Jennifer J. Coyne
Counsel
Direct Dial: 410-823-8247
jcoyne@milesstockbridge.com

February 19, 2019

VIA HAND DELIVERY AND
ELECTRONIC DELIVERY
Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Ruby.potter@maryland.gov

VIA ELECTRONIC DELIVERY ONLY
Kevin McDonald
Chief, Certificate of Need Division
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215
Kevin.mcdonald@maryland.gov

Re: Baltimore Nursing and Rehabilitation, LLC
Docket No. 15-24-2366
Certificate of Need Application – SUPPLEMENTAL MATERIALS

Dear Ms. Potter and Mr. McDonald:

Enclosed please find six hard copies of the enclosed Supplemental Materials to be considered in conjunction with the above docketed Certificate of Need ("CON") application, filed on behalf of Baltimore Nursing and Rehabilitation, LLC, for the establishment of a new comprehensive care facility in Baltimore City. The enclosed hard copies also include updated full-size drawings.

Also enclosed please find a CD containing searchable PDF files of the enclosed package and all exhibits and tables.

A copy of the enclosed materials in Microsoft Word also will be sent to you in electronic form via email contemporaneously with this delivery.

I hereby certify that a copy of the enclosed Supplemental Materials has been provided to the local health department, as required by regulations.

Sincerely,

Jennifer J. Coyne

Enclosures

cc: Mr. Michael Mahon
Mr. Paul Parker, Director
Suellen Wideman, Esquire, Assistant Attorney General
Mary Beth Haller, Interim Commissioner of Health, Baltimore City

BALTIMORE NURSING AND REHABILITATION, LLC

SUPPLEMENTAL FILING TO

DOCKETED CERTIFICATE OF NEED APPLICATION

Docket No. 15-24-2366

February 19, 2019

PREAMBLE

On April 10, 2015, almost four years ago, the Applicant originally filed this CON application to relocate 80 temporarily de-licensed comprehensive care facility beds to a new state-of-the-art post-acute facility located on Fayette Street in downtown Baltimore City (the "Project"). The Applicant timely responded to Completeness Questions on June 9, 2015. The CON application was docketed on September 24, 2015.

After docketing, no action was taken for over two years. In anticipation of the Project, the Applicant had entered into real estate contracts with the proposed site. Due to the inaction of the Commission, the lease agreement for the proposed site eventually expired. The Applicant was forced to seek another location for its facility in Baltimore City.

While the Applicant endeavored to locate a new site, several meetings and discussions were held with the Commission in an effort to preserve the proposed Project. The Commission staff then informed the Applicant that using a conventional need analysis, it did not find "need" for the Project due to the number of existing CCFs in the City. The MHCC, however, recognized the promise in the approach described in the CON, and determined that it could make a sufficient finding of need due to the unique and unusual services to be provided to the patient population. In recognition of the high level of skilled nursing care to be provided, the altogether distinct program model to be introduced, and the expectation of reducing both acute and post-acute costs of care, the Commission informed the Applicant that it would recommend approval if the Health Services Cost Review Commission (HSCRC) examined the proposal and supported the Project. The requirement for HSCRC review and approval involved a series of discussions, review, and amendment of the proposed relationship between UMMS and Mid-Atlantic, and, of course, added to the delay. After a thorough review, the HSCRC issued written approval of the Project in September of 2018.

Nevertheless, and despite satisfying all of the conditions imposed by the Commission, the Applicant's request for immediate approval of the CON again was

deferred. The Applicant had to change the specific, but not general, location of the new facility, and fortunately was able to arrange for a new location on the campus of and adjacent to the University of Maryland Midtown Hospital. The new location is perfectly suited to satisfy both the goals of the Applicant and Maryland's new Demonstration Agreement with CMS.

This CON application, therefore, is to be considered **in conjunction with the application filed in April 2015, the two sets of Responses to Completeness Questions, and the subsequent discussions with the Commission and the HSCRC.** For the convenience of the Commission staff, the Applicant has endeavored to consolidate all materials previously submitted into one package. The Applicant has included information on the new site, updated the entire Tables package, and provided updated data related to occupancy rates. It bears reminding, however, that this Application should not be subject to a new review. **It is merely responsive to a Commission request to supplement an already docketed Application. The Applicant does not expect or anticipate further delay in approval, and respectfully requests that the Commission honor its prior agreement to do so.**

For internal staff use:

MARYLAND HEALTH CARE COMMISSION

_____

MATTER/DOCKET NO.

_____

DATE DOCKETED

COMPREHENSIVE CARE FACILITY (NURSING HOME) APPLICATION FOR CERTIFICATE OF NEED

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

Required Format:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, III, and IV of the COMPREHENSIVE CARE FACILITY (NURSING HOME) application form**

- **Responses to PART IV must include responses to the standards in the State Health Plan chapter, COMAR 10.24.08*, applicable to the type of nursing home project proposed*.**
    - All Applicants must respond to the general standards, COMAR 10.24.08.05A.
    - Applicants proposing *new construction or expansion* of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed must also respond to all the standards in COMAR 10.24.08.05B.
    - Applicants only proposing *renovations within existing facility* walls using beds currently shown in the Commission's inventory as authorized to the facility must respond to all the standards in COMAR 10.24.08.05C in addition to the standards in .05A. Applicants for such renovations should not respond to the standards in .05B.
    - All Applicants must respond to the Review Criteria listed at 10.24.01.08G(3)(b) through 10.24.01.08G(3)(f) as detailed in the application form.

- **Identification of each Attachment, Exhibit, or Supplement**

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials and the applicant's responses to completeness questions in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

A pre-application conference will be scheduled by Commission Staff to cover this and other topics. Applicants are encouraged to contact Staff with any questions regarding an application.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

TABLE OF CONTENTS

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: Baltimore Nursing and Rehabilitation Center

Address:

Street	City	Zip	County
300 Armory Place and Linden Avenue	Baltimore	21201	Baltimore City

2. Name of Owner

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

For Ownership Information, please see **Exhibit A**, attached hereto.

All of the entities listed are owned by Scott Rifkin, Scott Potter, and Howard Friner.

Baltimore Nursing and Rehabilitation, LLC is the operating entity that will: 1) hold the license for the facility; 2) employ the employees of the facility; 3) provide care to the residents of the facility; 4) enter into contracts with residents, suppliers / vendors of the facilities; and 5) seek payment and reimbursement for care.

Mid-Atlantic Health Care Acquisitions, LLC is a transitional entity used by the owners for business development purposes. This entity will often enter into LOIs and contracts with third party prior to the formation of the operating and real estate holding entities that will actually own and operate the facility. This entity will then transfer the contract rights to the operating entity or the real estate holding company, as appropriate, prior to the closing of the transaction. It is anticipated this entity would transfer its rights to acquire the bed rights from Bayview to Baltimore Nursing and Rehabilitation Center, LLC prior to closing and to the Ground Lease Option Agreement to an entity with affiliated ownership.

Mid-Atlantic Health Care, LLC is a management company used by the owners to manage the financial, accounting, tax, human resources, and legal functions of the various facilities that are owned by the owners. This entity provides those services to all of the facilities owned by the owners through a Management Agreement between this entity and each operating entity.

3. APPLICANT. *If the application has a co-applicant, provide the following information in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee): Baltimore Nursing and Rehabilitation, LLC

Address:

8501 LaSalle Road	Towson	21286	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

N/A

5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation ☐
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☒	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☐	

See **Exhibit A** for an Organizational Chart showing the owners of the Applicant.

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: George Watson, VP Corporate Development

Company Name Mid-Atlantic Health Care, LLC

Mailing Address:

8501 LaSalle Road, Suite 303 Greenspring Drive, Suite 6	Towson	21286	MD	Baltimore
Street	City	Zip	State	County

Maryland

Telephone: 443-955-2543

E-mail Address (required): **gwatson@mahchealth.com**

Fax: **410-308-4999**

If company name is different than applicant briefly describe the relationship N/A

B. Additional or alternate contact:

Name and Title: Jennifer Coyne, Esq.

Company Name Miles & Stockbridge, P.C.

Mailing Address:

One West Pennsylvania Ave, Suite 900	Towson	21204	MD
Street	City	Zip	State

Telephone: 410-823-8247

E-mail Address (required): jcoyne@milesstockbridge.com

Fax: 410-823-8123

If company name is different than applicant briefly describe the relationship Legal Counsel

7. NAME OF THE OWNER OR PROPOSED OWNER OF THE REAL PROPERTY and Improvements (if different from the licensee or proposed licensee)

Legal Name of the Owner of the Real Property
Mid-Atlantic Health Care Acquisitions, LLC

Address:

8501 LaSalle Road	Towson	21093	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

If Owner is a Corporation, Partnership, or Limited Liability Company attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the in the real property and any related parent entities. Attach a chart that completely delineates this ownership structure.

For Ownership Information, please *see* **Exhibit A**, attached hereto.

8. NAME OF THE Owner of the Bed Rights (i.e., the person/entity that could sell the beds included in this application to a 3rd party):

Legal Name of the Owner of the Rights to Sell the CCF Beds

Mid-Atlantic Health Care Acquisitions, LLC

If the Legal Entity that has or will have the right to sell the CCF beds is other than the Licensee or the Owner of the Real Property Identified Above Provide the Following Information.

Address:

8501 LaSalle Road Suite 3030	Towson	21286	MD	Baltimore
Street	City	Zip	State	County

Telephone: 410-308-2300

9. If a management company or companies is or will be involved in the clinical or financial management of the facility or will provide oversight of any construction or renovations proposed as part of this APPLICATION, identify each company or individual that will provide the services and describe the services that will be provided. Identify any ownership relationship between the management company and the owner of the facility and/or the real property or any related entity.

Name of Management Company: Mid-Atlantic Health Care, LLC

Address:

Street	City	Zip	State	County
8501 LaSalle Road Suite 3030	Towson	21286	MD	Baltimore

Telephone: 410-308-2300

For Ownership Information, please see **Exhibit A,** attached hereto.

10. TYPE OF PROJECT

The following list includes all project categories that require a CON pursuant to COMAR 10.24.01.02(A). Please mark all that apply in the list below.

If approved, this CON would result in (check as many as apply):

(1)	A new health care facility built, developed, or established	☒
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☐

11. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is, why you need to do it, and what it will cost. A one-page response will suffice. Please include:

(1) Brief Description of the project – what the applicant proposes to do
(2) Rationale for the project – the need and/or business case for the proposed project
(3) Cost – the total cost of implementing the proposed project

(1) DESCRIPTION OF PROJECT.

The Project is the relocation of 80 temporarily de-licensed comprehensive care facility ("CCF") beds from Johns Hopkins Bayview Medical Center's ("JHBMC") CCF to a new CCF site. The new site will be located on the campus of the University of Maryland Medical Center – Midtown Campus ("UM Midtown"). The new facility will be managed by Mid-Atlantic Health Care, LLC ("MAHC"). The new facility will be the first state-of-the-art post-acute care facility in Baltimore City designed around the new reimbursement models operating in Maryland (Maryland's "Demonstration Model" under the Centers for Medicare and Medicaid Services ("CMS")), which rewards providers for reducing readmissions, improving quality, and reducing the overall costs of care.

The Applicant will partner with the University of Maryland Medical System ("UMMS") and UM Midtown to identify patients who may be appropriately served in the lower cost, post-acute setting in place of the higher cost acute care setting. Working with local hospitals, the Applicant will develop clinical programs to permit earlier discharge from the hospital or avoidance of the acute care stay altogether by admitting patients directly to the post-acute facility.

The proposed facility (the "Facility") is designed to be a **new model for nursing homes**, closely integrated with the hospital and equipped to operate much more broadly in the continuum of care. It will provide higher skilled staff and will be equipped to serve patients with continuing medical treatment requirements who are currently not admitted to area nursing homes. It will provide specialized equipment/customized facilities to accommodate dialysis patients, ventilator-dependent patients, and bariatrics patients; these are patients who currently linger in the hospital for extended stays due to lack of a post-acute alternative. It will provide a step-up unit for episodic treatment and monitoring. Finally, it will accommodate direct admissions for low acuity patients and deliver palliative care and symptom management for short stay admissions. This nursing home model and its complement of capabilities does not currently operate in Maryland, and as a result, has the full approval of the HSCRC (see **Exhibit B**). By elevating the clinical capabilities of the post-acute setting, incorporating more ancillary supports, and implementing medical

management protocols, this new facility will reduce reliance on the hospital setting. Its clinical capabilities and facility accommodations will permit hospitals to discharge many more patients earlier from the hospital and provide rehabilitative/restorative care in a lower cost setting, The effect will be a shift of volume from the higher cost hospital setting to the lower cost post-acute setting.

The Facility will be located at 300 Armory Place on the campus of the University of Maryland Midtown campus. A map of the location of the Facility is attached as **Exhibit C**. MAHC has signed a land option agreement with UMMS to redevelop this site. The building will be five floors and comprise approximately 103,700 square feet. It will be connected to the hospital on the second floor and include approximately 60,000 square feet of nursing home and 43,000 square feet of medical office building space for the hospital. The top floor will include a state-of-the-art rehabilitation gym, a communal dining room, and outdoor space on floors 3, 4, and 5 for residents to enjoy.

Eighty percent (80%) of the rooms (64 of 72 rooms) will be private and the remaining eight rooms will be semi-private (two beds). Each room will have its own private bathroom and temperature control. The Facility will have an upscale, "Ritz-Carlton" look and feel, comparable to the new construction at MAHC's formerly owned Restore Health Facility in Waldorf, Maryland. (Photographs of that facility are included in **Exhibit D** to provide a sense of the look and feel of the proposed facility). The Facility will provide a care setting and patient care experience not currently available in Baltimore City.

The Applicant does not request new licensed beds; the project is a new construction project.

The project will take 12-18 months to complete.

(2) RATIONALE OF PROJECT.

The Project responds directly to five (5) major needs of Baltimore City residents, Baltimore City hospitals, and the State of Maryland.

First, the proposed facility will meet a serious service gap in the West Baltimore community. Currently, there is no post-acute facility in the area that can accommodate medically complex patients and patients with requirements for continued IV care, medication monitoring and/or close monitoring for higher acuity conditions. In addition, nursing home capacity is severely limited for bariatric patients, dialysis patients, and patients with both dialysis and ventilation support requirements. As a result, these patients linger in the hospital for extended stays despite the fact that these patients no longer require an acute level of care.

Second, the proposed facility will increase access and provide more post-acute options to residents of West Baltimore. Currently, local area nursing home options are limited and are not meeting community need, as evidenced by the fact that 1,300 West Baltimore elderly sought nursing home care outside of Baltimore City.

Third, the new Facility will relocate existing licensed beds to a location that will be more responsive to unmet needs and that will leverage the relationships with the University of Maryland Medical System; the proposed site is ideally located geographically, on the same campus as UM Midtown and only 1 mile from the

UMMC/Shock Trauma campus. This will provide proximity to hospitals with some of the highest demand for post-acute placements of complex patients.

Fourth, the Project supports the goals of the Demonstration Model. Baltimore City hospitals need experienced post-acute providers committed to care management, reducing readmissions, and reducing the total costs of care. MAHC brings risk contracting experience, the data systems, and the track record to support Maryland's success under the Demonstration Model.

Finally, the Project has overwhelming community support and will create nearly 100 new jobs in Baltimore City upon its opening.

Each of these points is discussed more fully below.

1. The Facility will meet a serious service gap; no other post-acute facility in the area provides this type of care

The Applicant will be unique in the scope of clinical services and ancillary support, the staff capabilities, and the acuity levels that it is prepared to serve. This will assure patients and hospital clinicians that the transition to post-acute care will be safe and supportive of special care requirements, and will function to: (a) reduce length of stay and hospital spending; (b) reduce risks of hospital infection by discharging patients sooner; (c) minimize readmissions to the hospital; and (d) reduce the total costs of care in keeping with the goals of Maryland's Demonstration Model. The Facility will also provide the clinical rounding, the prevention activities, and the patient education to promote the self-care and family education components that strengthen successful transitions to home.

In order for the nursing home to serve this broader role, new service components must be incorporated and new facility design is required. Baltimore City's patient population is notable for the high rates of chronic disease and comorbidities, and case complexity often tied to social determinants and poor medical histories. As a result, the local community requires a nursing home setting that can deliver more services and accommodate the more complex patient. The Facility will require more space than traditional comprehensive care facilities in order to deliver continuing medical treatment in the post-acute care phase, ancillaries, rehabilitation, and dialysis/ventilator support. The facility design must also accommodate the unique requirements for bariatrics patients, accommodations which extend across patient care rooms, clinical areas, and support areas.

2. The Project will increase access/expand options to Baltimore City residents

In 2013, a total of 1,300 West Baltimore elderly residents utilized nursing homes outside Baltimore City ("outmigrated"). This data provides evidence of the limited options that were available more locally and/or limited options that were viewed by clinicians/families as suitable. Clearly, the community is seeking alternatives. The new Facility will provide a state-of-the-art, high quality program model for post–acute services. The Facility will be convenient to residents of West Baltimore and readily accessible by public transportation (*see* **Exhibit C**). Local physicians will be able to continue to follow their patients. The West Baltimore community deserves these options.

3. The new Facility will relocate existing licensed beds to an ideal location more responsive to unmet need and well-positioned to support effective care management.

The Facility is ideally located on the same campus as UM Midtown and only one mile from UMMC/Shock Trauma Center. This will provide proximity to hospitals with some of the highest demand for post-acute placements of complex patients, and hospitals that routinely experience long delays in placing patients with ongoing medical support requirements/resource requirements. The geographic proximity will promote strong clinical relationships between acute care physicians, discharge planners, social workers and nursing home staff to facilitate early discharge. Ongoing communication will promote staff development and will encourage flexibility/modifications to provide the most responsive service delivery. The proximity will also produce efficient referral processes and streamlined operations for data transfer/data exchange. This will support successful care transitions that rely on nurses, social workers and discharge planners to maintain effective communications. Finally, the new Facility is well-positioned geographically to also serve the broader Baltimore City community, as it is located only one mile from Mercy Medical Center, three miles from Bon Secours, and five miles from St. Agnes Hospital.

4.. The Project supports the goals of the Waiver and achievement of hospital performance targets, and MAHC has the relevant experience and track record to help Maryland achieve success.

Under the Demonstration Model, each hospital operates under a fixed budget and is incentivized to reduce readmissions, minimize unnecessary utilization, and control the total cost of care. Before this calendar year, hospitals were accountable only for hospital costs of care. However, with Phase II launched in January 2019, hospitals are now responsible for the total costs of care for its assigned population of Medicare patients. Through an attribution model, each Maryland hospital has been assigned a Medicare population for which it is accountable, and a portion of hospital revenue is at risk based on cost/quality performance measures for this attributed population *across the continuum of care*. This incentivizes providers to deliver the right care, at the right time, in the right setting. The State of Maryland, then, must invest in building effective post-acute networks if it is to achieve the total savings required by the waiver.

Beginning January 2019, Maryland also introduced the Episode Care Improvement Program ("ECIP") focused exclusively on the post-acute costs for defined clinical episodes. The ECIP is modeled on CMS' Bundled Payment model (BPCI Advanced), but focuses exclusively on the post-acute costs for each clinical

episode. The 90-day episode begins upon discharge from acute care, and the program incentivizes the hospital to reduce post-acute care costs. A target price is established specific to each clinical episode group selected, and the hospital can retain a portion of the savings generated. To achieve savings, hospitals are expected to build working partnerships with post-acute providers ("Care Partners"), and are then permitted to share savings with their post-acute partners. Care Partners may include SNFs, IRFs, hospice providers, home care agencies, physicians, mid-level providers and physical therapists. ECIP, then, aligns incentives and encourages acute hospitals to work closely with post-acute providers to better manage episodes of care and successfully transition patients back to home.

These dramatic changes in hospital financing and financial incentives will encourage broader and more effective use of the post-acute setting in Maryland. In this context, the Applicant's proposed facility – a state-of-the-art CCF – will function as a valuable transition setting for fragile elderly patients requiring more recuperative time, and as a lower cost setting for restorative care for patients of all ages. The Applicant expects to also serve as a short stay setting for patients transferred from the ER (following stabilization) and patients admitted directly from home, thereby avoiding the high cost hospital setting altogether. Currently, this is permissible with Medicare Advantage and commercial patients, only; going forward, the Applicant hopes that Maryland will be awarded a waiver of the 3-day rule, and the Facility will be positioned to serve direct admissions of Medicare patients as well. (*See e.g.*, CMS Guidance 2019 "SNF 3-Day Rule Waiver", attached hereto as Exhibit W, as representative of the direction in which CMS is headed.)

MAHC brings extensive experience as a post-acute provider. MAHC currently manages 21 facilities accounting for a patient census of approximately 3,200 patients per day. Its primary goal is to improve the quality of life for each resident. MAHC accomplishes this through implementation of proprietary in-house clinical programs (explained in detail herein) and use of propriety software integrated with electronic health records. MAHC has used these resources to support strong performance in the national bundled payment program (see below).

Consistent with Maryland's goals of aligning incentives across providers, MAHC will participate in a risk contract with UMMS to improve care management in the post-acute care arena. MAHC brings experience with bundled payments and a track record of success in achieving many of the same targets established by the Demonstration Model and the ECIP program.

MAHC has participated in CMS' bundled payment program through its Pennsylvania nursing homes. In Philadelphia, five MAHC facilities are participating in bundled payment contracts with Einstein Medical Center and affiliated physician practices in Pennsylvania. Together, this group of providers has contracted with CMS for management of selected DRG-defined episodes of care (e.g. orthopedic procedures) under a fixed payment for the episode of care to include hospital care, physician services nursing home care and home care. The provider group works to achieve a lower cost per episode through more effective care management, reliance on lower cost services settings, reduction in unnecessary utilization and quality of care improvements. As a participant in this initiative, MAHC has gained experience with working partnerships and effective care management strategies, and looks forward to bringing this experience to Baltimore City's health care providers.

Performance reports for MAHC demonstrate its high quality performance as measured by readmission rates of SNF patients; the figures below document a readmission rate in its Maryland facilities of 13% relative to the State of Maryland's average for nursing homes that was reported to be 23% in CY2012[2].

Figure 1
MAHC 30-Day Readmission Rate[3]
All Cause Readmission, All Payers
CY2016

Maryland facilities (12)	13%
Central Pennsylvania facilities (3)	13%
Philadelphia facilities (9)	18%

Source: MAHC

5. The Project has overwhelming community support and will create nearly 100 new jobs in Baltimore City upon its opening.

As the attached letter of support from Dr. Stephen Davis of UMMC indicates, UMMC strongly believes there is a need for the new facility. The Project also has garnered support from various other Baltimore City institutions, politicians, and individuals. The widespread support of this Project is demonstrated, in part, by the attached letters. (**Exhibit E**.)

(3) COST OF PROJECT.

The Budget for the total cost of the Project is estimated at $19.9 million. *See* **Table C** for additional information.

B. Comprehensive Project Description: The description should include details regarding:

(1) Construction, renovation, and demolition plans
(2) Changes in square footage of departments and units
(3) Physical plant or location changes
(4) Changes to affected services following completion of the project
(5) Outline the project schedule.

The Facility will be located at 300 Armory Place on the campus of the University of Maryland Midtown campus. MAHC will sign a ground lease option agreement with UMMS to redevelop the site. (See **Exhibit F**.) The building will be five floors and comprise approximately 103,700 square feet. It will be connected to the hospital on the second floor and comprise approximately 60,000 square feet of nursing home and 43,000 square feet of medical office building space for the hospital.

[2] Source: DelMarva Foundation of Maryland. "ICPC Quarterly Scorecard", 2009-2012, Appendix 2, page 141.
[3] MAHC defines its readmission rate as all MAHC residents that have an unplanned readmission to a hospital within 30 days of discharge from a hospital divided by all admissions to MAHC nursing facilities that had a hospital stay within the last 30 days prior to admission. MAHC tracks this all cause readmission rate for the total nursing home population (all payers).

Eighty percent (80%) of the rooms (64 of 72 rooms) will be private and the remaining eight rooms will be semi-private (two beds). Each room will have its own private bathroom and temperature control. The Facility will have an upscale, "Ritz-Carlton" look and feel – comparable to the new construction at MAHC's formerly owned Restore Health Facility in Waldorf, Maryland, (*see, e.g.*, Ex. D.) The Facility will provide a setting and a patient care experience not currently available at nursing homes in Baltimore City.

The Facility will be newly constructed and will include outdoor space on floors on 3, 4 and 5 for residents to enjoy. The top floor will include a state-of-the-art rehabilitation gym and communal dining room to promote interaction among the residents.

The project will take 12-18 months to complete.

12. Complete Table A of the CON Table Package for Nursing Home (CCF) Applications

TABLE A. BED CAPACITY BY FLOOR AND NURSING UNIT BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project. Applicants should add columns and recalculate formulas to address any rooms with 3 and 4 bed capacity.

Before the Project						After Project Completion				
		Based on Physical Capacity					Based on Physical Capacity			
		Room Count					Room Count			
Service Location (Floor/Wing)	Current Licensed Beds	Private	Semi-Private	Total Rooms	Physical Bed Capacity	Service Location (Floor/Wing)	Private	Semi-Private	Total Rooms	Physical Bed Capacity
COMPREHENSIVE CARE						**COMPREHENSIVE CARE**				
				0	0	Floor 3	32	4	36	40
				0	0	Floor 4	32	4	36	40
				0	0				0	0
				0	0				0	0
				0	0				0	0
SUBTOTAL Comprehensive Care						**SUBTOTAL**				**80**
ASSISTED LIVING						**ASSISTED LIVING**				
TOTAL ASSISTED LIVING						**TOTAL ASSISTED LIVING**				
Other *(Specify/add rows as needed)*				0	0	**Other** *(Specify/add rows as needed)*			0	0
TOTAL OTHER						**TOTAL OTHER**				
FACILITY TOTAL	**0**	**0**	**0**	**0**	**0**	**FACILITY TOTAL**	**0**	**0**	**0**	**80**

13. Identify any community based services that are or will be offered at the facility and explain how each one will be affected by the project.

The Facility plans to offer respite services to the citizens in West Baltimore. No other community-based services are contemplated at this time.

14. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 0.55 acres

B. Have all necessary State and local land use and environmental approvals, including zoning and site plan, for the project as proposed been obtained? YES_____ NO __✓__ (If NO, describe below the current status and timetable for receiving each of the necessary approvals.)

The land is zoned an H District or Hospital Campus District. In accordance with the Baltimore City Code, the Project is permitted. All required City permits for the Project will be applied for and prosecuted by Owner at the appropriate times consistent with the Project schedule.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: _____

(2) Options to purchase held by: Agreement of Purchase and Sale held by Mid-Atlantic Health Care Acquisitions, LLC

Please provide a copy of the purchase option as an attachment.

A copy of the purchase option agreement is attached hereto as **Exhibit F**.

(3) Land Lease held by: _____

Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: _____

Please provide a copy of the option to lease as an attachment.

(5) Other: _____

Explain and provide legal documents as an attachment.

15. PROJECT SCHEDULE

In completing this section, please note applicable performance requirements time frames set forth in Commission regulations, COMAR 10.24.01.12. Ensure that the information presented in the following table reflects information presented in Application Item 11 (Project Description).

Figure 2
Project Schedule Table

	Proposed Project Timeline	
Obligation of 51% of capital expenditure from approval date	16	Months**
Initiation of Construction within 4 months of the effective date of a binding construction contract	2	Months**
Time to Completion of Construction from date of capital obligation	14	Months**

*** Assumes Immediate Grant of CON.*

16. PROJECT DRAWINGS

Projects involving new construction and/or renovations should include scalable schematic drawings of the facility at at least a 1/16" scale. Drawings should be completely legible and include dates.

These drawings should include the following before (existing) and after (proposed), as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For projects involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. Specify dimensions and square footage of patient rooms.

See **Exhibit G**. A large scale of each drawing will be provided to the Commission.

17. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction and Renovation Square Footage worksheet in the CON Table Package (Table B)

TABLE B. PROPOSED NEW CONSTRUCTION AND RENOVATION SQUARE FOOTAGE

INSTRUCTION: Account for all existing and proposed square footage by floor. Further breakdown by nursing unit and building wing are at Applicants discretion and should be used by applicants if it adds valuable information to the description of the existing and proposed facilities. Add or delete rows if necessary.

Gross Square Footage by Floor/Nursing Unit/Wing	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Floor 1		22,600			22,600
Floor 2		23,450			23,450
Floor 3		20,140			20,140
Floor 4		20,140			20,140
Floor 5		17,370			17,370
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	0	103,700	0	0	103,700

TABLE J. CONSTRUCTION CHARACTERISTICS		
INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.		
	NEW CONSTRUCTION	**RENOVATION**
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☐
Excellent	☐	☐
Number of Stories		
*As defined by Marshall Valuation Service		
PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Average Square Feet		
Perimeter in Linear Feet	**Linear Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Total Linear Feet		
Average Linear Feet		
Wall Height (floor to eaves)	**Feet**	
Basement		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		
Freight		
Sprinklers	**Square Feet Covered**	
Wet System		
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project		
Type of Exterior Walls for proposed project		

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project and identify the provider of each utility. Specify the steps that will be necessary to obtain utilities.

The site is already served by public utilities for all essential utilities, including water, electricity, sewage and natural gas.

PART II - PROJECT BUDGET

Complete the Project Budget worksheet in the CON Table Package (Table C).

Table C is located on following page.

Note: Applicant should include a list of all assumptions and specify what is included in each budget line, as well the source of cost estimates and the manner in which all cost estimates are derived. Explain how the budgeted amount for contingencies was determined and why the amount budgeted is adequate for the project given the nature of the project and the current stage of design (i.e., schematic, working drawings, etc.)

Budget Assumptions are attached hereto as **Exhibit H**.

TABLE C. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. If the project involves services other than CCF such as assisted living explain the allocation of costs between the CCF and the other service(s). NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.d as a use of funds and on line B.8 as a source of funds

				CCF Nursing Home	Other Service Areas	Total
A.	**USE OF FUNDS**					
	1.	**CAPITAL COSTS**				
		a.	**New Construction**			
		(1)	Building	$12,424,721	$9,103,159	$21,527,880
		(2)	Fixed Equipment			$0
		(3)	Site and Infrastructure	$455,656	$333,844	$789,500
		(4)	Architect/Engineering Fees	$577,146	$422,854	$1,000,000
		(5)	Permits (Building, Utilities, Etc.)	$86,572	$63,428	$150,000
			SUBTOTAL New Construction	**$13,544,095**	**$9,923,285**	**$23,467,380**
		b.	**Renovations**			
		(1)	Building			$0
		(2)	Fixed Equipment (not included in construction)			$0
		(3)	Architect/Engineering Fees			$0
		(4)	Permits (Building, Utilities, Etc.)			$0
			SUBTOTAL Renovations	**$0**	**$0**	**$0**
		c.	**Other Capital Costs**			
		(1)	Movable Equipment	$1,909,353	$0	$1,909,353
		(2)	Contingency Allowance	$1,249,858	$915,728	$2,165,586
		(3)	Gross interest during construction period	$404,002	$295,998	$700,000
		(4)	Bed License Purchase	$500,000	$0	$500,000
			SUBTOTAL Other Capital Costs	***$4,063,213***	***$1,211,726***	**$5,274,939**
			TOTAL CURRENT CAPITAL COSTS	**$17,607,309**	**$11,135,010**	**$28,742,319**
		d.	Land Purchased/Donated	$0	$0	$0
		e.	Inflation Allowance	$288,573	$211,427	$500,000
			TOTAL CAPITAL COSTS	**$17,895,882**	**$11,346,437**	**$29,242,319**
	2.	**Financing Cost and Other Cash Requirements**				
		a.	Loan Placement Fees	$68,678	$50,318	$118,996
		b.	Bond Discount			$0
		c	CON Application Assistance			
			c1. Legal Fees	$57,715	$42,285	$100,000
			c2. Other (Specify/add rows if needed)			
		d.	Non-CON Consulting Fees			$0
			d1. Legal Fees	$86,572	$63,428	$150,000
			d2. Other (Specify/add rows if needed)			$0
		e.	Debt Service Reserve Fund			$0
		f.	Other *(Specify/add rows if needed)*			$0
			SUBTOTAL	***$212,964***	***$156,032***	**$368,996**
	3.	**Working Capital Startup Costs**		$1,750,000		$1,750,000
			TOTAL USES OF FUNDS	***$19,858,846***	***$11,502,469***	***$31,361,315***
B.	**Sources of Funds**					
	1.	**Cash**		**$3,859,695**	**$2,451,620**	$6,311,315
	2.	**Philanthropy (to date and expected)**				$0
	3.	**Authorized Bonds**				$0
	4.	**Interest Income from bond proceeds listed in #3**				$0
	5.	**Mortgage**		**$14,249,151**	**$9,050,849**	$23,300,000
	6.	**Working Capital Loans**		**$1,750,000**	**$0**	$1,750,000
	7.	**Grants or Appropriations**				
		a.	**Federal**			$0
		b.	**State**			$0
		c.	**Local**			$0
	8.	**Other *(Specify/add rows if needed)***				$0
			TOTAL SOURCES OF FUNDS	***$19,858,846***	***$11,502,469***	**$31,361,315**
Annual Lease Costs (if applicable)						
	1.	**Land**				$0
	2.	**Building**				$0
	3.	**Major Movable Equipment**				$0
	4.	**Minor Movable Equipment**				$0
	5.	**Other *(Specify/add rows if needed)***				$0

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   For ownership information, please *see* **Exhibit A**, attached hereto**.**

2. Are the applicant, owners, or the responsible persons listed in response to Part 1, questions 2, 3, 4, 7, and 9 above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   Yes. MAHC formerly owned and operated 21 skilled nursing facilities in Maryland, Pennsylvania and Delaware. MAHC and its principals now own two skilled nursing centers. Please *see* **Exhibit I**, attached hereto.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Question 2, above, been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No.

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) received inquiries in last from 10 years from any federal or state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with any state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

Mid-Atlantic of Delmar, LLC - On June 7, 2014, Mid-Atlantic of Delmar, LLC (herein "Delmar") made a submission pursuant to OIG's Self Disclosure Protocol. The OIG accepted Delmar into the Protocol on July 23, 2014. This case involved an employee who was hired as a nurse for the provision of nursing services for which payment was made under a Federal health care program from October 18, 2013 through May 30, 2014. Unbeknownst to Delmar, at the time of hiring, the employee had been listed on the OIG List of Excluded Individuals and Entities at the time of hiring. Upon discovery of the employees excluded status, the employee was immediately terminated. Delmar followed the law and self-reported the incident to the OIG. Delmar agreed to pay to OIG $92,344.60 dollars. In consideration of the obligations of Delmar, the OIG released Delmar from any claims or causes of action it had against Delmar under 42 U.S.C. §§ 1320a-7a and 1320a-7(b) (7). It should be noted, that the OIG recognized that Mid-Atlantic Health Care, LLC and it facilities had the integrity to self-report recognized reportable events. As a result, Delmar received the lowest penalty multiplier under the Civil Monetary Penalty formula. (See **Exhibit J**.)

5. Have the applicant, owners or responsible individuals listed in response to Part 1, questions 2, 3, 4, 7, and 9, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

   No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

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.

2/5/19	
Date	Signature of Owner or Board-designated Official
	VP, Corporate Development
	Position/Title
	George Watson
	Printed Name

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). The State Health Plan.

Every Comprehensive Care Facility ("CCF" -- more commonly known as a nursing home) applicant must address each applicable standard from **COMAR 10.24.08: State Health Plan for Facilities and Services -- Nursing Home and Home Health Services.**[4] Those standards follow immediately under ***10.24.08.05 Nursing Home Standards*.**

Please provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, please include the documentation as a part of the application.

10.24.08.05 Nursing Home Standards.

A. General Standards. The Commission will use the following standards for review of all nursing home projects.

(1) Bed Need. The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review.

RESPONSE:

The Applicant proposes to relocate 80 comprehensive care beds that are in the Maryland Health Care Commission's existing bed inventory to construct an 80-bed facility in West Baltimore on the campus of UM Midtown. Therefore, the Applicant is not seeking additional beds under the need methodology. The 80 beds to be used are beds that were temporarily de-licensed by the Johns Hopkins Bayview Medical Center (JHBMC) on November 15, 2013, with an extension issued by the Commission. MAHC signed a Purchase and Sale Agreement with JHBMC on September 19, 2014 to acquire these 80 beds, with the purchase contingent upon the issuance of a certificate of need to relocate the beds. (See **Exhibit K**.)

Under current regulations (COMAR 10.24.01.03C(1), a nursing home may temporarily de-license beds for up to one year by filing timely notice, and notifying the Commission at least 30

[4] [1] Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

days before the end of the time period that it will take one of the actions permitted under COMAR 10.24.01.03C(5), which includes executing a binding contract to transfer ownership of the previously licensed bed capacity, contingent on the filing within thirty (30) days of a letter of intent to apply for CON approval (or other applicable level of Commission action pursuant to COMAR 10.24.01.03 and 10.24.01.04 if required) to relocate the bed capacity.[5] To meet this timing, JHBMC requested, and was granted, a time extension to take one of the permitted actions, and within that extended time limit entered into the sales agreement with Mid-Atlantic Health Care Acquisitions, LLC, which assigned the agreement to Baltimore Nursing and Rehabilitation, LLC, which filed a letter of intent dated December 15, 2014, and again on February 6, 2015, with the Commission to construct a new CCF using the 80 beds to be purchased and relocated from JHBMC to a new site. Due to Commission delays, and through no fault of its own, MAHC was unable to retain the proposed location. The Commission has been made aware of the Applicant's concerns over the delays and the issues resulting from the Commission's delays. Since that time, a new location has been secured at 300 Armory Place, in Baltimore City.

As a result, the Applicant is not proposing an increase to the number of licensed and certified beds in Baltimore in this application. The Applicant will address the need for these beds in its response to COMAR 10.24.08.05.B(1) Bed need, herein.

Consistent with this allowance, the Applicant is not required to demonstrate need for these beds under current bed need methodology or utilization targets.

(2) Medical Assistance Participation.

(a) Except for short-stay, hospital-based skilled nursing facilities required to meet .06B of this Chapter, the Commission may approve a Certificate of Need for a nursing home only for an applicant that participates, or proposes to participate, in the Medical Assistance Program, and only if the applicant submits documentation or agrees to submit documentation of a written Memorandum of Understanding with Medicaid to maintain the proportion of Medicaid patient days required by .05A 2(b) of this Chapter.

(b) Each applicant shall agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction or region, whichever is lower, calculated as the weighted mean minus 15.5% based on the most recent Maryland Long Term Care Survey data and Medicaid Cost Reports available to the Commission as shown in the *Supplement to COMAR 10.24.08: Statistical Data Tables*, or in subsequent updates published in the *Maryland Register*.

[5] COMAR 10.24.01.03C(5)(e). The other available options include the following:
(a) Apply to relicense the temporarily de-licensed bed capacity;
(b) Submit and receive the Executive Director's approval of a specific plan for the re-licensure of the bed capacity or facility, that: (i) imposes stated time frames by which steps toward the re-licensure of the bed capacity or facility will be accomplished, or the bed capacity or facility will be deemed abandoned, and (ii) may be revised upon a proposal by the owner or operator, with the approval of the Executive Director;
(c) File a letter of intent, followed within sixty (60) days by a Certificate of Need application (or request the applicable level of Commission action pursuant to COMAR 10.24.01.03 and 10.24.01.04) for the relocation of the bed capacity or facility, or for a capital expenditure deemed necessary to relicense the temporarily de-licensed beds;
(d) Execute a binding contract to transfer ownership of the health care facility, if the requirements of COMAR 10.24.01.03.A are met; or
(f) Relinquish the bed capacity, or seek the appropriate Commission approval to de-license and permanently close the health care facility.

(c) An applicant shall agree to continue to admit Medicaid residents to maintain its required level of participation when attained and have a written policy to this effect.

(d) Prior to licensure, an applicant shall execute a written Memorandum of Understanding with the Medical Assistance Program of the Department of Health and Mental Hygiene to:

(i) Achieve or maintain the level of participation required by .05A 2(b) of this Chapter; and

(ii) Admit residents whose primary source of payment on admission is Medicaid.

(iii) An applicant may show evidence why this rule should not apply.

RESPONSE:

The Applicant agrees to serve the Medicaid patient population as required, and shall execute the required MOU with the Medical Assistance Program of the Department of Health and Mental Hygiene prior to licensure.

(3) Community-Based Services. An applicant shall demonstrate commitment to providing community-based services and to minimizing the length of stay as appropriate for each resident by:

(a) Providing information to every prospective resident about the existence of alternative community-based services, including, but not limited to, Medicaid home and community-based waiver programs and other initiatives to promote care in the most appropriate settings;

(b) Initiating discharge planning on admission; and

(c) Permitting access to the facility for all "Olmstead" efforts approved by the Department of Health and Mental Hygiene and the Department of Disabilities to provide education and outreach for residents and their families regarding home and community-based alternatives.

RESPONSE:

Consistent with its other facilities, the Applicant will provide information to all prospective residents about the existence of alternative community-based services, including but not limited to Medicaid home and community-based waiver programs, home care, medical day care, assisted living and other initiatives to promote care in the most appropriate settings. Please see **Exhibit L** for examples of such material distributed to prospective residents at other MAHC facilities.

The Applicant will initiate discharge planning on admission as part of its development of a care plan. MAHC has a strong track record of discharging residents from the nursing home to the community safely, with successful care transitions, as demonstrated by its relatively low hospital

readmission rate of 15% across its facilities[6]. Upon admission, an interdisciplinary group that includes the Director of Nursing, the medical directors, and department directors, reviews all patients demonstrating a change in status, abnormal lab values, unstable status or patient/family concerns. After discharging patients, MAHC continues to follow-up with residents after they leave the facility to ensure they are receiving the community-based services required to remain as healthy and as independent as possible.

The Applicant will permit access to all residents for the Olmstead efforts approved by the Department of Health and Mental Hygiene to provide education and outreach for residents and their families.

(4) Nonelderly Residents. An applicant shall address the needs of its nonelderly (<65 year old) residents by:

(a) Training in the psychosocial problems facing nonelderly disabled residents; and

(b) Initiating discharge planning immediately following admission with the goal of limiting each nonelderly resident's stay to 90 days or less, whenever feasible, and voluntary transfer to a more appropriate setting.

RESPONSE:

(a) MAHC serves nonelderly disabled residents at all of its facilities. All employees of MAHC facilities are required to complete 30 hours of online training each year. One of the training modules specifically focuses on age specific care. We have included the course description in **Exhibit M**.

(b) The third floor of the Facility will be designed to serve short stay patients of all adult ages. Non-elderly patients are expected to include the following patient cohorts:

- Rehabilitation patients – The proposed facility will serve patients discharged from acute care hospitals after injury, trauma, elective surgery, and similar reasons for hospitalization who require active rehabilitation programs but do not need the resources of an acute care hospital. As managed care plans, commercial insurers and ACOs are not constrained by the 3 day hospital rule, the proposed facility may admit non-elderly patients after 1-2 day stays in the hospital, or directly following outpatient surgery.

- Young adults with chronic neurologic conditions – There is a population of adults who have been treated at Mount Washington Pediatric Hospital, and who continue to need periodic treatments or "tune ups," but who have "outgrown" this pediatric facility. The proposed Facility, with its working relationship with University of Maryland faculty and its specialty capabilities, will be well positioned to serve this patient population that has grown into adulthood.

The Applicant will cluster non-elderly patients in rooms that are in close proximity and will provide staff with appropriate training; this is consistent with operations at other MAHC facilities. Discharge planning will begin immediately upon admission (for all patients) with the goal of managing stays to less than 90 days.

[6] MAHC defines its readmission rate as the number of MAHC residents who have an unplanned readmission to a hospital within 30 days of discharge from a hospital divided by all patient admissions to MAHC nursing facilities that had a hospital stay within the last 30 days prior to nursing home admission (all payers).

(5) Appropriate Living Environment. An applicant shall provide to each resident an appropriate living environment, including, but not limited to:

(a) In a **new construction** project:

(i) Develop rooms with no more than two beds for each patient room;

(ii) Provide individual temperature controls for each patient room; and

(iii) Assure that no more than two residents share a toilet.

(b) In a **renovation** project:

(i) Reduce the number of patient rooms with more than two residents per room;

(ii) Provide individual temperature controls in renovated rooms; and

(iii) Reduce the number of patient rooms where more than two residents share a toilet.

(c) An applicant may show evidence as to why this standard should not be applied to the applicant.

RESPONSE:

Eighty-nine percent (89%) of the rooms (64 of 72 rooms) in the Facility will be private and the remaining eight rooms will be semi-private (two beds). Each room will have its own private bathroom and temperature control.

(6) Public Water. Unless otherwise approved by the Commission and the Office of Health Care Quality in accordance with COMAR 10.07.02.26, an applicant for a nursing home shall demonstrate that its facility is, or will be, served by a public water system.

RESPONSE:

The location of the facility is within Baltimore City limits and is served by public water and sewer systems.

(7) Facility and Unit Design. An applicant must identify the special care needs of the resident population it serves or intends to serve and demonstrate that its proposed facility and unit design features will best meet the needs of that population. This includes, but is not limited to:

(a) Identification of the types of residents it proposes to serve and their diagnostic groups;

(b) Citation from the long term care literature, if available, on what types of design features have been shown to best serve those types of residents;

(c) An applicant may show evidence as to how its proposed model, which is not otherwise documented in the literature, will best serve the needs of the proposed resident population.

RESPONSE:

(a) The Applicant intends to serve three patient populations, defined below:

Cohort 1 represents patients whom nursing homes traditionally serve, but for whom demand is growing and/or supply is constrained. This cohort includes hard-to-place patients who routinely experience extensive delays until placement can be arranged. These hard-to-place patients include:

- Patients requiring dialysis;
- Patients requiring ventilation care and dialysis;
- Bariatric patients who require special staffing and/or equipment accommodations; and
- Low acuity patients such as wound care and cancer patients requiring light levels of care.

Currently, a very limited number of nursing homes accommodate these patients and oftentimes staffing limitations or physical capacity restrict the number of patients who can be accommodated at any one time. Under the Demonstration Model, the demand for post-acute placements will increase and population growth will drive further demand.

Cohort 2 represents higher acuity patients, patients who require nursing staff with a special skills set, or patients who require continued medical services or ancillary support. Cohort 2 can be divided into two types. Cohort (2a) includes patients who could be discharged from the hospital to the post-acute setting earlier if nursing home staff possessed an upgraded skill set, if protocols and specialty supports were strengthened, and/or if the facility could provide a step-up unit. The proposed facility will have these elements in place. Cohort (2b) includes patients who currently remain in the hospital for their full episode of care and are never even referred to the nursing home for lack of a suitable post-acute setting; these patients experience extended stays in the hospital to receive medical treatment/monitoring before they can be discharged home.

Cohort 3 represents the population of Medicare patients who could be served in the post-acute setting if the 3-day rule is waived. This Cohort represents a new volume of patients not currently served by nursing homes. It includes Medicare patients who only require 1-2 days in acute care, and who could then be discharged to a nursing home (currently, these patients may be kept in the acute setting for the extra day or two to meet the 3-day qualifying stay). This cohort also includes Medicare patients with low acuity medical need, patients admitted for pain management and palliative care, and patients who are admitted to acute care in a deconditioned state, requiring some level of rehabilitation services; many of these patients could be well-served in the post-acute setting.

Cohort 3 also includes patients who might be admitted directly from the Emergency Room or the Observation Unit if the 3-day qualifying rule is waived. (See **Exhibit W**.) This represents new volume to the nursing home, and may translate into a reduction in Observation hours and/or short stays at the hospital. This plan of care will reduce the infection risks associated with hospital stays, reduce the costs of care, and reduce the high copayments now borne by patients served in the Observation Unit.

(b) In the proposed Facility, 89% (64 of the 72 rooms) of the patient rooms will be private. The advantages of private rooms are well recognized, but the application includes an article as **Exhibit N** which discusses the psychological and clinical advantages to private rooms. The article cites the positive resident experience, discusses the psychological issues associated with privacy and highlights several studies that document lower rates of infection associated with private rooms. The article also mentions greater family satisfaction and privacy when visiting their loved ones in facilities with private rooms which helps families of both long and short stay

patients. Finally, the article also suggests that greater privacy enables better adherence to HIPAA regulations.

(c) The Facility's design is oriented toward treating both short stay patients (who might otherwise be served in a hospital) and more traditional comprehensive care residents. This facility will have a strong emphasis on rehabilitation and creating a restorative environment, which we believe is unique for Baltimore City facilities; its design will create a hotel-like look and feel as opposed to a typical, more institutional, nursing home environment. MAHC's facility in Charles County (BN&R Facility, opened in March 2015) provides an illustration of the proposed Facility in West Baltimore. This application includes photographs of this Charles County facility to provide a sense of the "look and feel" for the proposed Facility (*see* Ex. D).

As described above, the building is designed to serve both short-term rehabilitation patients as well as long-term residents. From a regulatory standpoint, the facility's rooms are designed to provide at least double the square footage required by COMAR for a private or semi-private room. According to COMAR 10.07.02, a private room must be at least 100 square feet per bed and a semi-private room must be at least 80 square feet per bed. The average private room in the proposed facility is 258 square feet which is almost 2.5 times the required size. The average semi-private room in the facility is 373 square feet which is over 2x the requirement.

Larger room size enables the facility to serve specific patient populations with distinct resource/service requirements. For example, bariatric patients require larger beds. Specifically, MAHC uses Invacare BAR750 beds which measure 48 in x 88 in versus MAHC's normal Invacare Carroll CS Series CS7 bed which measures 36 in x 80 in. The footprint of a bariatric bed therefore requires as much as 10 square feet of additional floor space. Rooms designated for bariatric residents also require larger bathrooms and space for additional equipment to be rolled in including lifts to aid the care staff to remove the resident from his/her bed. In addition, these rooms will include wider, double doors to allow easier access. Other patient populations will enjoy similar benefits, such as ventilator and dialysis patients who require bulky medical equipment by the bedside for their care.

The Facility will also be designed to promote a "neighborhood model" as described in **Exhibit O**. Neighborhood models attempt to create a more home-like setting and promote greater interaction among residents and increased patient satisfaction. Each of the top two floors has 24 rooms, creating its own neighborhood that includes a central activity/dining space and a café style dining area. MAHC used this design feature at its Waldorf facility, pictures of which were included in the original application. Food preparation is done around a central kitchen, with food then delivered to the cafes where it is served individually to each resident from hot warming stations. At the Waldorf facility, feedback has been very positive from residents who enjoy seeing their options and picking and choosing their own meals. Again, these features enhance the experience for both short stay and long term care residents of the facility.

The building's layout includes a shared entry for the facility and the medical office space, and a dedicated service entrance for the nursing facility. It is designed with green spaces, including terraces or balconies, on each floor so the residents can enjoy fresh air and the views afforded by the facility. Other elements of "green" design features and energy efficient mechanical systems are being evaluated.

The Applicant is prepared to equip the facility with the specialized equipment for dialysis (potentially at the bedside) and also a ventilation unit. Final determination on the design of patient care areas will be based on discussions with hospital partners. In addition, rooms will be designed to accommodate bariatric patients with oversized doors and specialized equipment

including specialized bariatric beds/mattresses and lift equipment to handle residents safely in a respectful manner.

Consistent with the design of facilities that MAHC has operated in the past, particular attention has been paid to resident safety. The Facility will be equipped with a WanderGuard monitoring system; a resident who might wander will not be able to leave the building without setting off an alarm. The Facility will be designed with additional safety features including:

- **Proximity of staff to residents**
  The nursing stations (one per floor) are located central to all the rooms in the facility so that nurses and other staff can see all the resident rooms from each station. The activity and dining areas are also located opposite the nursing stations so that nurses can observe residents while residents are in these locations.

- **Standardization**
  While the rooms may be slightly different in shape, each room will be equipped with common equipment.

- **Automation and Technology**
  MAHC is dedicated to using technology to help nurses and other care staff operate productively and proactively. The Applicant will include a wireless infrastructure in the Facility to enable the use of an electronic medical record system allowing nurses to obtain information efficiently at the point of care. Furthermore, the EMR will interface with Real Time Medical Systems, which is a data mining tool used in conjunction with the EMR to identify at-risk patents and alert nurses to the need for intervention **before** a resident may have an adverse event. These technologies promote greater accuracy, efficiency and improved quality of care.

- **Noise Reduction**
  The materials in the facility will be designed to reduce noise as much as possible to create a safer, more restful and enjoyable resident experience.

- **Resident Involvement in Care**
  Consistent with MAHC's philosophy, the proposed Facility will promote resident and family involvement in care whenever possible. The Facility is readily accessible to public transportation and is located directly next door to a large public parking garage with an exit just a few steps away from the entrance; this will facilitate and encourage family members and friends to visit their loved one easily and safely. The Facility will hold routine care planning meetings with resident and/or family participation. It will also create a resident council to solicit feedback from residents.

- **Precarious Events**
  The entire facility will be equipped with sprinklers, and staff will be trained to react quickly and safely to potential precarious events.

***(8) Disclosure*.** An applicant shall disclose whether any of its principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility.

RESPONSE:

None.

(9) Collaborative Relationships. An applicant shall demonstrate that it has established collaborative relationships with other types of long term care providers to assure that each resident has access to the entire long term care continuum.

RESPONSE:

*Protocol development with clini*cians - The Applicant has begun to establish collaborative relationships with local providers. As illustrated by the letter from Dr. Stephen Davis, Dr. Scott Rifkin, CEO of MAHC, is actively engaged with the Department of Medicine in the School of Medicine at UMMS (*see* **Exhibit P**) to develop clinical pathways that will advance patient progress, promote new research opportunities, and evaluate optimal care plans. Once the facility is open, MAHC expects to collaborate with the Local Area Office on Aging and other community-based providers, as detailed in Figure 3 below.

Figure 3
Anticipated Collaborative Partners

Assisted Living

ABC Assisted Living 1
All About Love II
All together Network, INC
Almost Like Home
Ambrozean Assisted Living Care Center
Angel's Cove Assisted Living
Betty's and Debbie's Family Place I
Caritas House Assisted Living
Chelsea Manor
Dorchester House
Esther's Place at Montebello
Esther's Place at Pinewood
Esther's Place at Strathmore
Esther's Place at the Park
Evergreen Valley Assisted Living
Harry & Jeanette Weinberg Park
Hawkin's Christian Care Home
Heavenly Grace Assisted Living #2
JL Care Enterprises, Inc.
Keswick Memory Care
Lamplight Inn of Baltimore
Peregrine's Landing At Tudor Heights
Roland Park Place
Rosemarie Manor II, LLC
Rosemarie Manor, LLC - Ashburton
Rosies Assisted Living
Scotland Manor
Serenity Garden Manor
Serenity Manor
Specialized Home Care
Springwell Senior Living
St. John's Community
Sterling Hospitality
Symphony Manor Premier Assisted Living and Memory
Victorian Inn, Inc.

Adult Day Care

A Caring Hand Medical MADC
Adult Medical Day Care of Overlea
Caring Hands ADC of Dundalk
Extended Family Adult Day Care
Golden Doves Senior Medical Day Ctr.
Golden Pond Adult Day Program, Inc.
Happy Days Health Care Center
Keswick Multi-Care Center
Levels Medical Adult Day Care
Levindale Adult Day Services
LIFE Adult Medical Day Care Services
Maryland Avenue Medical Day Care Center
Paradise Adult Medical Day Care Center
Phoenix Adult Medical Center
Providence Medical Adult Day Care, Inc.
Rainbow of Milbrook, LLC
Ravens Medical Adult Day Care
St. Ann Adult Day Services
The League for People with Disabilities
Today's Care and Family
Today's' Care & Family - Harford

Home Health

Amedisys Home Health of Baltimore
Amedisys Home Health of Maryland
Amedisys Home Health of Westminster
Amedisys Home Health, Greater Chesapeake
Bayada Nurses
Community Home Health of Maryland
Comprehensive Home Health Services
Gentiva Health Services
Home Health Connection, Inc.
HomeCall - Baltimore City
HomeCare Maryland, LLC
Johns Hopkins Home Health Services
Johns Hopkins Pediatrics at Home
MedStar Health VNA - Baltimore
MedStar Health VNA - Calverton
P-B Health Home Care Agency, Inc.
Personal Touch Home Care Baltimore
PHR of Baltimore
Stella Maris, Inc.
Visiting Nurse Association of Maryland, LLC

Hospice

Amedisys Hospice of Greater Chesapeake
Community Hospice of MD
Gilchrist Hospice
Heartland Hospice-Baltimore
Joseph Richey Hospice
Professional Healthcare Resources of Baltimore Hospice (PHR Hospice)
Seasons Hospice
Stella Maris Inc.

Care management and contract with UMMS – This new Facility, along with MAHC's track record of quality service delivery will be a huge asset to Baltimore City hospitals as Phase II of the Demonstration Model advances. Success under this model will depend on cost effective service delivery, care integration, and a focus on managing episodes of care that extend to the post-acute setting. The new Facility is ideal for shifting care from higher cost hospital settings to a lower cost setting. Working with the UMMS, MAHC expects to generate synergistic opportunities resulting in improved patient outcomes, reductions in avoidable and unnecessary hospital utilization, and savings to Medicare on the post-acute side. A proposal has been submitted to the MHCC outlining the proposed Risk Construct for the Management of Medicare FFS Total Cost of Care in Partnership with Mid-Atlantic Health Care by the University of Maryland Medical Center and the UMMC Midtown Campus (**Exhibit Q**). MAHC expects to reduce post-acute length of stay, reduce readmissions rate, and generate further savings to Medicare.

MHAC's prior experience in the Philadelphia market has provided the basis for projections. In this market, MHAC operated under case rate contracts for its facilities in Philadelphia with a Medicare Advantage plan. Under this contract, MAHC achieved a 5-day LOS reduction with no accompanying increase in 30-day all-cause readmission rates. Effectively, MAHC was able to increase therapy minutes per day as well as therapy days per week for its skilled nursing admits, allowing patients to return home sooner, at a lower cost to Medicare Advantage, and with no increase in adverse health outcomes.

Based on the close relationship to be established with UMMC and UMMC Midtown, MAHC expects that it will be able to achieve similar reductions in average length of stay ("ALOS") as compared with the ALOS of patients currently discharged to SNFs from these two hospitals. A 5-day reduction in the ALOS for MAHC's Part A admissions would produce a $1.7 million savings in Medicare spending as compared with the status quo. Further, MAHC believes this to be a conservative estimate, given the extensive opportunities for care coordination and innovative care delivery models with UMMS.

Figure 4
Projected Savings Tied to Effective Post-Acute Management
Savings Tied to Shorter Post-Acute Length of Stay

	TCOC Estimate
Part A admissions per Month	52
Months	12
Admissions per Year	624
Projected ALOS reduction in post-acute setting	5
Estimated Annual Days	3,120
MAHC estimated per diem	$534
TCOC Savings	**$1,666,080**

Readmission reduction - MAHC has also included a letter of support from the University of Maryland Medical Center Midtown Campus (UMMC Midtown) (**Exhibit E**). MAHC and UMMC

Midtown are assessing how to improve care coordination for patients discharged from the hospital and how to minimize ER visits and readmissions.

Discharge planning: Hospitals, community-based agencies, community providers - MAHC will coordinate closely with discharge planners and social workers at both hospitals to develop tools that will assist in care coordination.

B. **New Construction or Expansion of Beds or Services.** The Commission will review proposals involving new construction or expansion of comprehensive care facility beds, including replacement of an existing facility or existing beds, if new outside walls are proposed, using the following standards in addition to .05A(1)-(9):

(1) **Bed Need.**

(a) An applicant for a facility involving **new construction** or expansion of beds or services, using beds currently in the Commission's inventory, must address in detail the need for the beds to be developed in the proposed project by submitting data including, but not limited to: demographic changes in the target population; utilization trends for the past five years and expected changes in the next five years; and demonstrated unmet needs of the target population.

The section below provides evidence to demonstrate the need for a new nursing home in Baltimore City, describes the unmet needs of the target population, and identifies the expected changes in the next five years that will further increase the demand for post-acute care.

The need for new construction is based upon the assessments that were prepared in 2015 for the original CON application; these original analyses are re-presented here and supplemented with more recent occupancy rates for Baltimore City facilities.

A. Demographic projections and utilization patterns support the need for additional capacity to serve the West Baltimore community

The need for construction of a new nursing home is supported by the following: 1) The elderly population in Baltimore City is growing; 2) Nursing home volume for Baltimore City residents has increased; 3) Available bed capacity for comprehensive care in Baltimore City has declined, and the overall occupancy rate at Baltimore City nursing homes is 90%; and 4) A total of 1,300 elderly residents of West Baltimore sought nursing home care outside of Baltimore City, a strong indication of the need for more local area alternatives.

1) ***The elderly population in Baltimore City is growing.***

While the total population in Baltimore City is projected to remain relatively flat, the elderly population is projected to grow, resulting in an 8% increase in the elderly population between the years 2013-2020, and a 17% increase by the Year 2025.

Figure 5
Baltimore City Population
Historical and Projected, 2009-2025

	Actual					Projected	
Baltimore City	**2009**	**2010**	**2011**	**2012**	**2013**	**2020**	**2025**
0-64 Years	547,853	548,394	548,401	548,709	546,682	552,808	555,416
65-74 Years	38,442	38,590	38,781	40,442	42,155	49,379	53,257
75-84 Years	24,206	23,821	23,330	22,679	22,571	22,194	25,963
85+ Years	10,008	10,405	10,475	10,587	10,696	9,711	9,362
TOTAL	620,509	621,210	620,987	622,417	622,104	634,092	643,998
65+ Years	72,656	72,816	72,586	73,708	75,422	81,284	88,582
Annual % Change	**2009**	**2010**	**2011**	**2012**	**2013**	**2020**	**2025**
0-64 Years	-	0.10%	0.00%	0.06%	-0.37%	0.16%	0.09%
65-74 Years	-	0.38%	0.49%	4.28%	4.24%	2.29%	1.52%
75-84 Years	-	-1.59%	-2.06%	-2.79%	-0.48%	-0.24%	3.19%
85+ Years	-	3.97%	0.67%	1.07%	1.03%	-1.37%	-0.73%
TOTAL	-	0.11%	-0.04%	0.23%	-0.05%	0.27%	0.31%
65+ Years, Annual Change	-	0.22%	-0.32%	1.55%	2.33%	1.08%	1.73%
65+ Years, Change 2013-2020						**7.8%**	
65+ Years, Change 2013-2025							**17.4%**

Source: Maryland Department of Planning

2) Between 2009-2013, nursing home volume for Baltimore City residents increased by 14%, as documented below.

Figure 6
Baltimore City Residents - Utilization of Comprehensive Care
2009-2013*

	2009	**2010**	**2011**	**2012**	**2013**
# Discharges, Age 0-65	2,579	2,720	2,781	3,049	3,042
# Discharges, Age 65+	6,045	6,061	6,377	6,751	6,795
# Discharges, All Ages	**8,624**	**8,781**	**9,158**	**9,800**	**9,837**
% Annual	-	1.8%	4.3%	7.0%	0.4%
% Change, 2009-2013					14.1 %

Source: Long Term Care Minimum Data Set
*More recent data was not available through the MHCC to isolate Baltimore City residents

3) Available beds for comprehensive care in Baltimore City nursing homes has since declined, and the overall occupancy rate for Baltimore City facilities is 90% (2016).

The data below documents the 5-year utilization trend at Baltimore City nursing homes to highlight the overall occupancy rate for Baltimore nursing homes at 90.3%. This is an increase over the occupancy rate documented in the original CON application.

While average daily census has declined, the 90% occupancy rate has been maintained and may present barriers to placement going forward. The growth of the elderly population and the financial incentives to shorten hospital stays will intensify the demand for nursing home beds, and this occupancy rate may pose access barriers for patients seeking placement close to home.

Figure 7
Comprehensive Care Facilities in Baltimore City
Bed Capacity and Utilization Trends
FY2012 - 2016

	FY2012	FY2013	FY2014	FY2015	FY2016
Number of Available Beds*	3,061	3,850	3,738	3,744	3,643
Average Daily Census	3,449	3,400	3,398	3,394	3,291
Occupancy Rate	86.3%	87.8%	91.2%	90.5%	90.3%

Source: MHCC Public Use Files
Data provided directly by MHCC staff (February 2019)
*The number of available beds represents the average of the number of beds at the start of year and the number at the end of the year.

4) A total of 1,300 elderly residents from West Baltimore were admitted to out of area nursing homes; West Baltimore residents deserve more local area options.

A total of 1,300 elderly residents from West Baltimore were admitted to nursing homes outside of Baltimore City; this represents 40% of all nursing home admissions for West Baltimore residents. These figures present a strong indication of the need for more local area alternatives.

The figures below document the large numbers of elderly patients from each region of Baltimore City who “outmigrated,” I.e. sought nursing home care outside Baltimore City. This volume likely includes (a) patients who could not be served at Baltimore City nursing homes because of acuity level or distinct service requirements (“unmet need”), (b) patients who could not be accommodated at a Baltimore City nursing home because beds were unavailable (high occupancy rates), and/or (c) patients who did not find nursing home options in the area to be suitable/appealing. Dependence on out of area nursing homes imposes travel time, costs, and added hardship for family members/friends who want to visit loved ones. In addition, patients may be sacrificing continuity of care with their local physician/care manager when they are admitted to a distant facility.

Figure 8
Outmigration: Utilization Patterns of Baltimore City Elderly Patients
Number of Nursing Home Placements at Facilities Inside and Outside Baltimore City
Patients Age 65+ Years Old
CY2013

	Number of nursing home discharges at facilities in:		
Patient Residence	**Baltimore City**	**Outside Baltimore City**	**Total Nursing Home Discharges**
West Baltimore	1,679	1,300	2,979
East Baltimore	1,135	649	1,784
North Baltimore	1,124	908	2,032
Total Baltimore City residents, Age 65+ Discharged from nursing homes	3,938	2,857	6,795
Distribution of placements across Maryland facilities	58%	42%	100%

Source: Long Term Care Minimum Data Set
Summary data obtained through the Maryland Health Care Commission (April 2015)

5) The growth of Medicare volume at UMMC and its tertiary/quaternary programs, combined with shorter lengths of stay, is increasing the need for higher skilled, well-resourced post-acute settings in Baltimore City for medically complex patients.

Under the GBR model, UMMC experienced a decline in avoidable utilization, but significant growth in overall medical /surgical volume between FY2017-2018. The overall growth in **Medicare discharges** at UMMC is presented below to highlight the volume growth at this "partner hospital." With the growth of UMMC's tertiary/quaternary programs, the volume at UMMC is likely to further increase, increasing the demand for post-acute care by the medically complex patient population. This would include patients admitted for cardiac surgery, transplants, lung disease, and complex neurologic conditions.

Figure 9
Medicare Discharges at UMMC – Medical / Surgical Only
FY 2017-2018

	Medicare Discharges	
	FY2017	FY2018
University Hospital	7,275	7,784
Shock Trauma Center	1,439	1,432
Total, UMMC	8,714	9,216
% Change, Year-to-Year		*5.8%*

Source: HSCRC Abstract Dataset
Excludes Obstetrics, Pediatrics, Psych, Acute Rehab

As noted, the incentives under GBR drive shorter acute care stays, increasing the demand for post-acute placements from UMMC. UMMC clinicians are committed to the care management protocols that have been developed to reduce length of stay, but this requires post-acute settings with the necessary resources/capabilities to accommodate medically complex patients from UMMC. These post-acute settings continue to be lacking; there are no facilities in West Baltimore that provide the higher level of care that these patients demand.

B. Unmet need: While there is some limited nursing home capacity, area nursing homes are not equipped to meet this unmet need; these patients are generally not admitted by nursing homes, and instead linger in the hospital.

At UMMC, more than 60% of avoidable acute care days are attributed to discharge delays, and a significant percentage of these delays are tied to bed availability at an appropriate post-acute setting. Work sessions with social workers and discharge planners at both UMMC and at UM Midtown were conducted to review caseloads, identify barriers to placement, define patient care requirements and estimate potential volume for the proposed Facility. These work sessions and the data provided served as the basis for defining and estimating "unmet need."

Caseworkers identified some of the longest waits for nursing home beds to be associated with dialysis patients, vent patients and bariatrics patients; caseworkers documented the dramatically long delays in arranging post-acute placement for these patient populations. In addition, this group of professionals reported that there are no nursing homes in Baltimore City that will accept patients with continuing needs for IV care, close medical monitoring and/or specialty cardiac capabilities.

Unmet need is described more fully below, along with evidence of long hospital stays tied to delays in finding an available bed. The greatest unmet needs cited by UMMC and UM Midtown were defined as follows:

Unmet need: Bariatric patients

- There is a severe shortage of nursing home capacity to serve bariatric patients relative to the demand for beds. Few nursing homes are resourced with the facilities, the equipment and the extra staffing required to accommodate the needs of this population. Even those facilities that do accept bariatric patients typically limit the number of bariatric patients who can be accepted at any given time given the demand placed on nursing home staff. As a result, discharge delays for these patients are lengthy, with extended stays in the hospital that can last months until post-acute placement can be arranged The large majority of placements were preceded by a 1-4 week delay in discharge (i.e. 4 weeks of unnecessary hospital days).
    - It is critical to emphasize that **the demand for care is not fully reflected in CCF bed utilization reports because few nursing homes are serving these patients**. Therefore, while occupancy rates at area nursing homes might suggest that there is available capacity, most nursing homes are not equipped to accommodate this patient population.
- A two-day "snapshot" (two sample days) at UMMC Midtown confirmed that 1-3 bariatric patients were in-house awaiting placement on each day sampled. All 3 of these patients had been awaiting placement for > 4 months.
- A more recent report of FY2018 experience provided by UMMC is presented below to validate that this placement barrier continues to be significant for UMMC patients. The figures below document the number of unnecessary hospital days per bariatric patient

awaiting placement; this list represents just a sample of post-acute placements from UMMC.

Figure 10
Bariatric Patients at UMMC Awaiting Post-Acute Placement

Length of Stay and Avoidable Days
FY2018-2019 YTD (approx. 17 months)

Total Acute Care Stay (in days)	# Avoidable Days at UMMC
218	190
159	79
86	19
86	84
18	4
71	64
57	41 +*
34	Died
16	TBD
13	TBD

Total = 10 patients, Total, with complete data = 6 patients
Average # avoidable days per patient placed = 73 days

* Patient continues to be served at UMMC, acute care
Source: UMMC Department of Care Management (December 2018)

Unmet Need: Dialysis care and ventilator management / dialysis and tracheostomy care

- Only a limited number of facilities in Baltimore City accept patients who require dialysis, and oftentimes these facilities are operating "at capacity" and cannot accept additional dialysis patients. Only limited capacity for these patients exists at nursing homes in neighboring counties; sometimes, capacity is "capped" by the maximum number of patients who can fit in the transport vehicle to outpatient dialysis centers. UMMC typically discharges these patients to the chronic unit at UM Midtown for continuing care. At UM Midtown, caseworkers report that there are typically dialysis patients waiting for discharge from both the chronic unit and the acute units of the hospital.
- The result is that dialysis patients ready for discharge remain in the acute hospital awaiting placement. Therefore, the documented number of nursing home days understates the demand for CCF beds. Case managers at UMMC and UM Midtown indicate there can be 2-3 dialysis patients in the hospital at any one time who are awaiting placement. Case managers at UMMC note that capacity is even more limited for patients on ventilators and dialysis. The proposed facility will meet the needs of these patients in-house and will not have to transport patients for dialysis.

Unmet need: Staffing level and ancillary support for IV care and other ongoing treatment requirements

- Caseworkers consistently noted that while some patients may eventually make their way to nursing homes, many more could be discharged to nursing homes earlier if the receiving nursing home were equipped to manage:
    - NG tubes
    - TPN requirements
    - IV antibiotics
    - IV drips of heart medications for patients with heart failure
    - Treatment for low magnesium level
    - Continuous fluid exchange (requirement for wall suction)
    - Daily transport for radiation therapy
    - Close monitoring and daily lab results reporting for post-transplant patients

Unmet need: Medical monitoring after an acute cardiac episode

- Reportedly, clinicians are often uneasy about discharging cardiac patients to nursing homes due to concerns about the level of attention and monitoring that is provided. The result is that length of stay in the acute care hospital is extended when, in fact, a lower acuity/lower cost setting could meet the patient's needs. These patient days are not reflected in nursing home days reported for Baltimore City facilities because these patients are generally not served in nursing homes.

Unmet need: Patients with Left Ventricular Assisted Device (LVAD)

- Rehabilitation care for these patients is generally not provided in nursing homes because of the special equipment and skill set required to monitor these patients. While this cohort represents a relatively small number of patients, this volume is expected to grow with an accompanying increase in CCF patient days. Currently this demand for CCF beds is not fully reflected in the CCF bed days documented because these patients are served in the hospital.

Unmet need: Rigorous rehabilitation early on in the recovery process

- Because patients cannot be discharged to a nursing home while still on IVs/fluid exchange/TPN (see above), patients are delayed in being transferred to specialized rehabilitation programs. While acute hospitals do provide rehabilitation services, hospitals typically provide more limited rehabilitation programs. As a result, patient progress can be delayed. In contrast, the proposed facility will initiate a rigorous rehabilitation program more immediately to patients recovering from injury or illness while accommodating IV care, tube feeding, and other medical monitoring requirements, as needed.

The proposed Facility will meet these unmet needs. MAHC's facilities across the country have been designed and resourced with the staffing training, the staffing models, the physical space, the step-up units, and the medical management protocols to serve all of the patient populations identified above. This will translate into a reduction in acute care days and an increase in nursing home utilization, as the facility meets a need that is not currently served by area nursing homes.

C. Available capacity at area nursing homes cannot meet this unmet need.

It must be emphasized that historical utilization trends at area nursing homes do not reflect

the true demand for post-acute care because nursing homes have not been serving these patients for the most part. The "unmet need" is, by definition, not reflected in patient days and occupancy statistics because nursing homes generally have not admitted these patients; these patients are typically served in hospitals because area nursing homes are not resourced to admit these patients. Therefore, the fact that CCF occupancy statistics show available beds is not an indicator of bed capacity. Stated simply, the mere fact that there is licensed bed capacity available ("surplus beds") does not mean that patient care needs can be met. In fact, the evidence of long placement delays and patients lingering in hospitals testifies to the fact the "surplus beds" cannot be counted on to meet the needs defined above.

D. West Baltimore, in particular, requires post-acute support to meet readmission targets.

The State of Maryland requires post-acute providers who will help reduce Maryland's readmission rate. Clinicians in Baltimore City – striving toward more effective care management – should be supported with a progressive, state of the art nursing home in close proximity to the hospital.

Several local area nursing homes show higher than average readmission rates; West Baltimore needs a post-acute provider that will work aggressively to lower readmission rates of SNF patients and support success under readmission targets.

A recent report published by CMS documents Year 2017 standardized readmission rates for nursing homes across the country under the Value Based Program. This report documents Maryland's overall readmission rate to be **18.7%.** However, three of the six[7] nursing homes in the West Baltimore vicinity document rates above the Maryland average. This fact is an indicator of the need for stronger medical management in West Baltimore nursing homes.

Figure 11
Risk Standardized Readmission Rate: Medicare
CY2017

Facilities	Risk Standardized Readmission %
FutureCare Canton Harbor	17.7%
FutureCare Homewood	18.0%
Fayette Health & Rehab	18.1%
State of MD: All SNFs	**18.7%**
Maryland Baptist	**19.0%**
FutureCare Charles Village	**19.2%**
FutureCare Sandtown Winchester	**20.6%**

Source: CMS website, Value Based Purchasing, Medicare Program
https://data.medicare.gov/Nursing-Home-Compare/SNF-VBP-Facility-Level-Dataset/284v-j9fz/data

[7] No information was reported for Crawford Retreat.

E. Payment reform, anticipated policy changes, and market dynamics will increase utilization of the facility.

A number of market dynamics and policy changes will fuel higher utilization rates going forward. These dynamics include:

1) Use rates for nursing home care are expected to grow considerably under Maryland's new payment models – As hospitals become accountable for the total costs of care, they will be strongly incentivized to reduce costly hospital stays and steer patients to the lowest cost setting. In this context, providers will look to align with "preferred networks" of post-acute providers who demonstrate cost-effective utilization patterns within the post-acute setting. Already, several hospitals have invested heavily in care transition specialists, nurse practitioners based in nursing homes, additional physician support to nursing homes, and structured communications/reporting systems, all of which forecast increased utilization of nursing home capacity. MAHC's new facility will be committed both to admitting patients earlier from the hospital and managing the nursing home stay toward early discharge home. Area hospitals can be expected to align with this new facility with the goal of reducing both the acute and post-acute episode costs.

2) The Episode Care Improvement Program will generate additional demand that the Applicant's Project can satisfy - In January 2019, the Episode Care Improvement Program ("ECIP") was launched across Maryland. ECIP incentivizes hospitals to reduce post-acute costs tied to episodes of care that are initiated at the hospital. ECIP is designed to help the State meet the Phase II Total Costs of Care Model Waiver test by:

    - Broadening the accountability for success to include post-acute providers;
    - Providing the opportunity to gain-share with physicians who participate in a patient's episode of care; and
    - Incentivizing hospitals to invest in managing post-acute care costs by providing additional hospital payments to those hospitals that reduce post-acute care costs (through the Medicare Performance Adjustment).

    With this program in place, hospitals are incentivized to align post-acute providers, utilize the most cost-effective settings, and establish effective care protocols and care transition activities that minimize readmissions and control post-acute service utilization. The ability to succeed under this model requires close working relationships between hospitals and post-acute providers, and depends on highly experienced post-acute providers who are well-versed in the Total Cost of Care model and accustomed to utilizing data to support effective cost management/clinical management. The Applicant brings this experience and brings a track record for low readmission rates; the Applicant can be a genuine partner to hospitals and will support the success of area hospitals who participate in the ECIP model.

3) The working partnership between MAHC and UMMS will result in increased utilization of post-acute care in place of hospital days – In CY2014, UMMS and UM Midtown arranged approximately 450 nursing home placements per month. With the working partnership in place, the number of referrals to this new state-of-the-art facility is expected to grow as a function of

        o Reducing outmigration by offering a new, state-of-the-art, local service site

- Opportunity for clinicians to maintain their role as primary physician in this local facility
- Opportunity to leverage this new facility for post-acute care in order to reduce acute care length of stay, assure effective restoration/rehabilitation and lower the total costs of care
- ECIP and other risk-based contracting that will encourage a shift to a lower cost setting

4) Waiver of the three-day hospital rule is expected to result in further growth in referral volume from area hospitals and direct admissions from the community - CMS has waived the requirement for a three-day qualifying inpatient hospital stay prior to a Medicare-covered, post-hospital, extended-care service for Medicare Advantage Plans and in other limited contexts. Currently, this opportunity is available to Shared Savings Program ACOs that are currently participating in, or applying to, certain Shared Shavings Program performance-based risk tracks. However, as the Maryland Demonstration Model advances, there may be an opportunity for the State to negotiate a waiver of the 3 day qualifying stay. This waiver would provide increased flexibility to utilize the nursing home setting in place of acute care or Observation Care in the hospital, and would result in increased demand for nursing home beds to provide the following care:

   - Transfer of patients after 1-2 days stabilization in acute care
   - Transfer of patients stabilized in the Emergency Room or Observation Unit

   Caseworkers from UMMC suggested that the waiver of the 3-Day Stay Rule might result in **at least 20-25 additional referrals per month from the acute care service and emergency room**. This represents only one of several referring hospitals to the proposed facility, and represents the impact on only one nursing home facility; the projected increase in demand would affect virtually all nursing homes in the state. Therefore, the demand for beds would be expected to increase and occupancy rates would be expected to rise considerably across the State of Maryland.

5) Demand for direct admission of patients from the community for symptom management, pain control, and palliative care is expected to increase.

   Reports nationally call for increased resources dedicated to pain management and palliative care, but there are a limited number of practitioners with extensive training. Moreover, the literature documents disparities in palliative care to minority hospitals. The proposed facility will be equipped to provide this valuable service in a high quality, low cost service setting and will be positioned to support these resources in its 80-bed facility.

(b) For a **relocation** of existing comprehensive care facility beds, an applicant must demonstrate need for the beds at the new site, including, but not limited to: demonstrated unmet needs; utilization trends for the past five years and expected changes in the next five years; and how access to, and/or quality of, needed services will be improved.

RESPONSE:

1. Demonstrated need. Please see the comprehensive narrative and data provided above at pages 35-44, as well as the previously submitted CON and sets of Completeness Questions, and the HSCRC letter of support attached as Exhibit B as was discussed with the Commission.

2. Trends over the past five years and expected changes in Maryland in the future support this need. Please see the comprehensive narrative and data above at pages 35-44 as well as the previously submitted CON and sets of Completeness Questions, and the HSCRC letter of support attached as Exhibit B as was discussed with the Commission.

In addition, please note that available beds for comprehensive care in Baltimore City nursing homes has since declined, and the overall occupancy rate for Baltimore City facilities is 90% (2016).

The data below documents the 5-year utilization trend at Baltimore City nursing homes to highlight the overall occupancy rate for Baltimore nursing homes at 90.3%. This is an increase over the occupancy rate documented in the original CON application.

A 90% occupancy rate has been operating between 2014-2016 and may present barriers to placement going forward. The growth of the elderly population and the financial incentives to shorten hospital stays will intensify the demand for nursing home beds, and this occupancy rate may pose access barriers for patients seeking placement close to home.

Figure 12
Comprehensive Care Facilities in Baltimore City
Bed Capacity and Utilization Trends
FY2012 - 2016

	FY2012	FY2013	FY2014	FY2015	FY2016
Number of Available Beds*	4,061	3,850	3,738	3,744	3,643
Average Daily Census	3,449	3,400	3,398	3,394	3,291
Occupancy Rate	86.3%	87.8%	91.2%	90.5%	90.3%

Source: MHCC Public Use Files
Data provided directly by MHCC staff (February 2019)
*The number of beds represents the average beds at start of the year and number at the end of the year.

3. Access to and quality of care of these needed services will be improved.

The proposed relocation supports more effective use of currently licensed bed capacity.

- Historical data documents a 62% occupancy rate for these 80 beds, when these beds were located at the Johns Hopkins Bayview site; the average daily census was 50 patients. In contrast, the Applicant expects to operate these beds at 90-95% occupancy (based on the factors described below) thereby supporting a relocation plan that will maximize use of existing beds.

The proposed facility will increase access to care.

- *The proposed location will provide proximity to UMMC and UM Midtown, 2 hospitals that demonstrate some of the highest demand for post-acute placements of complex patients.* The proposed site is located directly on the campus of University of Maryland Midtown Campus and within 1 mile of University of Maryland Medical Center. In CY2016, these 2 hospitals accounted for more than 2,600 placements to post-acute

facilities.[8] In addition, the patient populations at these hospitals are noted for very high rates of chronic disease and high rates of comorbidities; these patients are ones who could benefit considerably from extended stays in a post-acute setting that will support self-care/family management before transitioning home. In addition, UMMC cares for some of the most medically complex patients in the State; this new nursing home model – designed to serve the more medically-needy patients – will increase access to post-acute care for patients who historically have not been admitted to nursing homes.

- *The proposed facility will expand options for post-acute care in Baltimore City, and improve access for the West Baltimore community, in particular* – As documented, more than 40% of Baltimore City residents travelled out of area for nursing home care. Several nursing homes in the immediate vicinity are operating at 90%+ occupancy, presenting particular challenges for West Baltimore residents who may seek a facility close to family and friends. The proposed facility will provide a new option for state-of-the-art nursing home care, close to family/friends, and it will support continuity of care by local physicians.

- *The proposed location will respond to the particularly challenging access needs in the West Baltimore community* - The proposed facility will provide Baltimore residents with a new alternative for post-acute care that has not been available before. The socioeconomic profile of many patients from West Baltimore creates an even greater dependence on nursing home care, as home settings may not provide the supports/suitable environment for recovery/restoration.

- *The geographic proximity to the University campus will support a program partnership for medical management, teaching, and research.* – **Exhibit C** demonstrates the location of the proposed facility and its proximity to other care providers.

The proposed facility will elevate the quality of care.

- MAHC previously owned and operated 18 nursing homes and served almost 3,200 residents across Maryland, Pennsylvania, and Delaware, and will bring to this new facility its experience and its care redesign initiatives, experience that promises quality improvement and increased patient satisfaction. Examples of care redesign and quality improvement initiatives include the following:

    - Care transitions – The "Nurse Liaison" program is designed to assure that referrals to Mid-Atlantic's nursing homes are appropriate and to assure that complete information exchange occurs at the point of transfer. With this in place, the nursing home is more immediately equipped to respond to patient needs, complication rates are reduced, and adverse events are minimized. This program also aims to conduct close discussion with patients and family members at the point of transition. Advanced directives are properly prepared and patient and family preferences/wishes around palliative care/end-of-life care are better communicated.
    - Patient assessment – An RN conducts an assessment of every new patient within 24 hours of admission. This promotes safety, reassures patients, and minimizes complications associated with patient transfer.

[8] Source: CRISP database.

- Increased surveillance/prevention with a Nurse Practitioner model – Nurse practitioners routinely round on high risk patients, and provide interim patient assessments between scheduled physician visits.
- Care redesign in the nursing home – MAHC introduced the "Stop and Watch" program which assigns CNAs increased responsibility for early detection and reporting of problems. In this model, CNAs are assigned to watch for subtle changes such as dehydration and nutrition problems, to document observations on a formal reporting form, and to submit this report to an RN or LPN for attention and direct response. This care redesign model assigns responsibility for observation/patient monitoring with the care provider who spends the most time with the patient and equips the CNA with tools to sharpen his/her diagnostic skills, and empowers the CNA to call for immediate attention to a concern.
- Treatment and restoration – (1) All of MAHC's facilities provided rehabilitation services seven days per week, a notable distinction among nursing homes. MAHC invested heavily in rehabilitation equipment: Its facilities typically included a modality suite to provide adjunct therapies to the traditional modes of therapy and speed up healing. (2) Each of MAHC's facilities typically developed a "specialty niche rehab program," in response to the needs of the local community. These programs included specialty fall programs, specialty dialysis programs, specialty neurologic programs, and specialty cardiac programs. The proposed facility will feature similar programs.[9]
- Improving information exchange and decision-making – As nurses identify concerns, they use a checklist to compile all relevant clinical information before calling the physician to discuss the need for possible hospital transfer. This avoids the unnecessary hospitalizations that may be due to incomplete profiles/lack of information, rather than clinical necessity. This protocol represents one of several protocols in place that has helped reduce readmissions.
- Prevention and monitoring: Early respiratory therapy treatment – MAHC provided in-house respiratory therapists (7 days/week) to conduct daily rounds on all patients with respiratory problems, provide regular staff training focused on assessment of pulmonary function / early detection of problems, and promote early management of problems detected (e.g. COPD-related flare up). Early detection of problems helps minimize the number of serious complications. Nurse

[9] By way of illustration, the programs included the following: A specialty dialysis program – This program is designed to customize the rehabilitation program schedule in response to the patient's treatment schedule and energy levels. Oftentimes, patients are so fatigued by dialysis that they must miss therapy sessions. MAHC schedules special rehabilitation session to stagger treatments and even provide evening therapy sessions to respond to patient need. A cardiac program (expected to operate at the Applicant's facility) – The Applicant will provide a team of nurses with advanced cardiac care training to care for patients discharged with more complex CHF-related diagnoses, and to respond to episodic needs of the general CHF patient population. Clinical capabilities and dedicated space will allow consolidation of CHF patients, and protocols will be designed to extend the protocols begun in the hospital; this will ensure that post-acute protocols are consistent with the hospital treatment plan, and that criteria for transfer to the acute care facility are jointly defined to ensure that post-acute protocols are consistent with the hospital treatment plan and that criteria for transfer to the acute care facility are jointly defined. In addition, this nursing team is expected to meet some of the urgent care needs of patients who are currently transferred to the ER. LVAD (Left Ventricular Assist Device) - Patients with this device are typically very weak and very deconditioned. Care for these patients requires specialized training and monitoring equipment. Mid-Atlantic is prepared to set up just such a "sub unit" (as it has in other facilities) as volume materializes. A Vent unit – MAHC served patients on ventilators at a number of its facilities including the facility in Berlin, Maryland, and expects to expand this unit. The unit in Berlin serves a number of short term patients on weaning protocols, and outcomes are excellent. This facility is in the process of developing the capacity for bedside dialysis for patients on ventilators.

training and skills upgrading to manage episodic needs are expected to reduce the number of ER visits and hospitalizations.

  - Structured approach to readmission reduction – Each day, an interdisciplinary group that includes the Director of Nursing, the medical directors, and department directors, reviews all patients demonstrating a change in status, abnormal lab values, unstable status or patient/family concerns. In addition, this group reviews every unplanned transfer to a hospital to consider what factors led to transfer, how the case was managed, and what opportunities there may have been for alternative management; every unplanned transfer to a hospital is review by this group to provide steady focus and ongoing progress to reduce unnecessary admissions. A retrospective analysis also occurs: The Senior Director of Transitional Care compiles a Quality Assurance tool for this effort, producing routine reports on readmission patterns, by unit, by shift, by physician, by diagnosis. These retrospective analyses identify specific opportunities for improvement and provide the hard data with which to design targeted initiative for care improvement.

- Training and education – "Assessment training" operates at Mid-Atlantic's facilities to establish exactly what skills nurses have mastered and to structure scenarios and clinical variables to which nurses must respond. Increasing emphasis has been placed on early detection, and nursing personnel now utilize checklists for patient assessments to sharpen diagnostic assessments and assure thorough evaluation.
- Step Up™ Unit – Step Up™ Units are specific units within a Mid-Atlantic facility where patients are temporarily placed to receive higher level observation and assessment by a more advanced and trained team including nurse practitioners, registered nurses and practitioners. These residents are typically experiencing an acute onset of a change in condition that may otherwise require then to be readmitted to the hospital. Once they are stabilized, they can return to a more standard level of care.
- Focus on progress and transition to home – As early as Week 1, therapists meet with the patient and family members to assess any issues that must be addressed for a successful transition to home. Therapists focus on what training, accommodations and service supports are required for patients to be safe and for caregivers to be well-trained.
- Real Time Medical Systems ("RTMS") – This sophisticated electronic records system generates relevant and real-time data to support successful care management. This electronic system receives hourly data feed from the electronic medical record of nursing home patients, summarizes and analyzes this data, and provides daily reports about abnormal test results, exceptions, and patient variability to clinical staff who can then respond directly. In this way, clinical staff can prevent minor problems from escalating and minimize the number of ER/hospitalizations. RTMS represents a dramatic advance in care management for the long term care arena, and produces consolidated reports on a daily basis to alert nursing staff of possible concerns/gaps/exceptions. Patients can be identified in distinct clinical cohorts (e.g. orthopedics), by physician, by specific contracting initiatives, or by specific interventions to allow comparative evaluations to be made across clinical cohorts and/or across intervention types.

A set of initiatives focused on the transition from nursing home to home will also be implemented to improve quality:

- Patient education and self-management – Patient education and self-management skills are explicitly incorporated into the careplan during the nursing home stay. This includes

review of the medication regimen, coaching for ongoing therapy, and discussion about early detection.

- Almost Home Program- In preparation for discharge from the facility, a team member will: (1) Review medication, therapy, and diet in context of the patient's normal daily routine, and restructure the daily schedule, as appropriate (2) Conduct a home visit and evaluate the patient's home setting to recommend adaptations (3) Conduct a "teach back" with the patient around medication, diet, and treatment instructions; include patient "mimicking" of normal home activities to demonstrate readiness for discharge
- Post-discharge communications – A nurse calls the patient within 24 hours of patient's return home, with calls again on Day 3, Day 7, and Day 30 post-discharge to assess compliance and ongoing needs. The patient is also assured of on-call telephone availability of a nurse.

Expectations are that the combined effect of these initiatives will be to reduce complications associated with poor compliance, reduce ER visits/re-hospitalizations, and heighten patient and family satisfaction.

The new facility, operating in partnership with UMMS, will support care management models at the 2 local UMMS hospitals in West Baltimore.

- UMMS has invested heavily in disease management programs, care management models, home-based services, and community-based services. Nursing home care is only one piece in the continuum of care and should work closely with community-based resources to ensure early discharge from the nursing homes and smooth transitions. The UMMS/MAHC partnership will mean that UMMS care managers will work closely with nursing home staff to link patients to community-based resources for longer-term support systems.

The new facility will help reduce readmission rates.

- Experience at MAHCs facilities in Maryland, Pennsylvania and Delaware demonstrates relatively low readmission rates, reflecting strong medical management that incorporates steady rounding and monitoring by nurse practitioners, structured assessments by nursing assistants, and response teams equipped to intervene when problems are identified. Evidence from MAHC's nursing homes documents the following readmissions rates. The State of Maryland will benefit from MAHC's medical management in West Baltimore.

The new Facility will help reduce the total costs of care for patients and for the health care delivery system.

- The proposed facility will offer better care at a lower cost. Under the total cost of care model, reducing both acute care and post-acute care costs is critical. Lower cost service settings should be encouraged and made readily available. The differential between the Medicare per diem at referring hospitals in West Baltimore relative to the projected revenue per day at the Applicant's facility is dramatic. Substituting nursing home days for hospital days would result in a significant difference in the costs of care. Ultimately, these savings can be made available for reinvestment in the West Baltimore community.

Figure 13
Per Diem Differentials
Hospital 2014 Actual vs. MAHC Projected

	Medicare per diem	Projected revenue per day
University of Maryland Medical Center		
Medicine Unit	$1,158	
Observation Rate (daily)	$1,971	
University of MD Midtown Campus		
Medicine Unit	$1,360	
Observation Rate (daily)	$ 828	
The APPLICANT's Per Diem		
Medicare		$ 534
Managed Care		$ 375
Private		$ 290
Medicaid		$ 275

(2) *Facility Occupancy*.

(a) The Commission may approve a nursing home for expansion only if all of its beds are licensed and available for use, and it has been operating at 90 percent or higher, average occupancy for the most recent consecutive 24 months.

(b) An applicant may show evidence why this rule should not apply.

RESPONSE:
N/A

(3) *Jurisdictional Occupancy.*

(a) The Commission may approve a CON application for a new nursing home only if the average jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period, as shown in the Medicaid Cost Reports for the latest fiscal year, or the latest Maryland Long Term Care Survey, if no Medicaid Cost Report is filed. Each December, the Commission will issue a report on nursing home occupancy.
(b) An applicant may show evidence why this rule should not apply.

RESPONSE:

A number of important facts related to occupancy rates must be emphasized here:

#1: As demonstrated in **Exhibit R**, the CY2016 occupancy rate for Baltimore City was reported to be 90%. This represents an increase in occupancy since the time that the original CON application was submitted. Baltimore City shows one of the highest occupancy rates across Maryland, with the exception of Southern Maryland.

#2: The CY2016 occupancy rates for the 7 nursing homes in the West Baltimore vicinity are even higher. Four of the seven nursing homes operated at > 91% occupancy rate.

Figure 14
Near Proposed Location
Occupancy Rates
FY2016

Facility Name	**2016**
Maryland Baptist Aged Home	94.0%
Fayette Health and Rehabilitation Center	95.1%
FutureCare - Sandtown Winchester	92.1%
FutureCare - Canton Harbor	91.3%
FutureCare – Homewood	89.7%
FutureCare - Charles Village LLC	87.2%
Crawford Retreat, Inc.	87.7%
Total, 7 area nursing homes	**91.4%**
Average daily census	**704**

Source: Maryland Health Care Commission, Public Use Files
Provided directly by MHCC staff (Feb 2019)

These occupancy rates support the need for an additional nursing home in West Baltimore, a facility that is easily accessible to community residents who often face transportation barriers to facilities outside the immediate service area, and nearby to hospital clinicians who are committed to continuity of care and strong care management. 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. Patients are more likely to maintain steady relationships with physicians who have been caring for them. Hospital-based physicians can provide ongoing support to post-acute patients and professional staff and community-based physicians will be encouraged to follow patients in the post-acute setting.

#3 Between 2009-2013, nursing home discharges for Baltimore City residents increased considerably, as documented below (more recent figures not available).

Figure 15
Nursing Home Utilization, Baltimore City Residents
2009-2013

	2009	2010	2011	2012	2013
# Discharges, Age 0-65	2,579	2,720	2,781	3,049	3,042
# Discharges, Age 65+	6,045	6,061	6,377	6,751	6,795
# Discharges, All Ages	**8,624**	**8,781**	**9,158**	**9,800**	**9,837**
% Annual	-	1.8%	4.3%	7.0%	0.4%
% Change, 2009-2013					14.1 %

Source: Long Term Care Minimum Data Set
Summary data obtained through the Maryland Health Care Commission (April 2015)
More recent data not available through the MHCC

#4 Finally, this standard is not applicable to this Application. The provision related to jurisdictional occupancy appears to be aimed at new facilities proposing a bed increase, which is not the case here.

(4) Medical Assistance Program Participation.

(a) An applicant for a new nursing home must agree in writing to serve a proportion of Medicaid residents consistent with .05A 2(b) of this Chapter.

(b) An applicant for new comprehensive care facility beds has three years during which to achieve the applicable proportion of Medicaid participation from the time the facility is licensed, and must show a good faith effort and reasonable progress toward achieving this goal in years one and two of its operation.

(c) An applicant for nursing home expansion must demonstrate either that it has a current Memorandum of Understanding (MOU) with the Medical Assistance Program or that it will sign an MOU as a condition of its Certificate of Need.

(d) An applicant for nursing home expansion or replacement of an existing facility must modify its MOU upon expansion or replacement of its facility to encompass all of the nursing home beds in the expanded facility, and to include a Medicaid percentage that reflects the most recent Medicaid participation rate.

(e) An applicant may show evidence as to why this standard should not be applied to the applicant.

RESPONSE:
The Applicant will comply with these requirements.

(5) Quality. An applicant for expansion of an existing facility must demonstrate that it has no outstanding Level G or higher deficiencies, and that it maintains a demonstrated program of quality assurance.

RESPONSE:

N/A. The Project involves new construction to house beds to be relocated from JHBMC.

(6) Location. An applicant for the relocation of a facility shall quantitatively demonstrate how the new site will allow the applicant to better serve residents than its present location.

RESPONSE:

See the responses discussing location throughout the original CON, the Responses to Completeness Questions, and herein. The Applicant intends to relocate the 80 beds it acquired to a location that will be:

- More responsive to the unmet needs in West Baltimore;
- Directly supportive of new care management models at the two local UMMS hospitals in the West Baltimore community; and
- Positioned to maximize the resources at the University of Maryland Medical System, with whom MAHC expects to work closely.

Additional rationale and evidence for relocating these beds to the proposed site include:

- The proposed location will support more effective use of currently licensed bed capacity – Historical data documents an occupancy rate for these 80 beds, when located at the Johns Hopkins Bayview site, of 62% for an average daily census of 50. MAHC expects to operate these beds at 90-95% occupancy (based on the factors described below) thereby supporting the relocation plan.
- The proposed location will provide proximity to three hospitals that demonstrate some of the highest demand for post-acute placements of complex patients – The proposed site will operate on the UM Midtown campus, approximately one mile from the University of Maryland Medical Center, one mile from Mercy Medical Center, three miles from Bon Secours Hospital, and five miles from St. Agnes Hospital. The patient populations at these hospitals are noted for very high rates of chronic disease and high rates of comorbidities; moreover, the socioeconomic profile is associated with lack of suitable housing and home supports for recovery. These are patients who can benefit considerably from post-acute stays to support recovery/restoration, medication management, and patient education before transitioning home.

C. Renovation of Facility. The Commission will review projects involving renovation of comprehensive care facilities using the following standards in addition to .05A(1)-(9).

(1) **Bed Status.** The number of beds authorized to the facility is the current number of beds shown in the Commission's inventory as authorized to the facility, provided:

(a) That the right to operate the facility, or the beds authorized to the facility, remains in good standing; and

(b) That the facility provides documentation that it has no outstanding Level G or higher deficiency reported by the Office of Health Care Quality.

(2) **Medical Assistance Program Participation.** An applicant for a Certificate of Need for renovation of an existing facility:

(a) Shall participate in the Medicaid Program;

(b) May show evidence as to why its level of participation should be lower than that required in .05A2(b) of this Chapter because the facility has programs that focus on discharging residents to community-based programs or an innovative nursing home model of care;

(c) Shall present a plan that details how the facility will increase its level of participation if its current and proposed levels of participation are below those required in .05A2(b) of this Chapter; and

(d) Shall agree to accept residents who are Medicaid-eligible upon admission

.

(3) **Physical Plant**. An applicant must demonstrate how the renovation of the facility will improve the quality of care for residents in the renovated facility, and, if applicable will eliminate or reduce life safety code waivers from the Office of Health Care Quality and the State Fire Marshall's Office.

RESPONSE:

The Applicant has responded in its response to New Construction on pages 9, 13, 16, 29, and 37-45.

10.24.01.08G(3)(b). Need.

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Fully address the way in which the proposed project is consistent with any specific applicable need standard or need projection methodology in the State Health Plan.
If the current bed need projection published by the MHCC based on the need formula in the State Health Plan does not project a need for all of the beds proposed, the applicant should identify the need that will be addressed by the proposed project by quantifying the need for all facility and service capacity proposed for development, relocation or renovation in the project.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the nursing home. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified and identify all the assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), and the relevant population considered in the analysis with information that supports the validity of these assumptions. The existing and/or intended service area population of the applicant should be clearly defined.

Complete the Statistical Projection (Tables D and E, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Table D must be completed if the applicant is an existing facility. Table E must be completed if the application is for a new facility or service or if it is requested by MHCC staff.

RESPONSE:

The Certificate of Need application submitted in April 2015 included 6 "Statements of Need and Supporting Evidence." These statements articulated the unmet need for post-acute resources and provided evidence from published reports and interviews to substantiate this need. Additional information was subsequently submitted in responses to Completeness Questions to further validate this unmet need and support the demand projections for the new nursing home model proposed. The CON application was docketed with no further questions.

Upon further evaluation, the Commission agreed to approve the Application upon the submission of a letter from the HSCRC approving the application; this reflects the Commission's recognition of the unique nursing home model proposed and the broader patient base the Applicant intends to serve. This letter was previously submitted to the Commission in 2018, but is provided again as **Exhibit B**.

The section following re-presents and consolidates the evidence submitted in the original CON application and Completeness Questions, with selected updates to further support the continuing need for the proposed facility in West Baltimore. In addition, a 7th "Statement of Need" is presented with evidence to underscore the particular importance of this new nursing home model to the West Baltimore community. Finally, additional evaluation by expert Berkeley Research Group ("BRG") (provided both in the original CON and in Responses to Completeness Questions) is provided in support of demand projections.

Statement of Need and Supporting Evidence

Interviews and work sessions were conducted with social workers and case managers from UMMC and UM Midtown to review discharge delays and pinpoint the factors tied to placement barriers. Discharge delays were variable, and it was not possible for the departments to document administrative days associated with the subcategories of patient populations. Instead, caseworkers were asked to estimate the number of patients discharged to nursing homes each month (in these hard-to-place-clinical categories), and the number of patients per month that experience discharge delays. Findings are presented below and summarized in a table following:

#1 Baltimore City requires a nursing home with capacity to serve dialysis patients and capacity to serve bariatric patients.

- There is a severe shortage of nursing home capacity for City residents who require both dialysis and ventilator care, or require dialysis and have a tracheotomy. The Director of Case Management and Social Work at the UMMC Midtown reported that there is no nursing home in Baltimore City that will accept patients who are dependent on both dialysis and a ventilator, nor patients who have tracheotomies and require dialysis. As a result, the hospital relies on three nursing homes in Anne Arundel County and Prince George's County for patients of this profile who require nursing home care, adding hardship to families of patients who confront travel time and travel costs.
- Nursing home capacity for other dialysis patients is limited: Only a small number of nursing homes in Baltimore City provide dialysis on site, and those facilities that provide patient transport to outpatient dialysis facilities are often "capped" by capacity of the transport vehicle.
    - Caseworkers at UM Midtown reported 44 placements in the prior year arranged for patients requiring both dialysis and ventilator/tracheotomy care, and an additional 85 placements arranged for patients who required dialysis only. However, wait time before placement was reported to be 1-3 weeks until a nursing home bed was made available.
    - In 2015, caseworkers at the UMMC Midtown reported **approximately 80 placements per year were arranged for patients requiring both dialysis and ventilator/tracheotomy care (**documentation not made available). They reported an additional 60 placements per year were arranged for patients who require dialysis. However, wait time before placement has been one to three weeks until a nursing home bed is available
    - Caseworkers at UMMC estimated that approximately 120 placements were arranged for patients requiring dialysis and ventilator care, and an additional 240 placements were arranged for patients requiring dialysis alone (these were informal estimates, only). Almost half of the dialysis referrals were reportedly delayed by 1-3 weeks due to lack of an available bed.
    - At both hospitals, dialysis patients routinely experience significant discharge delays as they await placement.
- The proposed facility will provide dialysis and will also provide care to patients on ventilators who require dialysis. The proposed facility will be designed to accommodate bariatric patients across private area, patient care areas, and communal space. The facility will not be limited by facility design in the number of patients who can be admitted.
- There is a severe shortage of nursing home capacity to serve bariatric patients relative to the demand for beds. Few nursing homes are resourced with the facility design, the equipment, and the extra staffing required to accommodate the needs of this patient population. Even those facilities that do accept bariatric patients typically limit the number of bariatric patients that can be accepted at any given time given the demand placed on nursing home staff.
- The volume of bariatric patients requiring post-acute care is significant
    - Caseworkers at UM Midtown reported nursing home placements for more than 80 bariatric patients during the prior year.

- Caseworkers at UMMC estimated approximately 50 bariatrics patients required nursing home placement during the prior year.

- Discharge delays for bariatrics patients are lengthy, with extended stays in the hospital that can last months until post-acute placement can be arranged.
  - The large majority of placements were accompanied by delays of 1-4 weeks' delay in discharge (i.e. 1-4 weeks of unnecessary hospital days).
  - A two-day "snapshot" record of two sample days at UMMC Midtown confirmed that 1-3 bariatric patients were in-house awaiting placement on each day. All 3 of these patients had been awaiting placement for > 4 months.
- Three years later, the situation has not changed and the unmet need remains. A more recent snapshot report of FY2018 experience provided by UMMC is provided below to validate that this placement barrier continues to be significant for UMMC. The figures below document the number of unnecessary hospital days per bariatrics patient awaiting placement; this list represents a sample of total post-acute placements from UMMC.

Figure 16
Bariatric Patients at UMMC
Awaiting Post-Acute Placement

Length of Stay and Avoidable Days
FY2018-2019 YTD (approx. 17 months)

Patient #	Total Acute Care Stay (in days)	# Avoidable Days at UMMC
1	218	190
2	159	79
3	86	19
4	86	84
5	18	4
6	71	64
7	57	41 +*
8	34	Died
9	16	TBD
10	13	TBD

Total = 10 patients
Total, with complete data = 6 patients
Average # avoidable days per patient placed = 73 days

* Patient continues to be served at UMMC, acute care; Source: UMMC Department of Care Management (December 2018).

#2 Baltimore City requires a nursing home setting that can serve patients who require continued treatment/monitoring and/or higher skilled care, and that can provide the ability for "step up" care when necessary to permit earlier discharge from the hospital; this will allow earlier transfer of complex patients and will minimize the need to transfer patients to the acute care hospital.

Local hospitals struggle to find post-acute placements for patients who still require specialized equipment, IV care, continued monitoring/diagnostics and/or more highly trained nurses. UMMC and UM Midtown together account for more than 2,500 nursing home and rehabilitation placements per year, with the addition of St. Agnes Hospital, there are more than 5,000 placements arranged at post-acute settings. However, many of these patients could be discharged from the acute care setting earlier if the post-acute setting could provide staff with cardiac care training and the capacity for "step up care". The resounding message from social workers and case managers was that hundreds of patients who no longer require an acute level of care remain in the hospital for extended stays because most nursing homes are not equipped to provide the distinct services/skill level required. More specifically, the need is for a post-acute setting that can serve patients with any of the following needs: NG tubes; TPN; IV antibiotics; treatment for low magnesium level; complex wound care; fluid drainage/wall suction; drips for heart failure patients; measurement of input/output; post-transplant care; and daily transport to hospital for radiation therapy.

- Caseworkers at UMMC estimate that up to 200 cases per year could be discharged earlier if higher skilled staff and these distinct treatments were provided in a nursing home. Currently, this volume is not reflected in nursing home utilization statistics because these patients are not accommodated in nursing homes until their needs are more limited. Caseworkers at UMMC and at UM Midtown reported that few, if any, area nursing homes will accept patients with these care requirements.
- Included in this volume were more than 30 transplant patients per year who might be transferred to a lower cost service setting for recuperative care (14-21 days) with higher skilled staff and ancillary supports. Transplant volume is expected to grow at UMMC and therefore this post-acute support will be increasingly valuable.

The Applicant will provide this level of service delivery in the new nursing home. The higher skilled staffing, the step-up unit and the collaborative relationships with hospitals will reduce length of stay in the hospital, assure high quality post-acute care to patients and their families, and minimize the need for re-visits to the hospital. This will improve the quality of care to patients, reduce readmission rates, reduce the disruption and disorientation often tied to long hospital stays, and improve Maryland's performance on the Waiver.

#3 The State of Maryland requires post-acute providers who will help reduce Maryland's readmission rate and reduce the total cost of care under episode management. Clinicians at hospitals in Baltimore City - - striving toward more effective care management - - should be supported with a progressive, state-of-the-art nursing home in close proximity to the hospital.

- Maryland's ability to meet the goals of the waiver will depend heavily on achieving cost/quality improvements in Baltimore City. Mid-Atlantic stands as a high performing post-acute partner prepared to invest in facilities, information systems and research activity to strengthen post-acute care service delivery, reduce readmissions, and reduce the costs of care.

- Although Maryland does not currently publish readmission rates from Maryland CCFs, two sources were examined to assess current performance:
  - A recent report published by CMS documents Year 2017 standardized readmission rates for nursing homes across the country under the Value Based Program. This report documents Maryland's overall readmission rate to be **18.7%.** However, three of the six[10] nursing homes in the West Baltimore vicinity document rates above the Maryland average (*see* Fig. 17 below). This fact is an indicator of the need for stronger medical management in West Baltimore nursing homes.

Figure 17
Risk Standardized Readmission Rate: Medicare
CY2017

Facilities	Risk Standardized Readmission %
FutureCare Canton Harbor	17.7%
FutureCare Homewood	18.0%
Fayette Health & Rehab	18.1%
State of MD: All SNFs	**18.7%**
Maryland Baptist	**19.0%**
FutureCare Charles Village	**19.2%**
FutureCare Sandtown Winchester	**20.6%**

Source: CMS website, Value Based Purchasing, Medicare Program
https://data.medicare.gov/Nursing-Home-Compare/SNF-VBP-Facility-Level-Dataset/284v-j9fz/data

  - MAHC's experience highlights the opportunity potential for improvement. MAHC's facilities in Maryland, Pennsylvania, and Delaware demonstrated relatively low readmission rates, reflecting strong medical management that incorporates steady rounding and monitoring by nurse practitioners, structured assessments by nursing assistance, and response teams equipped to intervene when concerns are identified. In this context, MAHC has benchmarked its all payer rates against the readmissions rates published by DelMarva for the State of Maryland, as well as national figures published by the Office of the Inspector General (2012 report). Evidence from MAHC's nursing homes documents the following readmission rates:

30-Day All Payer All-Cause Readmission Rates (2016)

MAHC: Maryland (12 facilities)	13%	(Range: 6-22%)
MAHC: Central PA (3 facilities)	13%	(Range: 11-16%)
MAHC: Philadelphia (6 facilities)	18%	(Range: 15-22%)

Source: MAHC.

  - Worth noting is MAHC's track record in reducing readmission rates after taking ownership of selected facilities:

[10] No information was reported for Crawford Retreat.

30 Day All Payor All Cause Readmission Rate: CY2012 vs CY2014
Maryland nursing homes (2012) = 15%
Maryland nursing homes (2014) = 12%

Pennsylvania nursing homes (2012) = 22%
Pennsylvania nursing homes (2014) = 15%

Delaware nursing homes (2012) = 20%
Delaware nursing homes (2014) = 14%

Source: MAHC

- MAHC's successful track record is reflected also in its experience under bundled payment contracts. MAHC is positioned to educate and advance Maryland providers in protocol development and leverage the post-acute setting.

#4 Baltimore City requires a nursing home that is positioned to meet the future demand for direct admissions and admissions of patients after a 1-2 day acute care stay. This provides the opportunity both to shorten hospital stays and avoid hospitalizations altogether.

At this time, MAHC can serve direct admissions for commercial patients and Medicare Advantage patients, only. Longer-term, Maryland expects to re-raise/re-negotiate a waiver of the 3-day rule under the Demonstration Model. If the 3-day rule is waived/eliminated, there will be a huge opportunity to serve short stay, low acuity cases at the lower cost nursing home setting. However, this will require the facility design, equipment planning, and staffing models in the nursing home to respond to treatment demands, transport issues, and the demand for palliative care/symptom management. The successful nursing home provider must also demonstrate collaborative relationships with hospital clinicians. MAHC will be positioned for this role.

The value-added of a nursing home equipped to serve this function include the following:

- Patient care will be delivered in a lower cost setting
- The number of patient transfers will be reduced, duplication of diagnostics will be avoided, costs of care will be reduced
- Hardships imposed on fragile elderly and/or disoriented elderly patients will be minimized by reducing the need for transfer/reorientation
- Hospital stays can be avoided altogether

Caseworkers at UMMC estimated that at the very least, 250 cases/year could be well-served in the lower cost nursing home setting through direct admissions; more specifically, caseworkers defined two examples of opportunities for direct admissions: Patients with (a) urinary tract infections and (b) IV Lasix treatment. Assuming an average length of stay of 5-6 days, this one hospital alone would account for 4 occupied beds for this group of patients.

#5 Residents of West Baltimore should be provided with more alternatives for post-acute care in their local community, and the opportunity to maintain relationships with their physicians

- The majority of nursing homes in the West Baltimore community are now operating at near or greater than 90% occupancy, and 1,300 West Baltimore residents "outmigrate" for nursing home care. The West Baltimore community deserves more options, and needs better access to state-of-the-art service settings for post-acute care that is close to home.

The proposed facility will improve access, increase choice, and deliver additional value to the West Baltimore community

- A West Baltimore facility will strengthen family supports by reducing travel time to post-acute care
- A West Baltimore facility will provide the opportunity for continuity of care with physicians, as MAHC encourages local physicians to maintain the role of primary care physician in the post-acute setting.
- Hospital-based physicians from UMMS can provide ongoing support to post-acute patients and professional staff. Residents from University of Maryland will also be permitted to care for nursing home patients at MAHC facilities
- The local area nursing home can support the longer-term goals for self-care/self-management and integration with community-based services. This goals can best be met through a partnership with a large delivery system such as UMMS

#6 The State of Maryland should support a new facility that can serve as a teaching and research site for progressive, state-of-the-art care for Geriatric Medicine.

- Geriatric Medicine will be an increasingly critical areas of study and a strong local training program can elevate the quality of care and influence newly-trained physicians to remain in Maryland for practice. This new facility, and its relationship with UMMS, will also be a long-term investment in high quality physician manpower in Maryland.

#7 West Baltimore is a critical location for investment.

- This community is a region that has been sorely neglected in resource investment population, and the disparities in health status are huge relative to the rest of Maryland. The goals for population health improvement will require investment across the continuum. This facility represents one important investment in achieving health status improvement, quality of life improvement, and quality of care improvement. In addition, this facility will create more than 100 new jobs in the area.

Summary of Assessments of Potential Demand

Two assessments were prepared in 2015 as the basis for volume projections:

(1) Sample days and estimates: (2 hospitals)

Discharge Planning/Social Work offices were not able to provide extensive documentation by subcategory of patient. Instead, data was compiled based on sample days ("snapshots") to document / estimate the number of patients awaiting a nursing home bed and the opportunity potential for patients who could be discharged if a "new nursing home model" operated that accepted the more medically complex or medically

dependent patient. **The estimates below do not represent total demand for beds: These figures reflect only the "hardest-to-place" patient populations, and only reflect volume from 2 hospitals in Baltimore City.**

Figure 18
"Hardest-to-place patient categories"
Sample day: Estimated number of inpatients ready for discharge, but requiring a nursing home bed
(includes only those categories expected to be served by the new nursing home model)

Patient Needs	UMMC	Midtown
Dialysis	2	2
Bariatrics	0-1	0-1
Drips: Heart Failure	1	0
Complex Medical	2-3	0-1
IV Antibiotics	2-3	0
Vent	2	0
Total	~10	~3

Sources: (1) UM Midtown, Director of the Department of Case Management and Social Work (2) UMMC, Department of Case Management

(2) An Expert Demand Assessment Supports Demand Projections.

Berkeley Research Group (BRG) prepared a demand assessment in the form of a "reasonableness test" with which to assess MAHC's volume projections. This was prepared using a framework of the patient populations expected to be served at the new nursing home. These categories were comparable to the patient cohorts described earlier in this application with some modifications to align with available data. The framework utilized and the assumptions applied are presented below; a summary presentation is provided in **Exhibit S**.

Figure 19
Framework for "Reasonableness Test"

Patient Population A: Hard-to-place patients/Bed shortage

This group represents the "hardest to place" patients, patients who currently experience some of the longest delays in discharge. This patient population includes:

- Patients requiring dialysis and ventilator/dialysis and tracheotomy care
- Patients requiring dialysis
- Bariatric patients.

The availability of more nursing home capacity for these patients will reduce hospital days by reducing delays in transfer to the nursing home setting.

Patient Population B: Patients requiring higher skilled staff/distinct treatment capabilities

This group largely represents new transfers to the nursing home, as these patients are generally not served by existing nursing homes. These are patients who can be discharged from the acute care setting, but continue to require the skilled care and facility resources to care for NG tubes, TPN, post-transplant surveillance, complex wound care, and other skilled capabilities.

Patient Population C: Local residents served in out of area facilities

Restore Care can expect that its new facility will come to serve a percentage of existing referrals that are now discharged to out of area facilities.

Patient Population D: Patients currently admitted to UMMC and UMMC Midtown for PQIs. This group of low acuity, short- stay patients represent admissions to the hospital that are avoidable; PQIs are one of three categories defined by the HSCRC as potentially avoidable utilization (PAUs). MAHC can provide a lower cost service setting to meet the needs of many of these short stay patients who, in fact, still need an inpatient, monitored setting for care. Reason for admission may include urinary tract infections, dehydration, and asthma in older adults (see full list of PQIs in **Exhibit T**). Direct admissions of Medicare patients would hinge on obtaining a waiver of the 3 day hospital stay; direct admissions of non-Medicare patients could be designed in context of clinical pathways and program models developed by UMMC and MAHC providers.

BRG prepared a demand assessment for MAHC to test the reasonableness of MAHC's projections based on the total volume of patients in Patient Populations A, B, C, and D using the following data:

- Patient Populations A+B: Placements from UMMC and UM Midtown
  - Verbal reports/estimates from caseworkers at UMMC and UM Midtown about total placements arranged, by category;
  - Estimated capture rates of 75% for dialysis/vent patients (given shortage of providers).
  - Patient Population A: (Hard to Place)
    - Estimated capture rate of 10% share of dialysis and bariatric patients (given that other nursing home providers exist to meet some of this demand)
  - Patient Population B: Complex medical
    - Estimates from caseworkers at UMMC and UM Midtown about total opportunity potential;
    - Estimated capture rate of 90% (given that existing nursing homes do not provide these capabilities/level of care).
  - These nursing home days will effectively substitute for hospital days, as these patients are served in the hospital today.
- Patient Population C: Redirection of 5% of out of area placements
  - Based on 5% of the current number of West Baltimore residents admitted to out of City nursing homes (reflects expectation that a new, local area nursing home will function to retain a % of local residents' volume).
- Patient Population D: PQIs

- Documented volume from the HSCRC Abstract Database, by hospital, coded with a PQI diagnosis
- Estimated capture rate of 25% for non-Medicare patients and 50% for Medicare patients.

MAHC supplied assumptions about market share and length of stay for each category to project total volume that Restore would be expected to serve. This "capture rate" was based on a number of premises:

- MAHC will be working in partnership with UMMC in bundled payment models
- MAHC will be working in partnership with UMMC on care protocols to promote use of the lower cost serving setting
- MAHC will be providing one of the few nursing home settings in Baltimore for ventilator and dialysis care, but will be one of many facilities providing dialysis care and care to bariatric patients; MAHC is not aiming to shift market share away from existing providers, but aims to substitute nursing home days for hospital days by reducing discharge delays (i.e. making beds more available where shortages are evident).

Based on these assumptions, BRG prepared a volume projection to test the "reasonableness" of MAHC's projected volume. This assessment indicates that MAHC can expect to achieve a census of 71 patients, even absent the waiver of the 3 day stay, and can expect to achieve a census of 76 patients when Medicare patients may be admitted as direct admissions. **This volume projection reflects a minimum census, as referral volume for "hard-to-place patients" from other City hospitals is not included here. (***See* **Exhibit S** - Table: Reasonableness Test for Projected Volume).

TABLE D. UTILIZATION PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Account for all inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY										
1. ADMISSIONS										
a. Comprehensive Care (public)										
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL ADMISSIONS										
2. PATIENT DAYS										
a. Comprehensive Care (public)										
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS										
3. NUMBER OF BEDS										
a. Comprehensive Care (public)										
b. Comprehensive Care (CCRC Restricted)										
Total Comprehensive Care Beds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Assisted Living										
d. Other (Specify/add rows of needed)										
TOTAL BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
4. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. Comprehensive Care (public)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. Comprehensive Care (CCRC Restricted)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Comprehensive Care Beds	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Assisted Living	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
5. OUTPATIENT (specify units used for charging and recording revenues)										
a. Adult Day Care										
b. Other (Specify/add rows of needed)										
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

TABLE E. UTILIZATION PROJECTIONS - NEW FACILITY OR SERVICE

inpatient and outpatient volume that produce or will produce revenue. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 3 & 4, the number of beds and occupancy percentage should be reported on the basis of proposed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**		
1. ADMISSIONS							
a. Comprehensive Care (public)	219	933	933	933	933		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**219**	**933**	**933**	**933**	**933**	**0**	**0**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL ADMISSIONS							
2. PATIENT DAYS							
a. Comprehensive Care (public)	5,080	25,885	27,010	27,010	27,010		
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care	**5,080**	**25,885**	**27,010**	**27,010**	**27,010**	**0**	**0**
c. Assisted Living							
TOTAL PATIENT DAYS	***5,080***	***25,885***	***27,010***	***27,010***	***27,010***		
3. NUMBER OF BEDS							
a. Comprehensive Care (public)	80	80	80	80	80	80	80
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**80**	**80**	**80**	**80**	**80**	**80**	**80**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL BEDS	***80***	***80***	***80***	***80***	***80***	***80***	***80***
4. OCCUPANCY PERCENTAGE ****IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. Comprehensive Care (public)	17.4%	88.6%	92.5%	92.5%	92.5%	0.0%	0.0%
b. Comprehensive Care (CCRC Restricted)							
Total Comprehensive Care Beds	**17.4%**	**88.6%**	**92.5%**	**92.5%**	**92.5%**	**0.0%**	**0.0%**
c. Assisted Living							
d. Other (Specify/add rows of needed)							
TOTAL OCCUPANCY %	**17.4%**	**88.6%**	**92.5%**	**92.5%**	**92.5%**	**0.0%**	**0.0%**
5. OUTPATIENT (specify units used for charging and recording revenues)							
a. Adult Day Care							
b. Other (Specify/add rows of needed)							
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the project. It should also identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including the alternative of the services being provided by existing facilities.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development cost to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why

the proposed project provides the most effective goal and objective achievement or the most effective solution to the identified problem(s) for the level of cost required to implement the project, when compared to the effectiveness and cost of alternatives including the alternative of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

RESPONSE:

The alternative settings to the proposed facility include:

1) Hospitals – A large percentage of the patients to be served by the Applicant are patients who currently must remain in the acute care hospital due to the lack of post-acute settings that can meet their service needs. The existing nursing home capacity in Baltimore City is not available to meet the demand for dialysis care or the medical monitoring requirements for some of the higher acuity patients. Social workers at UMMC and Midtown consistently report that only a small number of nursing homes in the area will accept bariatric patients and patients who require dialysis, and that bed availability for these patient cohorts is severely limited. As a result, hospital stays are often extended until a nursing home bed becomes available. These patients currently spend unnecessary days in the hospital.

- In high level terms, the cost of care comparison is stark: the average revenue per day in a Medicine Unit at UMMC is approximately $1,158 per day; the Medicare revenue per day at the Applicant's facility is projected to be $550 per day.

2) Existing nursing homes – There is a smaller percentage of patients that the Applicant will serve who could go to existing nursing homes. The Applicant, however, represents a viable, responsive, and cost-effective alternative to those other facilities for several reasons:

- Lower readmission rates - Mid-Atlantic has a documented track record of low readmission rates averaging 15% as compared to the state average of 25%.
- Reduced delays – As noted herein, the Applicant will be equipped to accept patients earlier than other nursing homes are prepared to accept, which will reduce acute care days.
- Employment of local Baltimore City residents – the Applicant will create approximately 89 new positions upon its opening and of these jobs likely to go to Baltimore City residents.
- Proximity of the facility to Baltimore City residents – the Applicant will be right in the heart of Baltimore City.

10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

Complete applicable Revenue & Expense Tables and the Workforce and Bedside Care Staffing worksheets in the CON Table Package, as required (Tables H and I for all applicants and Table F for existing facilities and/or Table G, for new facilities, new services, and when requested by MHCC staff). Attach additional pages as necessary detailing assumptions with respect to each revenue and expense line item. Instructions are provided in the cover sheet of the CON package and on each worksheet. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable. If the projections are based on Medicare percentages above the median for the jurisdiction in which the nursing home exists or is proposed, explain why the projected Medicare percentages are reasonable.

RESPONSE:

Please see **Exhibit H** for rationale for financial projections.

TABLE F. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. The table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table D reflecting changes in volume and with the costs of the Workforce identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projected revenue and expenses specifying all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with calculations detailed in the attachment and Contractual Allowance should not be

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years - ending with full utilization and financial stability (3 to 5 years post project completion) Add columns if needed.						
Indicate CY or FY										
1. REVENUE										
a. Inpatient Services										
b. Outpatient Services										
Gross Patient Service Revenues	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Allowance For Bad Debt										
d. Contractual Allowance										
e. Charity Care										
Net Patient Services Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
f. Other Operating Revenues (Specify/add rows if needed)										
NET OPERATING REVENUE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
2. EXPENSES										
a. Salaries & Wages (including benefits)										
b. Contractual Services										
c. Interest on Current Debt										
d. Interest on Project Debt										
e. Current Depreciation										
f. Project Depreciation										
g. Current Amortization										
h. Project Amortization										
i. Supplies										
j. Other Expenses (Specify/add rows if needed)										
TOTAL OPERATING EXPENSES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
3. INCOME										
a. Income From Operation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
b. Non-Operating Income										
SUBTOTAL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
c. Income Taxes										
NET INCOME (LOSS)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Inpatient Days										
1) Medicare										
2) Medicaid										
3) Blue Cross										
4) Commercial Insurance										
5) Self-pay										
6) Other										
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE G. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). This table should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the utilization projections in Table E and with the Workforce costs identified in Table H. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Revenue should be projected based on actual charges with detailed calculation by payer in the attachment. The contractual allowance should not be reported if it is a positive adjustment to gross revenue. Specify the sources of non-operating income.

	Projected Years (ending five years after completion) Add columns of needed.				
Indicate CY or FY	**2021**	**2022**	**2023**	**2024**	**2025**
1. REVENUE					
a. Inpatient Services	$ 2,091,329	$ 10,171,811	$ 10,795,387	$ 10,795,387	$ 10,795,387
b. Outpatient Services					
Gross Patient Service Revenues	***$ 2,091,329***	***$ 10,171,811***	***$ 10,795,387***	***$ 10,795,387***	***$ 10,795,387***
c. Allowance For Bad Debt	$ 40,833	$ 218,688	$ 227,453	$ 228,338	$ 228,959
d. Contractual Allowance					
e. Charity Care					
Net Patient Services Revenue	***$ 2,050,496***	***$ 9,953,123***	***$ 10,567,934***	***$ 10,567,049***	***$ 10,566,428***
f. Other Operating Revenues (Specify)	362,709	762,579	577,247	621,514	652,553
NET OPERATING REVENUE	***$ 2,413,205***	***$ 10,715,702***	***$ 11,145,181***	***$ 11,188,563***	***$ 11,218,982***
2. EXPENSES					
a. Salaries & Wages (including benefits)	$ 1,998,586	$ 4,683,688	$ 4,752,761	$ 4,752,761	$ 4,752,761
b. Contractual Services	347,241	1,491,059	1,554,148	1,554,148	1,554,148
c. Interest on Current Debt					
d. Interest on Project Debt	501,316	997,875	927,982	927,982	927,982
e. Current Depreciation					
f. Project Depreciation	425,097	859,055	871,917	871,917	871,917
g. Current Amortization					
h. Project Amortization					
i. Supplies					
j. Other Expenses (Specify)	658,077	2,532,448	2,721,499	2,720,614	2,719,993
TOTAL OPERATING EXPENSES	**$ 3,930,318**	**$ 10,564,126**	**$ 10,828,306**	**$ 10,827,421**	**$ 10,826,800**
3. INCOME					
a. Income From Operation	**$ (1,517,113)**	**$ 151,576**	**$ 316,875**	**$ 361,142**	**$ 392,181**
b. Non-Operating Income					
SUBTOTAL	***$ (1,517,113)***	***$ 151,576***	***$ 316,875***	***$ 361,142***	***$ 392,181***
c. Income Taxes	(339,657)	(60,185)	14,443	14,443	14,443
NET INCOME (LOSS)	***$ (1,177,456)***	***$ 211,761***	***$ 302,432***	***$ 346,699***	***$ 377,738***
4. PATIENT MIX					
a. Percent of Total Revenue					
1) Medicare	56.3%	54.6%	56.1%	55.9%	55.8%
2) Medicaid	23.1%	30.7%	30.8%	30.7%	30.6%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	3.2%	4.3%	4.4%	4.4%	4.4%
5) Self-pay	2.6%	3.5%	3.6%	3.5%	3.5%
6) Other	14.8%	7.0%	5.1%	5.4%	5.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Inpatient Days					
1) Medicare	50.0%	42.0%	42.0%	42.0%	42.0%
2) Medicaid	40.5%	47.0%	47.0%	47.0%	47.0%
3) Blue Cross	0.0%	0.0%	0.0%	0.0%	0.0%
4) Commercial Insurance	5.2%	6.0%	6.0%	6.0%	6.0%
5) Self-pay	4.3%	5.0%	5.0%	5.0%	5.0%
6) Other	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted)*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Administrator			$0	1.0	$120,000	$120,000				1.0	$120,000
Receptionist			$0	2.0	$25,000	$50,000				2.0	$50,000
Billing			$0	1.0	$50,000	$50,000				1.0	$50,000
Human Resources			$0	1.0	$50,000	$50,000				1.0	$50,000
Admissions			$0	1.0	$50,000	$50,000				1.0	$50,000
Medical Records			$0	1.0	$31,200	$31,200				1.0	$31,200
Total Administration			$0	7.0		$351,200	0.0		$0	7.0	$351,200
Direct Care Staff *(List general categories, add rows if needed)*											
Director Of Nursing			$0	1.0	$110,000	$110,000				1.0	$110,000
Assistant Director Of Nursing				1.0	$80,000	$80,000				1.0	$80,000
Evening Nurse Supervisor				1.0	$78,000	$78,000				1.0	$78,000
Night Nurse Supervisor				1.0	$78,000	$78,000				1.0	$78,000
MDS Coordinator				1.5	$70,000	$105,000				1.5	$105,000
Quality Assurance				1.0	$78,000	$78,000				1.0	$78,000
Infection Control Nurse				1.0	$80,000	$80,000				1.0	$80,000
RNs				11.0	$66,500	$731,500				11.0	$731,500
LPNs				8.0	$52,000	$416,000				8.0	$416,000
CNAs			$0	28.0	$30,000	$840,000				28.0	$840,000
Floor Secretary			$0	1.0	$26,000	$26,000				1.0	$26,000
Total Direct Care			$0	55.5		$2,622,500	0.0		$0	55.5	$2,622,500
Support Staff *(List general categories, add rows if needed)*											
Central Supply				1.0	$40,000	$40,000			$0	1.0	$40,000
Staff Development				1.0	$78,000	$78,000				1.0	$78,000
Social Service				1.0	$50,000	$50,000			$0	1.0	$50,000
Activities				1.0	$35,000	$35,000				1.0	$35,000
Asst. Activities				1.4	$22,880	$32,032				1.4	$32,032
Nurse Liason				1.0	$65,000	$65,000				1.0	$65,000
Food Service Mgr				1.0	$50,000	$50,000				1.0	$50,000
Cooks				3.5	$31,200	$109,200				3.5	$109,200
Cooks Helpers				4.2	$20,880	$87,696				4.2	$87,696
Laundry				2.0	$41,600	$83,200				2.0	$83,200
Housekeeping Supervisor				1.0	$35,000	$35,000				1.0	$35,000
Housekeeping Staff				4.4	$20,800	$91,520				4.4	$91,520
Maintenance				1.0	$55,000	$55,000				1.0	$55,000
Total Support			$0	23.5		$811,648			$0	23.5	$811,648
REGULAR EMPLOYEES TOTAL			$0	***86.0***		$3,785,348			$0	***86.0***	$3,785,348
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**						**967,413**					**967,413**
TOTAL COST	***0.0***		***$0***	***86.0***		***$4,752,761***	***0.0***		***$0***		***$4,752,761***

TABLE I. Scheduled Staff for Typical Work Week

INSTRUCTION: Quantify the staff that will provide bedside care that would be counted toward the current minimum staffing as required by COMAR 10.07.02.12

	Weekday Hours Per Day				Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**	**Day**	**Evening**	**Night**	**Total**
Registered Nurses	16	16	16	48	16	16	16	48
L. P. N. s	16	16	16	48	16	16	16	48
Aides	0	0	0	0	0	0	0	0
C. N. A.s	96	80	64	240	96	80	64	240
Medicine Aides								
Total				336				336
Licensed Beds at Project Completion				80	**Licensed Beds at Project Completion**			**80**
Hours of Bedside Care per Licensed Bed per Day				4.2	**Hours of Bedside Care per Licensed Bed Per Day**			4.2

	Weekday Hours Per Day				Weekend Hours Per Day			
Staff Category	**Day**	**Evening**	**Night**	**Total**	**Day**	**Evening**	**Night**	**Total**
Ward Clerks (bedside care time calculated at 50%	4	4	4	12	4	4	4	12
Total Including 50% of Ward Clerks Time				348				348
Total Hours of Bedside Care per Licensed Bed Per Day				4.35	**Total Hours of Bedside Care per Licensed Bed Per Day**			4.35

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies to demonstrate the financial condition of the entities involved and the availability of the equity contribution. If audited financial statements are not available for the entity or individuals that will provide the equity contribution, submit documentation of the financial condition of the entities and/or individuals providing the funds and the availability of such funds. Acceptable documentation is a letter signed by an independent Certified Public Accountant. Such letter shall detail the financial information considered by the CPA in reaching the conclusion that adequate funds are available.

- If debt financing is required and/or grants or fund raising is proposed, detail the experience of the entities and/or individuals involved in obtaining such financing and grants and in raising funds for similar projects. If grant funding is proposed, identify the grant that has been or will be pursued and document the eligibility of the proposed project for the grant.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project (see Part I question 15) and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, obtaining State and local land use, environmental, and design approvals, contracting and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame(s).

RESPONSE:

MAHC plans to finance the construction and operations of the Applicant through a combination of equity from its owners and debt financing from a financial institution. A letter from the independent certified public accountant firm that is the auditor for many of the other Mid-Atlantic Health Care entities is attached attesting to the ability of the applicant to provide the equity and debt financing needed for the Project. *See* **Exhibit U.** There is also a letter from a local lending institution with whom MAHC has financed other construction projects attesting to their interest in exploring the financing. *See* **Exhibit V.** Please see prior submissions, and comments throughout, concerning compliance with performance requirements.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

***INSTRUCTIONS**: List all of the Maryland Certificates of Need that have been issued to the project applicant, its parent, or its affiliates or subsidiaries over the prior 15 years, including their terms and conditions, and any changes to approved Certificates that needed to be obtained. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.*

RESPONSE:

MAHC was issued one Certificate of Need to build a 67-bed facility in Waldorf, Maryland in Charles County. The initial CON (Docket No. 11-08-2325) was issued September 10, 2010, but was modified in 2012 to change the location due to issues with the seller completing certain storm water improvements for the location. MAHC has since completed the construction of the Facility in 2015 and opened in March 2015. The project was completed on time and within the budgeted cost.

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

***INSTRUCTIONS**: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:*

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On Payer Mix;
c) On access to health care services for the service area population; and
d) On costs to the health care delivery system.

RESPONSE:

a) Volume of Service. Existing health care providers will not be impacted significantly as a result of this Project for several reasons.

#1: A large percentage of patients to be served at this new facility are patients who are now served in the hospital, not in nursing homes. The Applicant's primary aim is to shift volume from the hospital setting to the nursing home setting. This will be accomplished by providing higher skilled post-acute care, specialized resources/facility design to accommodate hard-to-place patients, and a lower cost service setting for low acuity admissions. As outlined in the original CON application, the proposed facility expects to target three patient populations, which can be described in three distinct patient cohorts:

Cohort 1 represents patients whom nursing homes traditionally serve, but for whom demand is growing and/or supply is constrained. This cohort includes hard-to-place patients who routinely experience extensive delays until placement can be arranged; only a small number of nursing homes can accommodate these patients. These hard-to-place patients include:

- Patients requiring dialysis;
- Patients requiring ventilation care and dialysis;
- Bariatric patients; and
- Low acuity patients such as wound care and cancer patients requiring light levels of care.

Population growth will drive increased demand by this cohort. Meanwhile, only a limited number of nursing homes can accommodate these patients and staffing limitation restrict the number of bariatrics patients who can be accommodated at any one time.

Cohort 2 represents higher acuity patients or patients who require nursing staff with a special skills set/continued medical services.

Cohort 2 can be divided into two types. First, this Cohort includes patients who could be discharged to the post-acute setting earlier if nursing home staff possessed an upgraded skill set, if protocols and specialty supports were strengthened, and if the facility could provide a step-up unit. The Applicant's facility will have these elements in place.

- UMMC provided an estimate of potential demand for this care. Caseworkers estimated that at least ten patients/month (120 patients per year) could be discharged earlier (this includes short stay and long stay patients in the nursing home). Although these cases may eventually have been admitted to nursing homes in the State, many of these patients could have been transferred earlier. The Applicant will meet this need which is not being met by existing facilities.

The second type in Cohort 2 includes patients whose length of stay in the hospital is extended for lack of a suitable post-acute setting and are then discharged home. These are patients who currently remain in the hospital and are never even referred to the nursing home.

- Caseworkers at UMMC estimated that at least ten patients/month (120 patients per year) might be discharged to a nursing home if a suitable setting were provided. This cohort

might include LVAD patients (patients with left ventricular implants) who require specialized equipment and nurse training to provide recuperative care. MAHC currently cares for these patients in its other facilities.

Cohort 3 represents additional Medicare patients who could be served in the SNF setting if the 3-day rule is waived. This Cohort represents a new volume of patients not currently served by nursing homes. It 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). It also includes Medicare patients with low acuity medical need, patients admitted for pain management and palliative care, and patients who are admitted to acute care in a deconditioned state and would benefit from a rehabilitation stay.

- Caseworkers at UMMC estimate that approximately 20 patients per month (240 patients per year) might be referred for placement. This would translate into a reduction in acute care days and incremental patients/incremental days of nursing home utilization.

Cohort 3 also includes patients who could be admitted directly from the Emergency Room or the Observation Unit. This represents new volume to the nursing home, and may translate into a reduction in Observation hours at the hospital. This plan of care will reduce the infection risks associated with hospital stays, reduce the costs per day, and reduce the high copayments now borne by patients in the Observation Unit.

- Caseworkers at UMMC estimate that approximately 10-12 patients per month of this profile might be served in the post-acute setting (120-144 patients per year of new demand). This category would likely include patients who suffer falls – for whom neurologic and cardiac issues have been ruled out, but who are deconditioned and could benefit from additional time for restorative care and rehabilitation.

#2: The new facility aims to accommodate local patients who now travel out of area for nursing home care. There will be minimal impact to area nursing homes, as this population has not been served by area nursing homes; it represents a shift from out of area providers to the local service area.

As documented earlier, more than 40% of West Baltimore residents over the age of 65 who utilize nursing homes are placed at nursing homes outside of Baltimore City.[11] These numbers include patients requiring dialysis and ventilator care who must be discharged to nursing homes in Prince George's County or Anne Arundel County, or patients who could not be accommodated at local nursing homes because of high occupancy rates (see Figure 14). These numbers may also reflect the choices made by City residents to utilize newer facilities. The proposed nursing home will provide a new, state-of-the-art nursing home option for the West Baltimore community, in close proximity to families and support systems, and strongly connected to the UMMS delivery system to support continuity of care. In response, outmigration rates will be reversed, care management will be strengthened, and family satisfaction should increase. This supports the goals of the waiver, community health improvement, and the Triple Aim. As stated, there will be minimal impact to area nursing homes, as this population has not been served by area nursing homes.

[11] This data is based on the Minimum Dataset provided by MHCC staff for the CON reflecting 2013 utilization. The MHCC staff no longer provides this data for inclusion in a CON.

#3: The projected volume is also premised on the demographic growth of the elderly population (documented in the original CON application) to drive increased demand. This volume does not represent a shift from existing providers, but represents new market growth. Therefore, it will not impact the volume at existing nursing homes.

#**4: Any volume shifts that occur from existing providers will be distributed across many nursing homes; no single nursing home is likely to be negatively impacted by this shift.** Moreover, the Baltimore City jurisdiction now operates at >90% occupancy rate.

In conclusion, the Applicant maintains that the proposed facility will not significantly impact area providers. This premise was supported by an analysis prepared by Berkeley Research Group ("BRG") and documented in "Completeness Questions (June 9, 2015). BRG determined that MAHC's volume target could be met largely by shifts in hospital volume and shifts from out of area facilities, and that projected census did not depend heavily on volume shift from existing nursing home providers in the Region.[12] BRG noted that while there will undoubtedly be some shift from area nursing homes, this volume will be drawn from more than 20 nursing homes in Baltimore City. BRG agreed that no single nursing home would be likely to be significantly impacted by this shift.

b) **Payer Mix**. The new facility will not impact the payer mix at area nursing homes because the patient volume projected for the new facility is generally not served in area nursing homes currently. As the discussion above indicated, the projected volume for the new facility includes:

- Higher acuity patients or patients who require specialized resources/staffing capabilities/accommodations - These patients are currently served in the acute hospital with longer-than-necessary acute care stays. The proposed facility will effectively shorten length of stay in the hospital, shifting patient days from the hospital setting to the new nursing home. This shift will not significantly impact area nursing homes because these patients are generally not served in area nursing homes.
- Patients now served at out-of-area nursing homes – The volume shift from out-of-area nursing homes to the new facility will not impact the payer mix for area nursing homes because these patients are not served at area nursing homes.
- Transfers after 1-2 acute care days and direct admissions from the ER – Under a Federal waiver of the 3-day rule, a new cohort of patients would be served by the nursing home. Currently, these patients are treated in the hospital setting (until these patients qualify for transfer). The projected volume will not have an impact on area nursing homes because this volume is not currently served by nursing homes.
- New demand driven by population growth and the aging of the population - This represents new volume to the market as a function of demographic growth. This volume does not represent a shift from existing providers in the area and therefore will not impact the payer mix at area nursing homes.

[12] The one exception to this is the referral of patients with dialysis and ventilator care requirements, who are now referred to distant out-of-area facilities in Prince George's County and Anne Arundel County. At this time, estimates can only be made from the verbal reports of UMMC and UMMS Midtown; BRG did not have data available from other area hospitals. Reports from these two hospitals – expected to be the major referral sources to the new facility – estimate that more than 150 total dialysis/ventilator or dialysis/tracheotomy patients were placed at "out of area" facilities in the past year. The very large majority of these patients would be expected to be referred to the new facility, where patients can be closer to local friends and family members. We note that the proposed facility is very accessible by public transportation, which is not the case for distant facilities.

- Patients now served at area nursing homes who may instead opt for the new facility – This volume *would* represent a shift from local nursing homes, but nursing home volume for Baltimore City residents is distributed widely across more than 20 Baltimore City nursing homes. Therefore, there will be minimal impact on individual nursing homes.

c) **Access to Health Care Services** - The Project will improve access to post-acute care for Baltimore City residents who currently face very limited options for the level of care described above. Stated simply, there is no post-acute setting of this kind in the immediate area. As a result, post-acute patients with complex medical conditions, requirements for continued medical treatment, and/or requirements for specialized monitoring, equipment, staffing or facility design typically remain in the hospital or are discharged to distant facilities.

The Project will improve access for residents of the West Baltimore community, in particular. In this region, local area nursing homes currently operate at 90+% occupancy rates and residents are often admitted to out-of-area nursing homes. The most recent outmigration data made available shows that nearly two thirds of West Baltimore nursing home patients are served at out-of-area facilities,[13] farther from home and family supports. Moreover, the overall occupancy rate in Baltimore City nursing homes in FY2016 is reported to be 90.3%.[14]

d) **Health Care Costs**. The proposed facility will support the Waiver goals to improve quality of care and reduce the total costs of care by reducing acute care lengths of stay and by reducing 30-day readmission rates.

Specifically, the Project will reduce acute care length of stay by permitting earlier discharge from the hospital. The Applicant is distinguished by its ability to care for the more complex medical patients and patients with distinct service needs who are generally not able to be accommodated in other area nursing homes. This will permit earlier discharge from the acute care hospital, thereby reducing overall acute care days and health care costs for Maryland. The positive impact will be reflected in:

- Increased patient satisfaction as a result of shorter hospital stays
  - Patients will not have to remain in the hospital for lack of an appropriate post-acute setting
- Lower costs to payers and patients
  - The Applicant's per diem is expected to be more than $600 -$1,000 lower relative to the per diem at UMMC. This will result in savings to both payers as well as to patients, who are bearing increasing copayment burdens.
- Improved performance under the Medicare waiver test
  - Leveraging the lower cost setting will translate into a reduction in the "total Medicare spend;" this will support Maryland's performance under the waiver test which requires Maryland to generate $300 million in compounded annual Medicare savings in Phase II of the Demonstration Model.

In addition, MAHC will reduce length of stay in the post-acute facility. In its Philadelphia facilities, MAHC reduced the average length of stay in the nursing home by five days with no corresponding increase in the 30-day all-cause readmission rate.

[13] Minimum Data Set, 2013, obtained through the MHCC.
[14] Maryland Register, Vol. 45, Issue 16 (August 2018).

Moreover, the Project will support performance under the readmission waiver test. Phase II of the Demonstration Model continues to require that the State of Maryland achieve hospital readmission rates below the national average. This is a challenging goal, given that the national average is a moving target. In order for the State of Maryland to meet this performance measure, UMMS will require post-acute resources that respond to the specialized resource requirements/complexity of its patients, as well as post-acute partners who work closely with UMMS clinicians on clinical protocols and care management.[15]

The Applicant will provide these in-house clinical capabilities, the caliber of nursing home staff, and the close working relationships with hospital clinicians to minimize the need for hospital transfers. This will reduce readmission rates of nursing home patients from UMMS hospitals, a patient population that has demonstrated historically high readmission rates., and the need for close working relationships between acute and post-acute clinicians.

Mid-Atlantic has a successful track record in reducing readmissions to the acute hospital. Readmission rates at Mid-Atlantic's nursing homes are lower than the industry average. It has invested heavily in clinical staff and reporting mechanisms to closely monitor patient conditions and quickly mobilize resources and manage clinical issues in the nursing homes. Its track record testifies that the Applicant will be a valuable partner in helping individual hospitals and the State of Maryland achieve their readmission targets.

The proposed facility will reduce costs by working closely with UMMC in a "Risk Construct for the Management of Medicare Patients." This model will incentivize both providers to control the costs of care. With this relationship and data systems in place, administrative processes will be streamlined and transfers will occur far more quickly; staff across the institutions will collaborate regularly, and the goal for timely discharge to the post-acute setting will be the priority; administrative delays tied to patient assessment, insurance verification, and transfer process will be minimized.

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[15] The Medicare readmission rate at Maryland hospitals represents one of the core performance measures which Maryland is required to meet under the terms of the Demonstration Model. The figure cited in the CON application - - a 16.94% readmission rate --represents Maryland's 30-day readmission rate for Medicare patients only; CMS compares this performance measure to the nation's 30-day readmission rate for Medicare patients. Maryland's CY2014 readmission rate of 16.94% was 8% higher relative to the nation's CY2014 Medicare-only readmission rate of 15.73% (source: HSCRC's Final Recommendation for Updating the Hospital Readmission Reduction Incentive Program for RY2017, presented March 2015). More recently, the casemix adjusted readmission rate for Maryland hospitals declined to below the national average. However, Maryland will continue to be required to demonstrate improvement.

A second relevant indicator is the admission rate of nursing home patients to the acute care hospital. A report issued by the Office of the Inspector General ("OIG"), based on 2011 data, cites a 25% national admission rate for nursing home patients, and a Maryland-specific rate of 25.3%. This figure is a very different metric as compared with the readmission rate for all Medicare *hospital* patients cited above. The figures calculated by the OIG represent the readmission rate to the hospital for nursing home patients, only, and is not limited to a 30-day window. Not surprisingly, this admission rate is higher than the 30-day readmission rate for all Medicare patients discharged from Maryland hospitals, given the health status and fragility of the nursing home patient population and the broader time period examined. (Note, as well, that the OIG figures reflect 2011 data.)

A more recent report issued for the SNF Value-Based Purchasing Program (2017) documents risk standardized readmission rates from nursing homes across the country in CY2015; it documents a national unadjusted average of 19.0% for all cause readmissions from SNFs across the country. This same report documents risk standardized readmission rates for individual nursing homes. Of the seven nursing homes in the West Baltimore community identified in the CON application, five nursing homes documented higher than average readmission rates.

In summary, the proposed facility will provide a higher skilled nursing home in the area, with greater resources to manage care in the nursing home setting; this will function to reduce readmissions. The proposed facility will provide care at a lower cost, and make hospital GBR dollars available for reinvestment in the community.

If the applicant is an existing nursing home, provide a summary description of the impact of the proposed project on costs and charges of the applicant nursing home, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

RESPONSE: N/A.

TABLE OF TABLES

TABLE OF EXHIBITS

Exhibit	Description	Application Page Number Reference
A	Ownership Information and Organizational Chart	1, 2, 4, 5, 19
B	HSCRC August 2018 Approval Letter	6, 42, 43, 53
C	Location Map of Proposed Facility	7, 9, 44
D	Samples of Planned Interior Look – Photographs of Restore Health Facility in Waldorf, Maryland Purchase Option	7, 12, 28
E	Letters of Support	11, 32
F	Ground Lease Option Agreement	11, 13
G	Facility Drawings (Large Scale Drawings provided separately)	14
H	Budget Assumptions	17, 66
I	Listing of Other Facilities Managed by Mid-Atlantic Health Care, LLC	19
J	Communication from DHHS CMS Concerning Delmar Settlement Agreement between OIG and Mid-Atlantic of Delmar, LLC	20
K	Purchase and Sale Agreement for 80 Beds	22
L	Sample Material Distributed to Prospective Resident at other Mid-Atlantic Facilities / Maryland Department of Health and Mental Hygiene Handout (Concerning Community Care)Map – Proposed Facility Location and Location of Nursing Facilities in Immediate Area	24
M	Course Description for "Age Specific Care"- part of the Health and Safety Compliance Training Curriculum	25
N	"Envisioning your future in a Nursing Home" by Margaret P. Calkins, Ph. D (Article Discussing the psychological and clinical advantages to private rooms)	27
O	"Household Models for Nursing Home Environments" by Gaius G. Nelson, SMArchS, NCARB ("Neighborhood Model" Discussion)	28
P	Letter from UMMS Department of Medicine (Davis)	30
Q	UMMS Proposal to HSCRC: Risk Construct for the Management of Medicare FFS Total Cost of Care in Partnership with Mid-Atlantic Health Care	32
R	Table: Average Annual Bed Occupancy Rates	48
S	Demand Assessment for Applicant: Reasonableness Test for Projected Volume (prepared by BRG)	60, 62

T	**PQI Discharges at Baltimore City Hospitals (FY2014)**	**61**
U	**Letter from CPA dated April 3, 2015 Attesting to Ability of Applicant to Provide Equity and Debt Financing Needed for Project**	**71**
V	**Letter from Bank Concerning Financing**	**71**
W	**Medicare Shared Savings Program – Skilled Nursing Facility 3-Day Rule Waiver – January 2019, Version #7**	**10, 27**
X	**Affirmations**	