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October 15, 2014

VIA Email & U.S. MAIL

Robert Jepson, Vice President
Business Development
Adventist HealthCare, Inc.
820 West Diamond Ave.
Gaithersburg, MD 20878

Re: Adventist Healthcare, Inc. d/b/a Washington Adventist Hospital Replacement of Washington Adventist Hospital and Reconfiguration of the former Washington Adventist Hospital Campus in Takoma Park -- Matter No. 13-15-2349

Dear Mr. Jepson:

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 September 29, 2014. We have a number of questions and requests for additional information 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 DESCRIPTION

1. Please explain the nature of and progress toward developing the clinically integrated physician network described on p. 10 to align physician and hospital incentives around cost and quality goals.

PROJECT BUDGET

2. Explain how the gross interest (part of the Non Current Capital Cost) and interest income (among the sources of funds for the proposed project on page 15) and the project budgets for Options 2 and 3 were arrived at. (In responding, take note of your response to the first completeness letter, your response to question #3 of the second completeness letter, and questions 2a and b of the March 4, 2014 completeness letter.)

3. Explain why the amounts budgeted for legal and CON consulting fees submitted in the original application are not carried over on this updated project budget.

4. The central utility plant (CUP) to be constructed by a third party should be included as part of this project, with its cost reflected in the project budget and the third party investment included in the sources of funds. Please revise PART II - PROJECT BUDGET accordingly.

CONSISTENCY WITH GENERAL REVIEW CRITERIA (COMAR 10.24.01.08G(3))

a) The State Health Plan

COMAR 10.24.10 - ACUTE HOSPITAL SERVICES standards

Charity Care Policy

5. The financial assistance policy (Exhibits 11 and 12) state that probable eligibility will be communicated within two business days of submission of an application for charity care. Please submit a copy of the application form and explain how the determination of probable eligibility is made.

Quality

6. The application references the engagement of a consultant (IMA) whose charge is to work with physicians and staff to improve the length of stay. Please provide a brief description of their (IMA) background and qualifications. Have they made recommendations re: ER throughput and has WAH implemented any? Are any results apparent yet?

7. Please address and explain the expected impact of the proposed project on the time from ED arrival to departure for patients who are treated and released, and from admission decision to a bed for patients who are admitted.

Adverse Impact

8. Please provide documentation for the statement that the most recent publicly available HSCRC annual filing (FY 2013), Washington Adventist Hospital's average age of plant is 23.0 years, second highest average age among 47 hospitals in the State of Maryland (p.26 of the application).

9. Please address the part of standard 4(a) that states: *If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the full adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group.*

10. Please provide the exhibits 24 and 25 (at least the travel distance/time tables) in a format such as Excel so that they can be read more easily by freezing column and row panes.

Cost-Effectiveness

11. Please provide a detailed explanation of the assumptions made in preparing the financial projections for Options 2 and, 3, including volumes, rates, charges and expense and inflation assumptions.

12. For the financial projections for each option in Exhibit 30 specify the size of any rate increase for capital and the effective date.

13. Explain the decision to allow a third party to construct the Hospital's CUP, and to purchase the utility services from that third party, comparing the cost effectiveness of that approach to the hospital's construction and ownership of the facility. Are you aware of other hospitals that followed this approach, and their experience with it?

Construction Cost of Hospital Space

14. Please provide the following clarifications for the data presented in Exhibits 32 through 35:

    a. <u>Submit the calculations that resulted in an unadjusted interest cost of $21,378,750 allocated to the building funds</u>. MHCC staff calculated the interest and financing cost for MVS comparison to be $28,473,339. MHCC staff calculated the project costs for MVS comparison building costs net of interest to be $140,050,000, if all of the WAH's identified extraordinary costs are accepted. The $140,050,000 is 56.9% of the total current capital cost $246,200,000. 56.9% of the WAH estimated gross interest plus loan placement fee of $50, 054,524 is $28,473,339.

    b. Submit the calculations that resulted in extraordinary capitalized construction interest of $2,607,000.

c. Explain why $150,000 in signs is considered an extraordinary cost (Exhibit 33) for purposes of comparison to the MVS benchmark when interior and exterior signs are budgeted under the other line of the project budget (p. 14) which is not included in the $180,000,000 unadjusted cost used in the comparison with the MVS benchmark on page 40.

d. Describe the penthouse in terms of construction material and use of the space. Explain why the MVS base cost for mechanical penthouses (Section 15, page 19) was not used for the 3,105 sq. ft. penthouse.

e. What is the wall height of the penthouse?

15. There appears to be a discrepancy between the square footage reported in Exhibit 35 -- **Marshall Valuation Service Departmental Cost Factors** – and that included in the table at the top of page 42 (e.g., the departmental cost factor calculation lists the ICU/CCU as 19,930 sq. ft. while the table at the top of page 42 indicates that it will be 13,680 sq. ft.). Please explain.

Patient Safety

16. Why are only half of the pre/post surgery spaces designed as private if those features are important for infection control and privacy as stated? (p48)

Financial Feasibility

17. Please provide the following additional information and clarifications:

a. Reconcile the 2014 and 2015 patient revenues set forth in Tables J and K with the Global Budget Revenue agreement.

b. In the financial assumptions (Exhibit 37), please explain the basis for the update factor, age adjusted population growth, market share, deferred revenue, and other reversals as they relate to current HSCRC policy considerations. Provide calculations where necessary to reconcile with projected Global Budget Revenue.

c. Provide the expense assumptions used in these projections explaining why they are reasonable.

Emergency Department Treatment Capacity and Space

18. The tables and prose associated with the **Parameters Determining Size for Emergency Department** portion of the application (pp. 52, 53) are not at all clear (the second table in that series may be mislabeled?). Please explain the story the tables tell about ED space needs.

19. What is the projected ED visit volume through 2020 (including not just the outpatients but also those who are admitted)? Discuss the basis for the projections.

20. Do the ratings presented vis a vis the parameters for high and low range reflect current operations or those expected after the proposed relocation to White Oak?

21. From these tables it appears that the ALOS for all ED patients is not expected to improve (with the proposed project) to less than 3.5 hours. Please explain why the ALOS should not improve to at least less than 3.5 hours and ideally less than 2.5 hours?

22. With regard to of the population health programs designed to *reduce use of emergency department for non-emergency medical care,* have any of the programs discussed on pages 60 through 63 yielded any quantifiable evidence of impacting ED volume? If yes, please submit.

23. Please speak to WAH's having considered the need for beds and other facility system capacity that will be affected by greater volume of ED patients as required by subpart (c) of standard 15.

Shelled Space

24. The standard requires an estimate of the likely timeframe for using the shelled space. It appears that Exhibit 40 assumes that timeframe to be three years. Please confirm this and explain that expectation.

25. Please explain the reference (under *Program Flexibility* on page 64) to a 28,000 sq. ft. reduction in this iteration of the proposal, given that the current total proposed square footage is 427,662 while the prior plan was for 428.412 sq. ft.

<u>COMAR 10.24.12 - ACUTE HOSPITAL INPATIENT OBSTETRIC SERVICES standards</u>

26. Is there a letter or certificate documenting the result of the November 2012 site visit DHMH cited on page 66? Are such site visits a routine, periodic practice, or was the visit precipitated by an event or program change?

27. Explain why the relocated hospital would not attract sufficient Obstetric volume from each of the following zip codes to be included in the expected service given their proximity to the proposed location and/or their location in relation to other zip codes that are expected to be in the service area: 20720, 20721, 20723, 20724, 20860, 20868, and 20895.

28. Explain why the need analysis includes the female population 45 through 64 when obstetric projections are typically only based on the female population 15 through 44.

29. On page 113 the application cites an analysis performed by WAH "to understand the differences in market share by zip code as a result of the proposed relocation to White Oak." You stated that that analysis took into account the location of the new hospital, proximity of other hospitals, drive times, major streets and highways, current market share of other providers and physician relationships. Please explain how each of these considerations were weighted and how they affected the resulting market share adjustments for each zip code in the expected service area as detailed on page 114.

30. Explain why a 65% occupancy rate was assumed for projecting service area need (as differentiated from a single hospital's need) for obstetric beds.

31. Submit a step by step explanation and calculation of the 7817 discharges projected for 2023 (p.117).

32. Page 116 contains this statement: "*Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital – White Oak TSA were examined. It was found that although the majority of the Female – Childbearing population, women ages 15-44, are estimated to decrease approximately 0.5% annually, newborns are expected to increase 0.5% annually. Therefore, an increase in the use rate of 1.0% was applied each year to consider the expected higher rate of births within the Washington Adventist Hospital – White Oak TSA.*" Was this apparent contradictory projection from Claritas explored or vetted for likely accuracy?

33. Please provide the 2012, 2013, and the 2023 female population ages 15 to 44 and 45 to 64 by zip code.

34. Which of the design features of the OB unit described on p.81 are upgrades over the present facility? Explain the advantage offered by each of these features.

35. The tables at the top of p. 117 need further explanation. Extracting data elements from them seems to yield the following for the assumed White Oak TSA in 2013.

Females of childbearing age	188,638
Newborns	38,884
OB discharges	7,413

   a) Does this mean that 1 of every 4.85 females of childbearing age delivered a baby in 2013?
   b) How is it that there were 38,884 newborns but just 7,413 OB discharges?

The same anomaly appears in tables on pp. 140, 141.

COMAR 10.24.11 GENERAL SURGICAL SERVICES standards

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

36. In accordance with standard 2(a)(i) please provide historical trends for both WAH and the expected service area. For WAH, provide at least the CY 2011 and CY 2012 surgical utilization data for the mixed use and special cardiac operating rooms.

37. Subparagraph (2)(a)(iii) asks for an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital in the case of a replacement hospital project involving relocation to a new site. Please speak to this.

38. For the Mixed Use and Specialty Cardiac tables on p. 90, provide the assumptions and information used to project the number of inpatient, outpatient, and cardiac cases from 2014 through 2023. Please explain the rationale for the assumption that the average minutes per case will remain at 85 minutes per case for mixed use and 267 minutes for cardiac cases over this ten year period?

39. In Exhibit 38, the number of minutes for outpatient surgery for 2013 (237,123) differs from the 260,583 minutes reported for the six mixed use ORs on p. 89. Please explain.

Operating Room Capacity and Needs Assessment - Assumptions Regarding Operating Room Capacity

40. Please provide the assumptions and data used to arrive at the optimal capacity of 1,188 hours per year (1,485 hours per year for full capacity) for the Projected Operating Room Statistics (Specialty Cardiac) table on p. 90. This should include any information related to the population and/or facility need for each operating room, the documented demand for each operating room, and any unique operational requirements related to the special purpose operating room used as the basis to support a rate of 1,188 hours per year for optimal capacity.

41. Paragraph .06(A)A(2) assumes "an average room turnaround time of 25 minutes" but also allows *An applicant that proposes an alternative to these assumptions as a more appropriate basis for determining the need for operating room capacity* the opportunity to *fully explain and justify the basis for the alternative assumptions.* Please provide the assumptions and justify the basis for using a turnaround time of 30 minutes for the 6 mixed use ORs and 40 minutes for the 2 Specialty Cardiac ORs.

42. The line diagram presented in the application identifies one of the mixed use ORs measuring 685 sq. ft. as a "hybrid OR." What types of cases will occur in this OR?

<u>COMAR 10.24.17 Cardiac surgery standards</u>

43. On p.95 the application states that quality metrics are measured through the Society of Thoracic Surgeons (STS) Cardiac Surgery Registry and reviewed quarterly with the entire Cardiac Surgery team. What are the metrics and what are the results?

44. Provide the list of indications and contraindications for cardiac surgery referenced on p.96.

45. Provide samples of the educational materials distributed to patients about treatment options.

46. The table labeled *Risk-Adjusted Major Procedures Mortality* on p. 97 includes several terms that we would like defined. They are:

    a. the column heading "like" (assumed to be "like hospitals," but how are like hospitals defined/selected?)

    b. "in hospital mortality"

    c. "operative mortality"

47. With regard to the section of the standards requiring a program to "Establish and review compliance with physician minimum volume guidelines recommended by the American College of Cardiology, the American College of Surgeons, or other appropriate professional organization..":

    a. The application states an inability to find a definitive published minimum volume guideline for cardiac surgery. Please document that search with appropriate citations from the literature and/or professional societies.

    b. The application does speak to minimum volumes set by WAH. Those prescriptions (exhibit 67) allow lower volumes for more senior members of the staff. Please define the rationale for this stratification.

(b) Need

MSGA beds

48. On page 103 the application states that when estimating likely market share changes that would result from the hospital's relocation, factors that were judged likely to have an impact were drive times, major streets and highways, current market share of other providers, and physician relationships. Please explain how each of these considerations affected the market share adjustments for each zip code detailed on page 105.

49. To supplement the information regarding changes in the service area cited on page 106, please identify:

    a. the zip codes that will no longer be in either the primary or secondary service area;

    b. the zip codes which are in WAH's current PSA, but are expected to slide to the secondary service area after the relocation to White Oak.

50. In response to question 29b of the October 23, 2014 completeness letter WAH stated that consideration was given to including zip codes 20868, 2077, 20759, and 20723 to the expected service area but they were not included as they did not meet the definition of primary or secondary service area. Please respond to the following questions about these and other zip codes that are adjacent to the expected service as shown on page 106:

    a. It appears that zip code 20723 is included in the expected service area after all. Please explain the apparent change in assumptions.

b. Explain why each of these excluded zip codes did not meet the definition of primary and secondary service area.

51. Explain why the relocated hospital would not attract sufficient volume from each of the following zip codes to be included in the expected service given their proximity to the proposed location and/or their location in relation to other zip codes that are expected to be in the service area: 20716, 20720, 20724, 20769, 20832, 20860, and 20895.

52. On page 109 (3rd paragraph) the application states: "this assumption… indicate(s) a total use rate change of approximately negative 15% between 2013 and 2016;" the table on the same page (*Use Rates by Age Cohort Originating in WAH's TSA*) shows that 15% decrease occurring between 2013 and 2023. Does this mean an assumption that use rates will only decline through 2016, and then flatten? Is the math on that table correct? The total looks smaller than the component cohort.

(d) Viability of the Proposal

53. Please reconcile the numbers for 2013 (dollars and ratios) on page 129 with the audited financial statement especially the consolidated schedules at the back of the audited financial statements on pages 45 through 47. Note that the table on page 129 shows an operating income of $8.7 million and excess of revenue over expenses as $12.1 million for 2013; meanwhile on page 47, those numbers are $9.6 million and $13.2 million, respectively.

54. Please submit the calculation of each financial ratio (for 2013) on page 129, referencing and reconciling the inputs to the calculation with the audited financial statements and explaining any discrepancies.

55. Explain the significant increase in operating revenue and excess of revenue over expenses that begins with 2014 as shown on the table on page 129.

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).

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,

Kevin McDonald
Chief, Certificate of Need

cc: Howard L. Sollins, Esquire
Thomas Dame, Esquire
Richard McAlee, Esquire
Susan Silber, Esquire
Nancy Lane
Ulder Tilman, M.D., Montgomery County Health Department
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