

STATE OF MARYLAND



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## MARYLAND HEALTH CARE COMMISSION

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February 10, 2015

Jeff Johnson, Healthcare Strategy Consultant  
Prince George's Hospital Center  
3001 Hospital Drive  
Cheverly, MD 20785

Mary Miller, CFO/Vice President  
of Finance and Business Development  
Mt. Washington Pediatric Hospital  
1708 W. Rogers Avenue  
Baltimore, MD 21209

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

Dear Mr. Johnson and Ms. Miller:

Staff of the Maryland Health Care Commission ("MHCC") has reviewed the modified Certificate of Need application referenced above, first filed on October 4, 2013 and submitted as a modification on January 16, 2015. We have a number of completeness questions concerning this application. These questions follow immediately. We ask that you respond to this request, following the rules at COMAR 10.24.01.07.

## PROJECT IDENTIFICATION/GENERAL INFORMATION

1. Who is/will be the owner of the proposed new Prince George's Regional Medical Center?

## **PROJECT DESCRIPTION**

2. The application states that the majority of Prince George's County residents who seek health care services do so outside of the County. With respect to the health care services that are the subject of this application, acute hospital services, given the county's location within a major metropolitan area and the basic health planning tenet that high cost, low volume services should be regionalized, please explain why it is an inherently bad thing for residents to travel to major hospitals that are close at hand, especially for higher level services?
3. Please confirm all services that will be located in the Ambulatory Care Center (ACC). The submitted drawings show the services to be mechanical, clinics, administration, conference, and cancer center. Please be specific about what is included in "clinics." Also define which of the services planned for the ACC are rate-regulated hospital services.
4. Regarding Exhibit 1 Table B Departmental Gross Square Feet, please fill out the "current" column reflecting the existing Cheverly location.

## **PROJECT BUDGET**

5. The project budget shows the CUP cost in a separate column. Can we assume that the cost of the Ambulatory Care Center is included in the "Hospital Building" column? If so, what is the cost of that element of the project? If not, please provide that information.

## **CONSISTENCY WITH GENERAL REVIEW CRITERIA**

### **(COMAR 10.24.01.08G(3))**

#### **a) The State Health Plan**

#### **COMAR 10.24.10 - ACUTE HOSPITAL SERVICES standards**

##### **Identification of Need and Addition of Beds**

6. The licensed bed column of Exhibit 1 Table A is not consistent with the Hospital's current number of licensed acute care beds and is not consistent with the Hospital's Acute General Hospital Licensed Bed Designation form (attached). Please correct the form or explain the changes.
7. Regarding the definition of PGRMC's new service area, please provide the following clarifications;
  - a. On page 54 in the third paragraph it is stated that drive times were generated from selected zip codes to each Maryland, District of Columbia and Virginia hospital; however, the first<sup>t</sup> paragraph does not identify any Virginia hospitals that were

used in the proximity ranking. Were any Virginia hospitals used in the proximity ranking? If yes, please specify.

- b. On page 61 Table 9 shows service area population by age and inpatient service for 2012 for both the current and expected service areas, as well as the 2022 projected population for the expected service area. Are the populations shown for each MSGA age group (15-64, 65-74, and 75+) and the Pediatric population (0-14) for the distinct zip code areas identified for each age group on pages 53 through 60 or were the zip code areas combined in some way to identify one service area for all age groups. If the service areas were combined in any way explain how.
8. Explain the note below Table 16 on page 66, which says: "*Total discharges by zip code were determined using each zip code's proportion of the service area in 2013.*" An example applying the methodology to a zip code area would be helpful.
9. On page 80 below Table 24, it states that "PGHC developed assumptions regarding out of service area discharges that reflect 10% to 28% increases over the service area discharges depending on cohort." Explain how out-of-service area discharges can be 10% to 28% of in-service-area discharges when the service areas were defined as the area that accounts for 85% of a hospital's discharges. Shouldn't the out of service area discharges approximate 15%? Provide an example of the calculation for each service and age group.

### **Financial Feasibility**

10. Project GBR for 2015 through 2022 detailing year to year adjustments including annual update, population, market share and capital-related rate increase. Reconcile the projections with Tables G1 and H1.

### **Emergency Department Treatment Capacity and Space**

11. Please respond to the following:
  - a. Explain the wide fluctuations in ED visits between FY 2013 and FY 2015 (i.e., a 7.1% drop in FY 2014 followed by a 27.6% increase in FY 2015) reported in Table F1?
  - b. Explain the basis of the statement by Prince George's County Fire/EMS Department that "the number of transport calls in the new catchment area (Largo) will be significantly greater than in PGHC's existing catchment area (Cheverly)." How was this information used in projecting future ED visits? Quantify the impact of this information on such visit volume.

## **COMAR 10.24.11 GENERAL SURGICAL SERVICES standards**

### **Transfer Agreements**

12. Exhibit 40 provides a number of agreements from health care providers who transfer patients to PGHC for care and treatment. Please provide evidence of any transfer agreements that PGHC has or will have with hospitals capable of managing cases that exceed the capabilities of PGHC.

### **Need – Minimum Utilization for Establishment of a New or Replacement Facility**

13. There is a discrepancy between what PGHC reported to MHCC's *Supplemental Survey: Inpatient Monitoring Capacity* in fiscal years 2012, 2013, and 2014 and what is stated in the application. The response to the survey in each of those years listed one dedicated Cystoscopy Procedure Room and nine operating rooms (one dedicated inpatient and eight mixed-use) in the hospital's inventory. However, the applicant states on page 178 that PGHC currently maintains ten operating rooms. Please clarify the discrepancy.
14. Regarding the needs assessment for operating rooms on page 179, please provide (a) the annual projected OR utilization numbers for cardiac, non-cardiac, and trauma surgical cases from FY 2012 through FY 2022; and (b) explain why PGRMC's OR need analysis did not use FY 2013 or FY 2014 numbers for MSGA admissions, non-cardiac or trauma cases, or outpatient Cases.

### **Patient Safety**

15. While your response to the Acute Care Chapter Standard 10.24.04B(12) on pages 135-159 addresses patient safety for the medical center in general, this standard seeks any such plans that address patient safety specific to the surgical department.

## **COMAR 10.24.17 CARDIAC SURGERY standards**

16. COMAR 30.08.05.09 lists cardiac surgery as a *desirable* service for a Level II trauma center, not an *essential* one. Given that the existence of a Level II Trauma Center is one of the key justifications for the presence of a cardiac surgery program at PGRMC, please:
  - a) Provide a three-year history of the number of trauma patient requiring cardiac surgery.
  - b) Describe what the alternative approach would be for trauma patients who did require this capability if it were not available at PGRMC.

17. The application failed to provide a response to an earlier completeness question, which was:

*As an existing cardiac surgery program, PGHC should be reviewing morbidity and mortality rates and other indicators of patient outcomes, and compliance with established processes of care as compared with regional or national averages [See COMAR 10.24.17.06B(2)(e)]. Please describe PGHC's history of participation in the Society for Thoracic Surgeons (STS) cardiac surgery registry during the last five years and provide the STS Coronary Artery Bypass Graft Composite Scores reported by STS for the PGHC cardiac surgery program for any reporting period during the last five years. Please identify the reporting period for each reported composite score.*

The response (on page 200 of the modified application) does not directly answer that question, and instead speaks to the current quality assurance program that is in place for cardiac surgery. It also stated:

*PGHC completed an agreement with the Society of Thoracic Surgeons ("STS") in May 2014 and also contracted with AXIS, an approved STS software vendor. A STS data coordinator was hired and software / AXIS training was recently completed. In addition, the data coordinator has participated in several data manager training seminars and received one-on-one training from the UMMC STS data manager. In accordance with the regulatory changes in the State Health Plan, data has been collected on all cases since July 2014. The first submission of outcomes data will be submitted in February, 2015, allowing for a sufficient number of cases to be harvested and reported on.*

MHCC staff infers from this response that the request for PGHC's history of participation with the STS is moot (as apparently there is no such history) as is the request for composite scores reported by STS for the PGHC cardiac surgery program. **Therefore, in lieu of providing the answers initially requested, please submit the outcomes data referenced in the application as being available in February 2015.**

## **(b) Need**

### Mount Washington Pediatric Hospital

18. Table 67 on page 208 uses two years of actual admissions data (2013 and 2014) to calculate an admission rate for MWPH at PGHC. Please provide admission data for 2009 through 2012 and project future admissions based on the average of the last five years and the five year trend. If there is no distinctive trend of increasing or decreasing admission rate, it is only necessary to project future admissions based on the average admission over the period from 2009 through 2014.

## **(c) Availability of More Cost-Effective Alternatives**

19. A theme that runs through the entire plan and proposal is an assertion that the many health challenges faced by Prince George's County<sup>1</sup> require the installation of an academically-affiliated tertiary care center. In explaining the additional square footage per bed proposed for this project compared to other recent projects in Maryland, the applicant states that the other projects "are not directly comparable in scope or level of service to PGRMC" (page 27, footnote).

Explain why the relocated hospital needs to be an "academically-affiliated tertiary care center" with such a specialized scope of services instead of a modern, full-service and academically-affiliated community hospital.

A. Wouldn't a new community hospital with a network of physician offices and community clinics and continued and enhanced collaboration with tertiary care programs in Washington, DC and Baltimore be able to meet a very high proportion of the patient services projected to be provided in the CON application at the relocated hospital. at a lower cost?

B. Why wouldn't development of a new community hospital be able to address the challenges of inadequate numbers of primary care physicians, higher rates of ambulatory care-sensitive visits to the hospital and ED, and higher rates of chronic diseases? *What is the unique capability of an academically-affiliated tertiary care center hospital that makes such a hospital able to overcome these challenges while a community hospital with a similar academic affiliation cannot?*

## **(d) Viability of the Proposal**

20. Please submit revised Tables G1 and H1 with separate estimates and projections of revenue for inpatient and outpatient services.
21. The assumptions include a 49% increase in MSGA discharges from 2020 to 2022. MHCC staff cannot decipher the derivation of the increase based on discharge and patient day projections as they appear in Table F1 for years 2019 through 2022; staff calculated an increase of 20.5% from 2020 to 2022. MHCC staff also calculated an increase in discharges of 34.5% between 2019 and 2022 (including significant increases from 2019 to 2020). Please submit the calculation of the 49% increase reconciling it with the projections in Table F1.

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<sup>1</sup> Application cites problems such as a substantially lower ratio of primary care providers; higher rates of ambulatory care-sensitive hospitalizations and emergency department visits; higher rates of chronic diseases, including diabetes, heart disease, hypertension, asthma and cancer, than those residing in neighboring counties.

22. Exhibit 1 page 15 includes the assumption that market share volume increases related to recapture at the new hospital will be recognized immediately in the year of volume growth. Please submit revised Tables G1 and H1 based on the alternate assumption that revenue increases for market share growth occur in the year following the volume growth.
23. On page 213, projected depreciation is reported as \$25.2 million<sup>2</sup>, but on Table G1 (Revenues and Expenses un-inflated) it is projected to be \$25.9 million for FY 2020. Explain or correct this apparent discrepancy.
24. Explain why project interest is reported on Table G1 as \$14 million for FY 2020 and \$11.4 million for FY 2022, but is reported on Table H1 as \$14.4 million for FY 2020 and \$12.3 million for FY 2022. If the only reason or one of the reasons is inflation, explain why interest on project debt should be subject to inflation assumptions.
25. One of the expense assumptions for both Tables G1 and H1 is the lease of 60,000 square feet for administration. Given the construction of a new hospital, explain the need and the cost effectiveness of leasing such space. Where is this lease cost accounted for on the tables?
26. With respect to Mount Washington Pediatric Hospital (“MWPH”) projected revenues and expenses, please provide the following clarifications:
- a) No statement of and basis for assumptions was submitted for Tables G2, H2, J and K. Please submit a statement of all assumptions made to project the revenues and expenses on these tables. Also check the tables to insure that Table H2 and K include inflation. And table G2 and J do not. The percentage year to year increases in patient revenue and total operating expenses on G2 and H2 and J and K appear to be the same when the tables with inflation should be higher. Tables G2 and J should reflect changes in revenues and expenses associated with changes in volume but not inflation. Specify the base year for the revenue and costs reflected on these tables.
  - b) On page 213 it states that since MWPH is in leased space and not responsible for any debt, this project will not impact charges. It also states that rent will increase as reflected in Tables G2 and H2. Wouldn't it also be reflected in Table J? How much is the expected rent increase? Which line of the tables reflects this increase? Explain why the rent increase will not impact charges.

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<sup>2</sup> which is presumably for 2022 when interest on project debt is reported to be \$11.4 million on page 213 and on Table G1

## **(f) Impact on Existing Providers and the Health Care Delivery System**

27. To complete the picture of where Prince George's County residents are currently going for secondary and tertiary care (shown on Table 69, page 217), please provide the total number of Prince George's County residents seeking secondary and tertiary care from all Maryland hospitals, from all DC hospitals and all VA hospitals (i.e., summation by state, not by individual hospital).
28. Please provide the quantitative basis for the allocation of the discharges expected to be recaptured as shown in Table 70 (32% of the MSGA discharges from Maryland and 68 % from out-of-state).
29. On pages 218 through 223 the application material demonstrates how discharges that are expected to be recaptured are distributed for the impact analysis. This appears to be based on the allocation of the recaptured discharges by age set forth in Table 70 and the projected distribution of discharges to the expected Largo service area by age. It is not clear how the projected recaptured discharges from in-state and from out-of state were allocated to each zip code area as shown on pages 220 through 223 for the population 15-64. Please explain and demonstrate how this allocation was done.
30. On page 219 it states that "with the projection of recaptured discharges split between In and Out of State, the impact was allocated to other hospitals based on their FY 2013 proximity adjusted market share by zip code within each cohort." However the example shows that for zip code area 20743, PGRMC is expected to recapture 28 discharges and that 12 of these are expected to come from Doctors Community Hospital (page 221). Doctors pre-recapture market share of zip code area 20743 was 19.9% (page 220) and 19.9% of 28 equals 5.6 not the 12 shown on page 221. Please provide further explanation and examples to demonstrate how the recaptured discharges were allocated among the hospitals.
31. To back up the statement (page 226) that MWPH at PGHC provides a more geographically proximate alternative for patient's families than the MWPH campus in Baltimore, please provide admissions by county for: Prince George's County; the other counties of Southern Maryland; and other counties adjacent to Prince George's County. Data for FY 2014, if available would be preferred.

Please submit six copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter ([ruby.potter@maryland.gov](mailto:ruby.potter@maryland.gov)).

All information supplementing the applicant 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)764-5982.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin McDonald", with a long horizontal flourish extending to the right.

Kevin McDonald  
Chief, Certificate of Need

cc: Thomas C. Dame, Esquire  
Jack C. Tranter, Esquire  
Andrew L. Solberg  
Patricia Cameron, MedStar  
Peter Parvis, Counsel to Doctors Community Hospital  
Camille R. Bash, CFO, Doctors Community Hospital  
Howard Sollins, Esquire  
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