STATE OF MARYLAND

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May 17 2016

By E-Mail and USPS

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Re: Project Status Conference Summary
Dimensions Health Corporation d/b/a Prince George's Hospital Center
Mt. Washington Pediatric Hospital, Inc.
Docket No. 13-16-2351

Dear Counsel and Ms. Creekmur:

I am writing this letter to summarize the project status conference held today, regarding the Certificate of Need application filed by Dimensions Health Corporation ("Dimensions"), d/b/a Prince George's Hospital Center ("PGHC") and Mt. Washington Pediatric Hospital, Inc. ("MWPH"). The application seeks CON approval to relocate PGHC and the MWPH unit at PGHC to a replacement general hospital to be constructed in Largo.

Present at the project status conference were the following representatives of the parties in this review:

Applicants Dimensions Health Corporation and Mt. Washington Pediatric Hospital, Inc.:
Thomas C. Dame, Esquire
Ella R. Aiken, Esquire

Sherry Perkins, Exec. Vice President & COO, Dimensions
Lisa Goodlett, Sr. Vice President & CFO, Dimensions
Carl Jean-Baptiste, Sr. Vice President & General Counsel, Dimensions
Jeffrey Johnson, Sr. Vice President Strategic Planning & Business Development, Dimensions
Justina Starobin, Vice President of Outpatient Services, MWPH
Darryl Mealy, Vice President Facilities, University of Maryland Medical System (UMMS)
Stephen Bartlett, M.D., Ex. Vice President and Chief Surgeon, UMMS
John Ashworth, Sr. Vice President System / Network Development, UMMS & Interim CEO, University of Maryland Medical Center
Andy Solberg, Healthcare Consultant

Interested Party Anne Arundel Medical Center:
Jonathan Montgomery, Esquire
Paula Widerlite, Chief Strategy Officer, Anne Arundel Medical Center

Interested Party Doctors Community Hospital:
Richard Coughlan, Healthcare Consultant

Interested Party Prince George's County Health Department:
Pamela Creekmur, R.N., Health Officer

The attached document, which was distributed at the project status conference, outlines areas of non-compliance and recommended modifications. I have concluded that these changes are needed to bring the project into compliance with standards in the State Health Plan and with Certificate of Need review criteria.

As I noted at the project status conference, the applicants may choose to make the recommended modifications to their application. I hope that the applicants will decide to make the modifications, which will enable me to issue a Proposed Decision recommending that the Maryland Health Care Commission grant a Certificate of Need for the replacement hospital. I believe that this is the route most likely to expedite the construction of a modernized replacement hospital for Prince George's County.

Alternatively, the applicants may decide that they want to make no changes to the application. In that case, within 30 days, I will release a Proposed Decision recommending that the Commission not grant a Certificate of Need for the project. Dimensions, MWPH, and other

parties could then file exceptions to the Proposed Decision (or responses to exceptions) and present arguments at an exceptions hearing held before the Commission at its July 21 meeting.

The applicants must let me know on or before 4:30 p.m. on Monday, May 23, whether they will modify the application or whether they choose to go forward with the application currently under review. If the applicants choose to modify the application, I request that they provide me with an estimated date by which a modified application can be filed.

I want to remind all parties that this is a contested case and that the *ex parte* prohibitions in the Administrative Procedure Act, Maryland Code Ann., State Gov't §10-219, apply to this proceeding until the Commission issues a final decision.

Sincerely,

Robert E. Moffit
Commissioner/Reviewer

cc: Donna Kinzer, Executive Director, HSCRC
Ben Steffen, Executive Director, MHCC
Paul Parker
Kevin McDonald
Suellen Wideman, AAG

Application of Dimensions Health Corporation d/b/a Prince George's Hospital Center and Mt. Washington Pediatric Hospital, Inc.
for Certificate of Need for Prince George's Regional Medical Center
as Replacement and Relocation of Prince George's Hospital Center
Docket Number 13-16-2351

Project Status Conference
Robert E. Moffit, Commissioner/Reviewer
May 17, 2016

Areas of Non-Compliance with State Health Plan Standards and Certificate of Need Criteria, and Recommended Modifications

Introduction

This document provides information to Dimensions Health Corporation d/b/a Prince George's Hospital Center (PGHC) and parties in the review on the bases for my conclusions concerning areas of compliance and non-compliance of the proposed hospital relocation project with applicable standards and criteria. Its primary purpose is to provide guidance regarding changes in the proposed project or additional documentation that will be needed in order for me to make a positive recommendation to the Maryland Health Care Commission (Commission) with respect to the application.

I conclude, as have many others, that a new general hospital campus in Prince George's County is needed; a hospital that is modern, financially stable, and sustainable over the long-term, and competitive with other hospitals and health care providers in the Washington, D.C. metropolitan area. PGHC is the sole provider of some critical medical services in the County and an important provider of other inpatient and outpatient diagnostic and treatment services needed by the community. It must become the attractive alternative for physicians, patients, and payors that the current PGHC is not. I believe that the proposed project can be a vehicle for realizing these objectives. Certain changes need to be made in the proposed project, however, to achieve that end. My objective, in convening the Status Conference, is to initiate a process of project plan modification, by the applicants, that will result in a project I can recommend for endorsement by the Commission. Ideally, this might also result in a project that can gain the endorsement of the Health Services Cost Review Commission (HSCRC) for the changes in the hospital's global budget revenue needed to implement the relocation.

The State of Maryland and Prince George's County are providing $416 million for the construction of the replacement PGHC. At the acute care average daily census that PGHC experienced in the fiscal year that ended March 31, 2015, the hospital would need to operate 212 beds at an assumed average annual occupancy rate of 80%. Thus, the $416 million in public funding being provided for the PGHC hospital replacement, if used to build a hospital sized for the FY 2015 census of the hospital, would yield just under $2 million per bed. PGHC also proposes to operate 20 observation beds at the replacement hospital. If we add this non-licensed bed space to the licensed bed capacity needed in 2015, the public funding for the project would yield approximately $1.8 million per bed.

PGHC proposes to develop a replacement hospital with 216 acute care beds, 15 special hospital beds, and 20 observation beds at a total cost of $651.2 million, or $2.59 million per bed (including all the enumerated licensed and observation beds). The project involves construction of 749,828 square feet of building space, or 2,987 square feet per bed.

By way of contrast, approximately five months ago, MHCC authorized a replacement general hospital in Montgomery County (Washington Adventist Hospital) with 170 beds and a total estimated cost of approximately $331 million. Like PGHC, this replacement hospital included 20 observation beds. Unlike the PGHC project, it did not include any significant public funding and did not include a central utility plant in the project cost,[1] but it included shell space. That project involved construction of 427,662 square feet of building space. Adjusting the building space for the noted differences in the two replacement hospital projects to make them comparable, this Montgomery County project was authorized at 2,251 square feet per bed at an estimated cost of $1.74 million per bed.

I am struck by the dramatic contrast in space and cost between these two projects, both planned at the same time and in very close geographic proximity. I have also examined other new and replacement hospital projects in Maryland developed in the last six years and made comparisons with the proposed project, adjusting for differences in those projects and the PGHC replacement in order to make the comparisons fair and meaningful. I have found similar contrasts with the PGHC project, which is at the high end of the cost and space benchmarks. I have therefore concluded that the proposed project is unnecessarily large and thus, substantially more expensive than it needs to be or should be, given the importance of optimizing the chances for making this project financially successful.

Over the last fifteen hospital licensure years,[2] Prince George's Hospital Center has experienced a decline in acute care average daily census (ADC) of 39 patients (14.1%).[3] During this period, acute care ADC at PGHC peaked in FY 2002, at 207.1 patients and hit its lowest point, just under 153 patients, in FY 2012, a slide of over 26% over a ten-year period. While PGHC has experienced an increase in acute care ADC since that trough, to 169.3 patients in fiscal year (FY) 2015, data provided by HSCRC on May 3, 2016 shows that both readmissions and admissions associated with ambulatory care sensitive conditions that could have potentially been prevented through more effective outpatient care delivery, increased between calendar year (CY) 2014 and CY 2015.[4] This is a direction contrary to the goals of Maryland's new hospital payment model.

PGHC projects that acute care ADC will increase by approximately 9% between 2015 and 2022, primarily based on an assumption that the replacement PGHC will make substantial

[1] Washington Adventist proposed to purchase power from the third party developer of the utility plant.
[2] The twelve-month periods ending on March 31 of each year. So, in this case, through FYE March 31, 2015.
[3] This period corresponds with Maryland's current process for licensing acute care beds and the ADCs and fiscal years referenced here are those used in licensing, the twelve month periods that end on March 31.
[4] I note that this volume increase was cited by PGHC in responding to the HSCRC staff's October 23, 2015 assessment of the risk HSCRC staff saw in the competitiveness of the hospital's rate if volume increases were not achieved but the PGHC response did not address the disappointing direction that readmissions or Prevention Quality Indicators took in 2015.

gains in regional market share, with an unexplained skewing of this "market recapture" assumed to come from Washington, D.C. hospitals.

My analysis indicates that these utilization projections are quite aggressive. I foresee a market in which hospitalization rates will continue to decline in line with recent trends and the objectives of the payment model established in Maryland in 2014. I have also assumed that Medicare length of stay of medical/surgical patients, which is falling, will experience some further reduction and non-Medicare length of stay will see a slight increase. Most importantly, I have concluded that it is not likely that the gains in market share projected by PGHC will come as quickly as Dimensions has forecast and it is prudent to assume that the relocated hospital will be moderately successful in rebalancing competition among the systems and independent hospitals drawing patients from Prince George's County and the secondary hospital service area.

I am confident that the role projected for and being played by the University of Maryland Medical System in reviving PGHC, with the partnership and participation of the other private and public stakeholders involved in this effort, will allow PGHC to make substantial gains in market share throughout its service area and have incorporated this assumption in my capacity forecasts. However, I am not convinced that it is likely that the relocated PGHC will obtain the higher levels of dominance in certain parts of the service area that Dimensions projects. Following completion of this project, overcoming the deficits in the primary care network needed to assure the success of this ambitious hospital project must occur. This is not something that will be accomplished overnight; it is a process of bottom-up development that will take considerable time. Based on the evidence provided by Dimensions, I am unconvinced that its top-down perspective, in which moving and replacing the hospital itself becomes a unique catalyst for quickly and comprehensively creating the necessary primary care network, is warranted. This perspective requires a belief that the replacement hospital can quickly reach a position of parity or near-parity with more successful competing hospitals that have more established D.C regional networks, such as MedStar. Based on my different perspective on the market and how it is likely to change over time, as well as the larger forces mitigating against growth in the demand for hospital services, and the need to reduce the high levels of avoidable hospital use, I conclude that the project plan should trim service capacity as part of the plan to reduce the scale of construction and overall project cost. My direction that the project should be developed on the basis of more conservative projections of future volume and a more modest building plan and budget, will still require a plan for operation that will require the hospital to produce its services on a significantly more efficient basis than Dimensions has been able to achieve in the past.

I have also analyzed the impact of this project, in accordance with COMAR 10.24.01.08G(3)(f). I conclude that the impact of the proposed project on other hospitals does not provide a basis for its denial. In fact, I conclude that the impact of the replacement hospital is largely positive, due to the potential benefits it will afford to the population of Prince George's County.

Recommended Project Modifications

Standards and Criteria regarding Need, Cost Effectiveness, Efficiency, Viability, Financial Feasibility, and Impact on Costs of Hospital Service Delivery: COMAR 10.24.10 Project Review Standards (5), (6), (10), (11), (13), and (14); COMAR 10.24.11.05A Project Review Standard (1) and .05B Project Review Standards (2) and (8); COMAR 10.24.12 Project Review Standard (1); and COMAR 10.24.01.08G(3)(b), (c), (d) and (f).

I cannot find, based on the information and analysis provided, that the proposed size and scope of the project is needed or that it is a cost effective alternative for modernizing PGHC and putting it on a firm foundation for future success.

At this time, I cannot recommend that the Commission find that the proposed project is viable under COMAR 10.24.01.08G(3)(d). To date, HSCRC staff has not been able to render an opinion as to whether the proposed project is financially feasible. On the contrary, HSCRC staff has concluded that the CON application does not demonstrate: (1) qualification of the project, on a pro forma basis, for the expansion of budgeted revenue required for its implementation; (2) the ability to achieve the utilization levels and associated productivity improvements necessary to make the relocated PGHC price competitive with its peers; and (3) the sources of and capabilities for the additional borrowing capacity that the proposed project plan entails.

I concur with the HSCRC staff's views concerning the risks associated with Dimensions' analysis of future demand for hospital services at the relocated PGHC and its ability to achieve efficiencies through the economies of scale that only higher service volumes can provide, given the 50 percent variable cost factor allowed under volume changes in HSCRC's budgeting model. In my view, reducing the cost of this project should reduce the risk that this project will be inefficiently used and should improve the chances of overcoming the other gaps that HSCRC staff found in its review of the CON application.

Recommended Project Modifications: Reduce the size, bed capacity, and other service capacities to reduce the estimated cost of the replacement hospital. The space constructed should be no more than 2,400 gross square feet per bed[5] (exclusive of the space identified by Dimensions for "resident/faculty" space and the cancer center space). The bed capacity of the proposed hospital should be no more than 219 beds (204 general acute care beds and 15 special hospital-pediatric beds). The estimated construction cost of the hospital should be no more than $225 million and the total project cost estimate should be no more than $543 million.

- **In reducing the bed capacity of the replacement hospital, reduce MSGA bed capacity by at least 11 beds and obstetric bed capacity by at least three beds.**

- **In reducing the service capacity of the replacement hospital, reduce the number of finished operating rooms by at least one operating room (OR), eliminate the unfinished OR, and reduce the 10-OR suite to an 8-OR suite.**

[5] Including the 20 observation beds

- **In reducing the service capacity of the replacement hospital, reduce the number of Emergency Department treatment spaces to no more than 45 spaces and bring the size of the ED in line with this treatment capacity, consistent with American College of Emergency Physicians (ACEP) guidelines that are incorporated by reference in the SHP.**

Provide a complete and detailed analysis of how this project will improve operational efficiency and reduce staffing hours and cost per unit of service, beyond the ratio of nursing FTEs per unit of service in the nursing units included in the CON application. Quantify the financial impact of the projected operational efficiencies.

In addition, I request a full and detailed accounting of the progress made to date in the County in implementing the applicant's collaborative population health management practices, its transition to value-based care, its development of an ambulatory care network and increase in primary care providers, and its establishment of a clinically integrated network. I would like an analysis of the steps that remain to be taken in implementing and funding these plans.

I recommend that the applicants reexamine all aspects of the project in determining the best ways in which to reduce the size and cost of this project. My analysis indicates that attention should be focused on:

- The need for a dedicated ambulatory care center and the administrative space it includes. This distinct project component does not appear to be necessary for a hospital of this size.

- The need to construct new hospital space for the special hospital unit of Mt. Washington Pediatric Hospital. The applicants should examine and report on the potential of other hospital space alternatives that may already be available for lease in Prince George's County that could serve the purpose of housing this small specialized hospital.

In addition to meeting the required primary changes and to reflect them, a new pro forma schedule of revenues and expenses, with an accompanying statement of assumptions and certain other of the schedules included in the CON application will need to be revised, updated, and submitted. The applicants may send an email to MHCC staff, copying all parties, if they need guidance on these required form filings.

Information Regarding Charges: COMAR 10.24.10, General Standard (1)

The information on PGHC charges posted on its website does not comply with Part (a) of the standard, which requires that a Representative List of Services and Charges be made readily available to the public in written form as well as being posted on the hospital's web site. It is outdated and the link to both the financial aid application form and pricing information are also outdated**.**

Recommended Project Modification: Provide an updated Representative List of Services and Charges that is readily available in printed form and on the hospital's web site.

Construction Cost of Hospital Space: COMAR 10.24.10, Project Review Standard (7)

The construction cost per square foot estimate is slightly above index (estimated cost of construction is $3.05 per SF above the index, within one percent of index cost). This would not affect MHCC's ability to approve the project, but an approval would include the condition that $2.29 million plus a portion of contingency and future inflation be excluded from any rate request submitted to the HSCRC. Note: This finding of cost in excess of MVS benchmark is contingent on my assumption that all $32,496,000 of equipment for the Central Utility Plant (CUP) classified as "movable" should be re-classified as fixed and included in the comparison.

Recommended Project Modification: Clarify the accuracy of the CUP equipment classification.

Other Items That Must Be Addressed

The Need for Retaining a Licensed Pediatric Bed

While Dimensions proposed a reduction in pediatric beds, it is also seeking to add a pediatric clinical decision unit/observation bed capability, as part of its ED, with one licensed bed. PGHC has recently proposed elimination of pediatric services as a distinct inpatient service line specifically recognized by HSCRC in its payment model. Please provide a persuasive justification of the need to have a single licensed pediatric bed for the admission of pediatric patients rather than simply operating the proposed pediatric space as an observation unit without a licensed bed. Consider whether pediatric services should be eliminated as a separate inpatient service, given that, in recent years, PGHC has admitted only a handful of patients under the age of 15..

Governance, Management, and Project Sponsorship

The history of PGHC has been one of long-standing managerial and financial difficulties. One of the key objectives of UMMS' involvement is to assure a turnaround and put the institution on a path toward permanent progress. Please provide detailed plans for incorporating the Dimensions system into UMMS. Please provide a full and detailed accounting of the governance, management, and project sponsorship responsibilities of UMMS in light of actions taken by the Maryland General Assembly and the Governor in 2016.