 2.8% through the projection period? Please explain.
46. Please provide a detailed discussion of Exhibit 27, explaining what each column represents and outlining the assumptions and calculations used in each step of the impact analysis shown.
47. Please revise Table 5 for PGRMC to account for contract staff.
48. Contract staff expenditures for 2021 shown in the Table 3 for MWPH at PGRMC do not appear to be consistent with the contract staff expenditures shown in Table 5 for MWPH at PGRMC. Please clarify.

Please submit ten copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt. All information supplementing the applicant must be signed by person(s) available for cross-examination on the

Mary Miller  
John A. O'Brien  
October 21, 2013  
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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)764-3261 or Kevin McDonald at (410)764-5982.

Sincerely,

A handwritten signature in black ink that reads "PE Parker". The letters are stylized and cursive.

Paul E. Parker, Director  
Center for Health Care Facilities Planning  
and Development

cc: Thomas C. Dame, Esquire  
Jack C. Tranter, Esquire  
Andrew L. Solberg  
Kevin McDonald