MILES & STOCKBRIDGE P.C.

July 23, 2019

Via Electronic Mail Only
Paul E. Parker, Director
Health Care Facilities Planning
and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Paul.parker@maryland.gov

Via Electronic Mail Only
Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Ruby.potter@maryland.gov

RE: Baltimore Nursing and Rehabilitation, LLC
CON Docket No.: 15-24-2366

Dear Mr. Parker:

Please accept this correspondence in response to the Completeness Questions and the Requests for Additional Information dated June 18, 2019 concerning the above referenced Certificate of Need Application, filed on behalf of Baltimore Nursing and Rehabilitation ("BN&R") for the re-allocation of 80 delicensed beds in a new comprehensive care facility in Baltimore City.

The Commission granted an extension to respond to the Completeness Questions to Tuesday, July 28, 2019. As you may be aware, Applicant has had to locate yet another new location, and as a result, expects that additional information will be forthcoming in the near future, particularly with regard to the site. Naturally, the Commission will be informed of any new developments.

Also note that this CON Application has been pending since 2015, and at that time, the Commission engaged in a thoughtful and detailed exchanged of Completeness Questions to which the Application responded. Those questions focused, as some of these do, on need in Baltimore City. To the best of our recollection, the Commission was satisfied at that time that these issues were largely resolved. The issue that remained, and continues to plague this matter, is the ability to retain a site throughout the CON process.

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Nevertheless, please find enclosed six (6) copies of the Responses. As requested, an electronic copy of the Response will be sent to Ms. Potter in both Word and PDF format. In addition, I hereby certify that a copy of these Responses to Completeness Questions will be provided simultaneously with this transmission to the local health department, as required by regulations.

Given the expanded review process of this particular CON matter and the unfortunate loss of the second proposed location, Applicant suggests a meeting with the Commission to discuss this application further. Applicant welcomes any opportunity to discuss with the Commission the Applicant's intended investment in the community and the value this proposal brings to inner city Baltimore, and to answer any other lingering questions the Commission has with regard to this proposal.

Sincerely,

Jennifer Coyne

cc: Kevin McDonald (kevin.mcdonald@maryland.gov)
Suellen Wideman (Suellen.wideman@maryland.gov)
Dr. Letitia Dzirasa (Health.commissioner@baltimorecity.gov)

RESPONSE TO COMPLETENESS QUESTIONS:

PART I

1. Please describe the process, if any, used by the University of Maryland Medical System (UMMS) to decide that a partnership with the applicant was the best approach to achieving its objectives for improving the care of patients discharged from UMMS' Baltimore City hospitals to comprehensive care facilities (CCFs) and reducing the cost to Medicare and other payers of episodes of rehabilitative care in CCFs by these discharged patients. Did UMMS discuss a similar collaborative relationship with any Baltimore City CCFs or solicit bid proposals for collaborative projects of the type proposed in this application? If not, how did UMMS assure itself that the proposed partnership is the best alternative for achieving its objectives?

RESPONSE

BN&R does not and cannot speak on behalf of UMMS. As a result, BN&R is unable to provide the internal decision making process UMMS used to decide that a partnership with the Applicant was the best approach to achieving its objectives for improving care of patients and reducing costs. As demonstrated in the materials submitted to date, however, it is clear that the proposed partnership will achieve those goals.

It also is important to note that the working relationship with UMMS, while certainly collaborative, is limited to: a) a risk-sharing contract; and b) physician services and the development of care management protocols:

a) Risk-sharing contract
   - A risk-sharing model across UMMC/UM Midtown and BN&R was proposed to promote reductions in length of stay and readmissions. This is not a model exclusive to UMMS hospitals. BN&R may establish risk-sharing models with any number of hospitals, and UMMS may establish risk-sharing models with any number of nursing homes.
   - Under Maryland's Demonstration Model, these risk-sharing constructs are encouraged because they are designed to align incentives and promote effective care management across episodes of care.

b) Physician services and development of care management protocols
   - BN&R will work with University of Maryland School of Medicine faculty to develop care management protocols/clinical pathways, but this working relationship is not exclusive to UMMS. BN&R expects to work with other clinicians, as well, to strengthen post-acute care pathways for distinct clinical conditions. BN&R also expects to work closely with home care providers on care management protocols after discharge from the nursing home.

- The new facility will operate with an open medical staff. All of Mid-Atlantic's nursing homes operated with open medical staffs, permitting community physicians to continue managing their patients. In fact, this is an explicit goal of the new facility. As stated in the CON application: "A local nursing home in West Baltimore also will provide the opportunity for continuity of care with physicians, as MAHC encourages local physicians to maintain the role of primary care physician."

Note that Applicant is willing to pursue similar relationships with other area hospitals. In your August 2, 2016 preliminary indication, the MHCC requested a risk relationship with at least one hospital as proof or our ability and willingness to enter into such an arrangement. To date, Applicant has only had discussions with UMMC and UM Midtown. Once approved, however, we are certainly interested in expanding these types of relationships. Again, these are not exclusive arrangements.

2. A recent article in the Baltimore Sun indicates that the applicant no longer has an agreement to lease the site identified for this project. (See link below.) Please clarify the applicant's control of this site and its continued status as the proposed site for the project. http://www.baltimoresun.com/politics/bs-md-rifkin-20190612-story.html

RESPONSE

As stated in the Application, Applicant's original site at 300 W Fayette fell out of contract given the long approval time. Applicant then identified a site at 201 W. Lexington Street through a Baltimore Development Corporation (BDC) RFP process. Applicant was awarded the development rights for that property, but as it negotiated with UMMS on the risk agreement, UMMS expressed interest in locating the facility on its Midtown campus. This led to the ground lease option agreement submitted with the supplemental Application. At that time, Applicant notified the BDC of its intent to relocate the facility to the new location. As noted above in the article, that ground lease option agreement has since been cancelled.

Applicant has been searching for a new location for the facility. A letter of intent to acquire a new site has been submitted. The site is located less than two blocks from the previously anticipated UM Midtown location. The new site will necessitate a new project budget, but all the programming and needs analysis remains the same. Applicant will update MHCC on its ability to secure this site or else will identify another.

3. Provide more specific information on the success in effective care management of the five Mid-Atlantic Healthcare, L.L.C. ("MAHC") facilities in Philadelphia, as referenced on page 10, that are participating in bundled payment contracts with Einstein Medical Center. Specifically, for each DRG-defined episode of care, provide information on the reduction in cost per episode achieved. Specify the time period covered by this information on reduced cost and quantify, to the extent possible, the contributing factors, i.e., how much was the reduction in cost achieved through "more effective care

management," use of "lower cost services settings," "reductions in unnecessary utilization," and "quality of care improvements."

RESPONSE

MAHC participated in the BPCI Model 3 Program at its Philadelphia facilities from the program's inception in 2014 until December 31, 2016. The care models developed in response, which included following patients into the community, became the basis for MHAC's case rate model with CIGNA mentioned on page 32 of the application and described more fully in this response. This care model will be replicated to execute against the contemplated risk reimbursement model outlined with UMMC and UM Midtown and endorsed by the HSCRC.

The Model 3 BPCI program involves a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under this model, Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries in Model 3 episodes. The total expenditures for a beneficiary's episode are later reconciled against a bundled payment amount (the Target Price) determined by CMS. A payment or recoupment amount then is made by Medicare reflecting the aggregate performance compared to the Target Price. In Model 3, the Episode of Care is triggered by a Medicare beneficiary's acute care hospital stay and begins at initiation of post-acute care services with a participating skilled nursing facility. The post-acute care services included in the episode of care must begin within 30 days of discharge from the inpatient stay and end 30, 60, or 90 days after the initiation of the episode of care.

Under the Model 3 program, the skilled nursing center is the contracting party with CMS and referred to as the Convener of a case for an episode of 90 days. As the Convener, MAHC assumed the risk for these cases and partnered with other providers, including hospitals doctors and home health providers as gain-share partners, eligible to for bonus payments if a case was completed below the Target Price.

As mentioned, MAHC participated in the program at its inception with four initial conditions/DRGs:

1. Congestive Heart Failure (CHF)
2. Chronic Obstructive Pulmonary Disease (COPD)
3. Pneumonia (PN)
4. Urinary Tract Infection (UTI)

By definition, the BPCI program was developed to assure savings to the system since the Target Prices for each case were established at a 3% savings to Medicare against a FFS model. It is difficult to analyze savings per episode since the program evaluated performance against a national Target Price versus our past performance. Based on the program's performance, CMS has expanded the BPCI program to 48 DRGs and currently contracts with 577 participants nationwide. Again, as mentioned previously with the Application, due to the waiver, the BPCI program has not been widely available in Maryland.

Savings are not attributable to a specific element as asked above. Instead, it was the increased level of coordination and monitoring of these cases that reduces hospital readmissions and therefore cost. To support this program MAHC continued to monitor patients after they left the facility to assure adherence to their discharge plans.

4. Please complete Table J, page 16.

RESPONSE

Table J provides construction characteristics of the proposed project. At this time, the Applicant is revising its plans with regard to a proposed site, and as a result, we anticipate that the construction characteristics will be revised upon confirmation of that site. The Applicant requests additional time to prepare the appropriate documentation with regard to the new site.

5. Exhibit H states that "short stay residents" at the proposed CCF will include short term observation stays." Please clarify this patient classification or service classification.

RESPONSE

In Exhibit H, the reference to "Observation stays" **refers to a patient cohort,** which now is served in hospital Observation Units but could be appropriately served in the new nursing home. These patients include: a) short stay patients who may be served in the nursing home *instead of* being monitored for extended periods in a hospital observation unit, and b) short stay patients who may be referred *after* an observation visit.

a) Short stay nursing home stay in place of lengthy hospital observation visit
   - Many patients are assessed in the ER and experience lengthy "outpatient" stays in hospital observation units to receive IV care, transfusions, hydration, and/or continuous monitoring. (Medicare permits up to 48-hour stays before a determination about acute admission is made). The new nursing home may provide a more suitable setting for some of these patients, who will be predictably short stay residents in the nursing home.

b) Short stay nursing home stay recommended after a hospital observation visit
   - Clinicians may determine after an Observation stay that a patient does not qualify for acute admission but does require continued monitoring, medication management, rehabilitation services, and/or recovery supports; a short stay in the nursing home can provide a relatively low cost setting.
   - Clinicians may determine that a patient does not qualify for acute admission, but a suitable home setting may not be available for safe recovery; the nursing home can accommodate a short stay to assure safe recovery and prevent readmission.

As noted in the application, Medicare does not currently permit direct nursing home admission from the ER or observation status, but direct admissions are permitted for Medicare Advantage patients and commercial patients. Longer term, Medicare policy may evolve to follow Medicare Advantage policy to permit direct admissions to the nursing home for Medicare FFS patients as well.

PART II

6. Is the "Bed License Purchase" of $500,000 in the Project Budget estimate the same as the $550,000 "Purchase Price" in Part 2.3 of the "Purchase and Sale Agreement" of Exhibit K? Please clarify.

RESPONSE

Yes. The Bed License Purchase is actually $550,000. Applicant already has deposited $50,000 into an escrow account so the Project Budget listed cash needed for closing. We can amend the table to show $550,000 purchase price and source of cash as deposit.

PART III

7. Does the applicant currently own the two Pennsylvania facilities listed in Exhibit I? There are no Delaware facilities listed in Exhibit I, although page 19 refers to Delaware facilities owned and operated by MAHC. Are there former MAHC facilities missing from Exhibit I?

RESPONSE

Applicant currently owns the two facilities listed on Exhibit I. MAHC formerly owned one facility in Delaware, DelMar Nursing and Rehabilitation in Delmar, Delaware. MAHC sold that facility on December 1, 2015. The facility was mistakenly omitted from the facility listing. The list contains all other facilities owned or previously owned by Applicant or its affiliates.

PART IV

8. With respect to COMAR 10.24.08.05A(2) and COMAR 10.24.01.08G93)(e), MAHC developed a CCF in Charles County, Restore Health Rehabilitation Center, which opened in 2015 and, like the project that is the subject of this application, was designed to focus on short stay patients needing a course of rehabilitation following discharge from the hospital. The facility executed a memorandum of understanding with the Maryland Medicaid program agreeing that Medicaid patients would account for no less than 44% of total patient days at the facility. In FY 2017, the facility was reported to have fallen far short of this commitment, with Medicaid accounting for only 26% of total patient days. Why should MHCC view the response to COMAR 10.24.08.05A(2) and the Compliance

with Previous CONs criterion as credible, given this track record for MAHC's last Maryland project and the only project for which MAHC previously received a CON?

RESPONSE

MAHC closed on the sale of Restore Health Rehabilitation Center in Charles County to a new operator in December 2016. MAHC has no control over the operations and cannot comment on the census or admissions for the facility any further.

9. With respect to COMAR 10.24.08.05A(7):

A. Can the "hard-to-place" patient "cohort" be identified and counted in the hospital discharge data base, using the data fields for discharges to CCFs or other fields, or are estimates by case managers the only feasible approach?

RESPONSE

The question requests that the total number of "hard-to-place" patients be identified in the HSCRC Abstract Dataset and documented using the discharge disposition code, "discharged to CCFs." This task can only be partially accomplished. As noted in the original CON application and in the Completeness Questions**, many of the "hard-to-place" patients are never placed in nursing homes due to the lack of nursing home settings that will accommodate their requirements;** this is the very need that underlies this CON proposal.

Therefore, a significant number of hard-to-place patients will not have been coded as having been discharged to a CCF because a significant volume of cases simply remain in the hospital for extended lengths of stay. (That is one symptom of "hard to place").

In response to the information request, we can provide following data (below):

Total number of adult discharges identified by the following needs at discharge:

- Dialysis requirement
- Ventilator dependent
- Morbid obesity
- Combination of 2 or more of the conditions above

Total number of cases discharged to nursing homes vs. all other discharge locations

- **These figures do not, however, indicate how many patients required nursing home placement but were not discharged to nursing homes due to lack of options/lack of available beds**.

Average acute care length of stay for those patients discharged to nursing homes vs. average length of stay for those patients discharged to all other discharge locations

- These figures highlight the markedly long lengths of stays for those patients who *are* transferred to nursing homes. This fact provides further evidence of the delays associated

with locating suitable post-acute placements for patients with dialysis requirements, bariatric patient requirements and some combination of dialysis/vent/bariatric resource requirements.

- However, these figures mask the long lengths of stay associated with individual cases who wait for placement, linger in the hospital, and never secure a slot in an SNF. These cases are buried in the total volume of cases "discharged elsewhere."

Adult patients: Discharged with "dialysis status"
CY2018

	Discharged to SNF		Discharged Elsewhere	
	# D/C	Acute ALOS	# D/C	Acute ALOS
UMMC	36	16.1 days	804	8.7 days
UM Midtown	22	10.5 days	315	9.4 days
All other hospitals	1,280	9.4 days	13,413	5.8 days
TOTAL	1,338	9.6 days	14,532	6.1 days

Adult patients: Discharged with "vent status"
CY2018

	Discharged to SNF		Discharged Elsewhere	
	# D/C	Acute ALOS	# D/C	Acute ALOS
UMMC	11	49.2 days	123	38.4 days
UM Midtown	4	22.5 days	51	30.9 days
All other hospitals	235	16.6 days	909	22.5 days
TOTAL	250	18.1 days	1,083	24.7 days

Adult patients: Discharged with "morbid obesity"
CY2018

	Discharged to SNF		Discharged Elsewhere	
	# D/C	Acute ALOS	# D/C	Acute ALOS
UMMC	51	16.2 days	865	7.1 days
UM Midtown	6	4.5 days	192	7.6 days
All other hospitals	1,266	8.7 days	25,365	4.3 days
TOTAL	1,323	9.0 days	26,422	4.4 days

Adult patients: Discharged with 2+ of conditions identified above
CY2018

	Discharged to SNF		Discharged Elsewhere	
	# D/C	Acute ALOS	# D/C	Acute ALOS
UMMC	6	49.8 days	39	19.0 days
UM Midtown	3	15.3 days	43	23.0 days
All other hospitals	101	12.0 days	805	8.9 days
TOTAL	110	14.2 days	887	10.0 days

Source: HSCRC Abstract Dataset. Excludes deaths and discharges to hospice
Definitions
Age: Adults defined as age 18+ years

Vent status: Z9911

Dialysis status: Z992

Morbid obesity: E6601, Z6841-6844, Z68.39

B. Can the number of unnecessary hospital patient days associated with "hard-to-place" patients, specifically those identified in Exhibit S, be quantified more precisely than the "1-3 week" report of caseworkers applied to all such patients on page 54?

RESPONSE

The estimates provided by caseworkers were compiled through interviews with caseworkers and caseworkers' reviews of monthly logs in 2015 at the time the CON Application was first filed. At that time, electronic systems were not used to track this information. More recently, electronic systems have been adopted with a growing amount of detail attached. This allowed for the more detailed presentation of discharge delays associated with placement of bariatric patients (see Figure 10, page 38). Detail for other defined patient cohorts was not available.

C. What is the basis for believing that "low acuity patients such as wound care and cancer patients requiring light levels of care" are "hard-to-place patients?"

RESPONSE

This information was obtained in discussions with UMMC and UM Midtown executive staff and case managers.

D. Cohort 3 is said to represent "a new volume of patients not currently served by nursing homes." How was an average length of stay ("ALOS") of four days determined to be an appropriate assumption for this patient population? Isn't this effectively creating an "observation" service in the SNF setting?

RESPONSE

In its response, Applicant made note that this population typically, "includes Medicare patients who only require 1-2 days in acute care, and who could then be discharged to a nursing home for short stays or long stays (currently, these patients are often kept in the acute setting for the extra day or two to meet the 3-day qualifying stay)." Applicant is not suggesting an ALOS of four days, but instead pointing out that many of these patients remain in the acute care setting for 3-4 days and then qualify for a skilled nursing stay. We believe this cohort represents a lower acuity population that could be cared for more economically in the facility where daily rates can be as much as 50% less than those in acute care (See Figure 13). These lower rates will help impact total cost of care.

10. With respect to COMAR 10.24.08.05A(9), please provide more context for the MHAC "experience in the Philadelphia market" outlined on page 32.

A. Over what time period was the five-day length of stay reduction achieved? What was the length of stay prior to the reduction?

RESPONSE

Based on MAHC's bundled payment experience, it entered into a case rate contract with CIGNA, the largest Medicare Advantage plan in Philadelphia. That contract started in 2015. We compared our performance on CIGNA cases in 2014 vs 2015. These results were as follows:

MAHC Case Rate Contract Performance

	2014	2015
No. of Admissions	642	671
Avg Length of Stay	15.3	10.2
Therapy minutes per day	55 minutes	101 minutes
Therapy minutes per stay	842 minutes	1030 minutes

The case rate contract allowed MAHC to provide greater levels of care to these residents since MAHC was no longer capped by utilization measures on rehabilitation since it was paid a bundled rate. With properly aligned incentives, MAHC was able to reduce length of stay and return these residents back their homes faster.

B. Was any success achieved in reducing the rate of 30-day all cause readmission of patients discharges to skilled nursing facilities ("SNFs")?

RESPONSE

As described in Figure 17, MAHC's overall readmission rates were favorable versus state averages in both Maryland and Pennsylvania. In 2016, CIGNA and MAHC expanded the

relationship to Maryland and provided some comparative information on MAHC's performance compared to other facilities. Again in 2016, MAHC was able to maintain a reduction in length of stay and deliver better than average readmission rates.

MAHC Performance Vs CIGNA Peers
Jan – Jun 2016

MAHC Facility	Cases	ALOS	Hours of Care Per Day	30-Day Readmit Rate
York Nursing and Rehabilitation Center	71	10.5	1.78	16.9%
Cliveden Convalescent Center	62	11.0	1.91	14.5%
Care Pavilion	54	11.6	1.89	13.0%
Tucker House Nursing Home	48	11.1	1.89	18.8%
Maplewood Manor	22	10.0	1.81	9.1%
Parkhouse Providence Pointe	16	12.4	1.84	12.5%
Forest Haven Nursing Home (MD)	3	9.7	1.48	0.0%
Villa Rosa Nursing Home (MD)	1	15.0	1.41	0.0%
Fairfield Nursing Center, Inc (MD)	1	8.0	1.30	0.0%
Total MAHC	**278**	**11.0**	**1.85**	**14.8%**
Total Philly Market	**1,877**	**15.4**	**1.36**	**15.8%**

C. What is the current ALOS in SNFs of Medicare patients discharged to this level of care from UMMC and UMMC-Midtown? How does this ALOS compare with other hospitals in the Baltimore area and with other hospitals in the state?

D. What is the current 30-day all cause readmission rate of Medicare patients discharged from UMMC and UMMC-Midtown to SNFs? How does this rate compare with other hospitals in the Baltimore area and with other hospitals in the state?

RESPONSE to C and D

Staff requests data on SNF length of stay and SNF readmission rates for patients discharged from UMMC, from UM Midtown, and from other Baltimore area hospitals. This data is not readily available to the Applicant. Tracking the utilization of hospital-specific populations across sites would require use of the confidential data tapes and this requires authorization by the originating hospital. Therefore, the Applicant cannot document SNF utilization patterns for the total volume of SNF patients originating at UMMC and UM-Midtown.

E. More generally, can the applicant provide more specific information on the "up-side" potential for the proposed project? Can it be shown that positioning itself to primarily serve patients coming out of UMMC and UMMC-Midtown will align it to serve a patient population that clearly has a higher proportion of inappropriate hospital days awaiting discharge to a SNF, a higher ALOS in SNFs, and a higher rate

of readmission to the hospital than is seen in other parts of Maryland or in the state as a whole.

RESPONSE

UMMC is the largest hospital provider to the West Baltimore community, and UMMC represents one of Maryland's highest demand hospitals for post-acute placements. Therefore, it would be sound health planning to relocate the 88 underutilized CCF beds *already in Maryland's bed inventory* to the community that is:

- Demonstrating high CCF occupancy rates at its local nursing homes
- Experiencing lengthy placement delays at its local hospitals, and
- Generating a high volume of high acuity/high need patients who cannot be accommodated at most existing facilities

As described throughout the CON application, the upside potential is a reduction in acute length of stay, substitution of lower cost nursing home days for acute hospital days, and lower readmission rates. This will be accomplished by providing a more skilled staff and a better equipped nursing home facility designed to accommodate higher acuity/higher need patients, and by positioning this facility in West Baltimore. More broadly, the upside potential is a reduction in the total cost of care and improved quality care for patients who now linger in the acute care hospital for lack of discharge alternatives.

11. With respect to COMAR 10.24.08.05B(1):

A. The application states, on page 33, that "Nursing home volume for Baltimore City residents has increased" and "Available bed capacity for comprehensive care in Baltimore City has declined." However, Figure 7 on page 35, shows that the "Number of Available Beds" in Baltimore City (CCF beds) was 19% higher in FY 2016 when compared to FY 2012 and that the "Average Daily Census" of CCFs in Baltimore City in FY 2016 was 4.6% lower than the same figure for FY 2012. How can these contradictory statements be squared?

RESPONSE

Applicant noted that the number of licensed nursing home beds in Baltimore City has declined based on the reduction in bed capacity documented from Year 2014-2016 (see Figure 7, page 35). This Year 2014-2016 decline was noted because it coincided with the start of the Maryland Demonstration Model. At the same time, that pressure intensified to reduce acute care utilization, general nursing home bed capacity declined and no new program models were introduced to serve the higher acuity, higher need patient populations suitable for discharge to a lower cost nursing home setting.

B. The applicant cites "out-migration" for nursing home care from Baltimore City as a basis for finding a need for this project. However, MHCC's analysis of the nursing home data sets available to it indicate that, in 2016, over half of the state's jurisdictions experienced net out-migration of patient days (i.e., more patient days experienced by home jurisdiction residents out of the home jurisdiction than in-migrating patient days in the home jurisdiction experienced by residents of non-home jurisdictions). In some cases, the proportional amount of net out-migration relative to the size of the market was greater than that experienced by Baltimore City (Howard, Prince George's, Queen Anne's) or similar to that experienced by Baltimore City (Calvert and Worcester). In a geographically compact state and with respect to urban and suburban jurisdictions, is there a sound basis for finding a need for more bed capacity in a particular jurisdiction based on such patterns, given that the bed occupancy rates in these jurisdictions do not differ greatly and are not particularly high? Wouldn't such reasoning, if used in regulating supply, inevitably lead to excessive numbers of facilities and bed capacity in an attempt to counter patterns of patient migration?

RESPONSE

Staff challenges the need for additional beds in Baltimore City when overall occupancy rates do not appear to be particularly high relative to other jurisdictions. However, this overlooks the evidence provided in the application to show that local area nursing homes, in fact, are operating at relatively high occupancy rates (see Figure 14, page 49). It is widely recognized that the low income West Baltimore community is least able to afford transportation and is disadvantaged when it comes to public transportation. The community deserves ready access to local nursing home beds to assure that family members can easily visit loved ones who may be in the nursing home for very lengthy periods and/or end-of-life care.

Staff also suggests that approving additional beds would defeat the goal of regulating supply. This point overlooks the fact that the proposed facility intends to utilize existing beds, i.e. beds that are already in the State's inventory of CCF beds. Indeed, the proposed facility strengthens health planning efforts: The proposed plan relocates beds from a region of Baltimore City where they had not been well-utilized to a region of Baltimore City where there is documented need, provider support, community support, and high opportunity potential to reduce the costs of care.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this letter and its attachments are true and correct to the best of my knowledge, information, and belief.

George Watson, VP Corporate Development
July 23, 2019

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this letter and its attachments are true and correct to the best of my knowledge, information, and belief.

Miriam Suldan — Signature

7/23/19

Senior Managing Consultant
Berkeley Research Group, LLC — Date