David B. Paris, Esq.
901 Larch Avenue, Takoma Park, MD 20912
301-270-3168, dparis.law37@ymail.com

May 1, 2017

VIA EMAIL: Eileen.Fleck@Maryland.gov

Ms. Eileen Fleck
Chief of Specialized Services
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Ref: State Health Plan for Facilities and Services,
Freestanding Medical Facilities, COMAR 10.24.19

Dear Ms. Fleck:

The public interest is not well served by the proposed regulations, which were authored by hospitals seeking to shed inpatient services, sheltered by toothless pro forma information requirements. The regulations inappropriately reward the downsizing of hospitals and discriminate against hospitals that seek to maintain inpatient services through relocation. The state should refrain from continuing failed Maryland Health Care Commission (MHHC) policies that have resulted in Maryland being afflicted with the worst emergency room gridlock in the country.

Maryland residents contending with the onset of illness should not be forced to undergo unnecessary additional anxiety over whether they belong in an isolated emergency department or a segregated urgent care center. The state should provide a more humane and rational process by encouraging the creation of integrated Emergency and Urgent Care Centers (EUCCs), by providing a more meaningful local government role, and by requiring the routine preparation of objective studies of proposed major hospital changes.

Smart Medical Facility Planning Integrates Emergency and Urgent Care

The subject regulations that promote the continued addition of isolated hospital ERs to accommodate growing ER demand is akin to the fruitless cycle of building more roads to accommodate additional automobiles. Over recent years, Maryland ER gridlock has worsened, despite the growth of segregated emergency and urgent care facilities. The 40 existing Montgomery County urgent care centers collectively have been unable to make a dent in county ER usage, according to well-documented testimony submitted by Holy Cross hospital regarding the White Oak relocation application.

Failed MHCC emergency services policies, including a decade-long campaign to stifle plans for a Takoma Park EUCC, helps to account for Maryland's poor national showing regarding access to emergency services. The failure of the FMF regulations to incentivize integration of emergency and urgent care facilities continues the MHCC's decade-long campaign to kill off an integrated Takoma Park EUCC in favor of a segregated urgent care center. The White Oak recommended decision neglected to address evidence submitted by Takoma Park that an urgent care facility will be unable to accomodate the medical needs of 70% of the patients presently utilizing the existing Washington Adventist Hospital emergency department (ED).

"Maryland has the longest average ER wait time in the country. And while the wait time in Maryland has gone up, in the same span the national average has dropped," WMAR-TV recently reported. Maryland's poor record persists, despite a net increase of 470 additional Maryland ER treatment spaces between 2000 and 2015, according to the American College of Emergency Physicians. Maryland EDs have "one of the longest median ED wait times (367 minutes from ED arrival to departure for admitted patients) ... Maryland also has few EDs per capita (8.3 per 1 million people), despite relatively high rates of emergency physicians," the ACEP reports regarding Maryland's D rating.

Tightly integrated EUCCs discourage the use of segregated hospital ERs for sporadic crisis visits to address short-term medical needs, promote the establishment of ongoing relationships with medical providers located close to home, and encourage the development of more sustainable medical centers. EUCC's are best situated to serve as convenient gateways to the establishment of ongoing wellness and primary care services with providers located close to home.

Patients are more likely to return for follow-up and ongoing primary care appointments if they utilize the same facility where they receive emergency care or if they use adjacent medical providers attracted to the EUCC. However, delay in establishing a Takoma Park EUCC, when the WAH hospital moves in under 20 months is going to promote the deterioration of existing patterns of patronage and endanger Takoma Park residents whose ambulance services are not being bolstered, although the new facility will be seven miles away from the firehouse rather than seven blocks. Moreover, the extreme gridlock of the White Oak area is projected to worsen despite significant transit improvements.

Centura Health reports that about 75% of the patients at its group of hybrid Colorado integrated EUCCs are charged urgent care rates for visits with an average stay of 70 minutes and an average wait time of nine minutes. Hospital-affiliated integrated ED, urgent care centers reduce unnecessary emergency visits. Similarly, a Minnesota EUCC "is designed to offer emergency room–level care at lower urgent-care prices." WMAR-TV reports that in an effort to improve ER overcrowding "[s]everal hospitals in Baltimore, including the University of Maryland Medical Center, have opened urgent care facilities near the emergency departments." However, the current FMF regulations incentivize the elimination of inpatient services rather than the integration of emergency and urgent care.

The Mayo Clinic, which operates an integrated facility in La Crosse, Wisconsin, developed with the close participation of nursing staff, writes that by providing patients "[w]ith the combination of Emergency and Urgent Care in one location we eliminate the need to decide 'emergency room or urgent care' - just one entrance to both services and we will triage your situation and get you on the right track for care ... A Triage Nurse will assess each patient, and based on the health condition and established policies, he or she will determine which level of service is appropriate for each patient... During peak volume periods, we will provide 'urgent care services' using a 'fast track' process, which will allow us to be more efficient with our space and our staffing and reduce the length of stay for these patients. Likewise, caring for more complex conditions in the 'emergency services track' ensures those patients receive the level of care that they need in a more comfortable, private environment."

Furthermore, the FMF regulations should be revised to provide incentives to encourage cooperative arrangements between hospitals to promote important state goals such as increasing access to medical services and furthering competition between medical providers. In Minnesota, the Two Twelve Medical Center generates public and corporate benefits by leasing space in its EUCC to competing hospitals. During its first year of operation the facility treated 28,000 patients, considerably more than the estimated 13,000. Additional special services have been added to the facility, whose third anniversary was marked by the completion of a 73,000 square foot expansion project. The building, which has projected 42,000 patients for 2016, has reserved capacity to add multiple additional floors for further expansion.

The Kaiser Permanente and Geisinger Health systems have been cited by MHCC commissioners as potential independent FMF operators who could lend creativity and vitality to Maryland. See MHCC Meetings, June 18, 2015 and February 18, 2016.

In addition to enjoying greater access to medical providers, one EUCC's patients benefit from cost savings resulting from the direct admission of patients to some outside hospitals, an arrangement that avoids costly ED to ED transfers. Further, "[a]n estimated $2.5 million in healthcare cost savings are attributed to Two Twelve Medical Center delivering the appropriate level of urgent care rather than shifting patients to more costly emergency room care, according to Ben Nielsen, Ridgeview Medical Center's executive director." Both the urgent and emergency services are available 24 hours a day, seven days a week, and are billed at appropriate rates for the services rendered.

The current FMF regulations irresponsibly ignore the potential for collaboration between Maryland hospitals that was suggested by comments regarding the draft regulations that Holy Cross Hospital submitted on October 3, 2016. Instead of rewarding the unwanted shedding of inpatient services, the regulations should be modified to incentivize hospitals to address important state goals such as increasing access to care, reducing expenses, and increasing competition.

The availability of combined emergency and urgent care services would be reassuring to anxious patients, caregivers, parents, and EMS professionals who are concerned about whether an ER is required. Geographically segregated medical facilities force patients and medical professionals to "guess whether they should be seen in the urgent care or the emergency setting. This adds another anxiety to the experience," the Mayo Clinic reports because "if they have an injury, they're stressed and they've got to make a decision about where to go for care... What this offers is you don't have to think about it. Just go to the center, and we'll take care of it," Centura President Gary Campbell explains. "There is no condition we can't care for as well as a hospital emergency department … People don't need to decide between going to an urgent care facility or the ER during medical event," according to David Larson, a Two Twelve spokesman.

The uncertainty of patients is shared by EMS providers who report that it is often difficult to assess the extent of unseen injuries. In 2005, Paramedic Tom Potter told the Washington Post that he favored a Germantown FMF because it is safest to take many patients to full service emergency rooms since "[w]e never know what we're getting into," since often apparent symptoms can mask more serious illnesses." A satellite emergency room might charge higher rates than an urgent care center, said his colleague, paramedic Jason Masters, "but you'd get the best care. You get what you pay for."

In late 2015, the White Oak MHCC reviewer cavalierly turned a blind eye to the likelihood that anxious patients will go directly to segregated full service ERs run by WAH or Holy Cross to avoid the possibility of being sent to an ER eventually. Without holding an evidentiary hearing or seeking an impact study, her analysis uncritically concludes that a geographically segregated Takoma urgent care clinic would be frequented by most of the lower acuity patients presently served by WAH emergency services, primarily because it is going to be operated by WAH at the same location as the prior ER. WO Decision, p. 38. Her finding that "I do not conclude that it is appropriate to require AHC [Adventist Healthcare] to commit to a more expensive form of urgent and emergency care delivery, the freestanding medical facility model, at this time," is the result of a flawed analysis that caps off a ten-year MHCC obstructive effort.

It was inappropriate for the review to reject reasonable requests to hold an evidentiary hearing regarding complex issues associated with the relocation of a major general hospital of Maryland's most populous county, relocating 1,600 employees, an amount exceeding the total employment of the next nine largest Takoma Park employers. Moreover, the City of Takoma Park provided substantive support for its assertion that the urgent care center would be unlikely to serve up to 75% of the 48,000 patients presently utilizing the WAH ER annually. Response, p. 3. Further, Holy Cross Hospital presented materials detailing that the 40 existing county urgent care centers collectively have failed to make a dent in county ER usage.

Segregating emergency services at the White Oak hospital location, eight miles from the proposed Takoma Park urgent care facility, will motivate many patients to "play it safe" by driving directly to White Oak, skipping the more cost effective and potentially faster walk-in clinic. Many will seek to avoid the potential inconvenience of being told, perhaps after a long wait, that they do not belong in the isolated primary care facility, particularly when faced with the possibility that they might subsequently be forced to confront notorious and pernicious White Oak traffic, which has been identified as every bit as gridlocked as the Rockville Pike traffic congestion that prompted the founding of the Shady Grove Adventist Germantown Freestanding Emergency Center.

The 2017 Montgomery Planning Board Mobility Assessment Report identified "severe congestion" on Colesville Road rivaling Rockville Pike gridlock, Further, it found that south of the beltway evening northbound New Hampshire Avenue traffic, from the direction of Takoma Park, takes 76% longer than ordinary driving conditions and morning southbound traffic takes 47% longer than usual. Mobility p. 56. Moreover, the "Fairland/Colesville and Gaithersburg City Policy Areas have nine intersections that exceed the CLV thresholds established in the 2013 LATR/TPAR Guidelines. They are followed by Rockville City and the Silver Spring/Takoma Policy areas with six intersections that exceed the applicable CLV thresholds." Mobility at 3.

The absence of an independent study and an evidentiary hearing facilitated the White Oak reviewer's erroneous travel time analysis which utilized hopelessly outdated 2013 software that failed to reflect projected gridlock from 8,500 residences and 10,000 private sector jobs projected by county planners to result from adoption of the major 2014 White Oak Science Gateway Master Plan.

Additionally, the WAH facility, which is expected to have 2,200 employees, will be flanked by a megaproject with about 5,000 residential units and by the massive campus of the United States Food and Drug Administration (FDA), which is planning to add 5,900 employees by 2020 to its present White Oak workforce of 10,000. GAO, Planning Efforts for White Oak, Dec 2016, p. 1. A series of county planning studies have demonstrated that the gridlock will worsen despite over a billion dollars in contemplated transportation improvements, including a bus rapid transit (BRT) system. Technical Analysis Appendix, pp 656-657.

The final FMF regulations relegate citizens and their elected local government to a meaningless community meeting process that was designed by hospital lobbyists to serve as little more than a pro forma bump along the road to obtaining of a FMF. This toothless community role is in contrast to the virtual veto that the regulations confer to the Maryland Institute for Emergency Medical Service Systems (MIEMSS). A similar role should be delineated to local governments, which have significant health care and financial responsibilities. Patient advocates were poorly represented on the MHCC FMF advisory committee. Moreover, and there was little apparent effort by the MHCC to solicit comments from the general public regarding these regulations, despite an admonition to the staff during the February 2017 MHCC meetings and despite the contrasting public interest exhibited regarding the February and March 2016 General Assembly hearings regarding FMF legislation.

Further, the MHCC missed an opportunity to grant local governments the right to participate in FMF proceedings with the same legal standing as medical providers. Oral presentations by local governments to the MHCC regarding CON matters probably would be accorded greater weight if the localities also had a right to appeal the CON decision.

The MHCC ignored concerns of the City of Takoma Park that the White Oak recommended decision completely glossed over competent evidence submitted that the MHCC conditions imposed upon the Takoma Park campus were illusory since the Commission lacks authority to regulate urgent care and the behavioral clinic is a financial house of cards. Clearly the latter unit was removed from the original hospital for tactical reasons to create the illusion that the cost of the hospital was being reduced. The public has every right to lose confidence in the integrity of Maryland health care with the MHCC encouraging hospitals to game the system

MHCC Has Actively Thwarted the Integration of Urgent and Emergency Care

Since 2004, there has been a consistent pattern of MHCC footdragging to frustrate the promotion of freestanding facilities, despite four almost unanimous Maryland Assembly votes. In 2004, the MHCC rejected the application of Shady Grove Adventist Hospital to construct an emergency department with a handful of token inpatient hospital rooms. The hospital president added that "[a]n urgent care center, which would be forced to charge rates lower than hospitals, could not be self-sustaining or adequately serve the needs of the population ... Traffic congestion and the strain on Montgomery County Fire and Rescue units having to travel from upcounty points to Shady Grove also support the need for the satellite department,"

Traffic congestion levels that required construction of the Germantown FMF were outright ignored by the White Oak reviewer. Takoma residents deserve similar attention from WAH and the MHCC whose ongoing refusal to acknowledge the dangers of White Oak gridlock to ambulances brings to mind Exxon's decade-long denial of global warming. In addition to the access challenges relating to gridlock and distance the new hospital site is hemmed in on one side because the FDA has rejected allowing an additional county access road to travel through its secured campus.

"[T]here are only three roads into Viva White Oak, not counting the entrance from the Federal Research Center, which has controlled access (the gate is guarded)," according to a recent council staff memo. (p. 95 - circled). Recently, the planing board observed that "moderate to severe" upper New Hampshire Avenue congestion is "actually similar during the evening commute in both directions, perhaps influenced by FDA commuters accessing the beltway and points south." Mobility at 34.

In January 2005, legislation authorizing the Germantown FMF was introduced by Montgomery County legislators within a few months of the MHCC's 2004 rejection of an Adventist Healthcare (AH) proposal. Right before the FMF was rejected, a county legislator told the Gazette newspaper that the MHCC "don't understand the needs of our county." In 2006, when the Germantown FMF was opened the President of Shady Grove hospital emphasized , [i]n a medical emergency, minutes truly matter. The satellite ER was "strategically located to reduce travel times for Montgomery County residents, as well as facilitate speedier transport of patients."

Pam Barclay, interim executive director for the Maryland Health Care Commission, favored a Germantown urgent care center rather than a FMF because the "issue is a financial one, as many hospitals with crowded emergency rooms would like to open satellite emergency departments because they could bill patients and insurance companies at higher rates than they can for an urgent care center. Serving less critically ill patients at an urgent care center would keep costs -- and, in turn, insurance premiums -- down," according to a 2005 Washington Post article.

The Assembly overruled the judgement of the MHCC that public safety should take a back seat to financial considerations, despite the risk to residents caused by pernicious traffic gridlock impeding ambulance access to a general hospital. However, the subsequent MHCC footdragging regarding FMF regulations appears to have been intended to frustrating the legislative direction for licensing to begin on July 1, 2015.

In 2007, ignoring MHCC objections, a moratorium on freestanding ERs was overridden by a nearly unanimous vote of Maryland legislators to authorize the Queenstown Emergency Center to serve rural residents who were forced to rely on the Chesapeake Bay Bridge for access to hospital facilities. A year earlier, Senator Pipkin, the principal sponsor of the Senate bill told an Eastern Shore newspaper that the District 36 delegation members were "ready willing and able to jam through" legislation to override the moratorium.

In 2010, the General Assembly established a regulatory scheme for FMFs specifying that licensing would commence on July 2015. Health-General §§ 19-3A-03(c) and 19-3A-07(c)(2). This moratorium period, established at the request of the MHCC, was intended to allow time for the promulgation of regulations, according to a participant in the immediate legislative process. However, a series of fishy MHCC statutory interpretations, none of which have been explained by the MHCC, appear to have been calculated to delay the establishment of FMFs, particularly the Takoma Park facility.

Up to September 2014, MHCC employees represented that the FMF regulations would be in place by July when licensing was to commence. For example, MHCC health policy analyst Bill Chan wrote to me that "[t]he Commission will start work shortly on updating the regulations on freestanding emergency medical facilities, which is due by July 1, 2015." Email of September 24, 2014. Similarly, the MHCC September update stated that an upcoming "[s]tudy of the Impact of Rate Setting for Freestanding Medical Facilities"... "will include analyses useful for developing Certificate of Need (CON) regulations, as required by July 2015." See MHCC Update, September 18, 2014. However, the October update tersely states that "[i]n the previous monthly update. Staff mistakenly noted that this is required by July 2015. A Certificate of Need will be required to develop a freestanding medical facility beginning July 1, 2015; however, Staff is not required to have final regulations by this date." MHCC Update, October 16, 2014, p. 5.

Just prior to the commencement of the licensing period, an extended presentation by Paul Parker acknowledged that the 2010 legislation envisioned that regulations would guide the preparation and review of FMF applications, but neglected to explain why the regulations were not promulgated prior to the expiration of the moratorium as originally promised. MHCC Meeting, June 18, 2015. It appears that the decision to delay promulgation of the regulations for a year following the commencement of the FMF licensing period constituted an *ultra vires* MHCC extension of a legislatively specified deadline.

The MHCC has a duty to be more forthcoming with Maryland residents than the vague statement that "[p]rior to promulgation of CON regulations for establishing an FMF, staff anticipated potential statutory changes might be enacted in the 2016 legislative session." FMF Regs at 7. Eileen Fleck, MHCC Chief, Acute Care Policy and Planning, wrote me that Mr. Chen had been mistaken. Email of November14, 2014. When pressed about the September update and prior statements, she refused to elaborate, only writing that the "update on staff activities was in error." Email, November 16, 2014. When further pressed for an explanation, she wrote '[t]he reference to a July 1 deadline was a mistake. I was misinformed. The statute does not reference a deadline for adopting final regulations." Email, November 16, 2014.

Six months later, at the May MHCC meeting, further confusion was created by an inconsistent statement by MHCC Executive Director Ben Steffen that the MHCC is just "beginning work on the freestanding medical facility state health plan. We are required to have a plan out after July 1. We are not ready yet, to convene any public groups on that but staff is working to meet that deadline. Freestanding medical facilities have been in existence in the state, but there has been a moratorium for several years. With the publication of our evaluation in January, we are also responsible for developing a plan for how these facilities might be established going forward." Meeting, May 18, 2015.

The Maryland Assembly's mandate to commence licensing of FMFs has been undermined further by additional contradictory statements from MHCC principals regarding the Commission's authority to license FMFs before the issuance of final regulations. All participants during the MHCC's June 2015 meeting seemed to agree that authority to approve FMFs commenced on July 1 regardless of the availability of final regulations. However, without providing any explanation, all drafts of the FMF regulations blithely assert that "a new FMF may not be established in Maryland after July 1, 2015, until this chapter, which contains review criteria and standards ... is in effect and the Commission issues a CON finding that the application is consistent with the standards and criteria in this chapter and with CON review criteria." FMF Regs, p. 4, n. 2.

In February 2013, WAH executives told members of the publicly appointed City of Takoma Park hospital committee that the WAH had been interested in pursuing a Takoma FMF but that they had been instructed by the MHCC staff that the White Oak CON application was sure to be rejected if it included any provision for leaving behind Takoma Park emergency services. This appears to be a very 'fishy' administrative extension of a moratorium that the General Assembly specifically confined to licensing. The White Oak relocation decision was rendered six full months following the end of the licensing moratorium period. Without a EUCC, the Takoma campus is medically and financial unsustainable, and residents are endangered by long treks through gridlocked traffic for which additional ambulances have not been purchased. Moreover, the Takoma Park firehouse remains one of only two county firehouses lacking a paramedic.

A 2009 Gazette article chronicles one of WAH's repeated requests for assistance obtaining state authorization of a TP FNF. " While some City Council members want a full-service emergency care facility as opposed to a part-time urgent care center, hospital President Jere Stocks said the decision is still very much in the air at this point. .. We're going to provide the maximum amount of care as we can here after we leave," Stocks said. "The good news is we've got plenty of time, [but] we're going to need the help of the community to talk to the state in terms of 'here's what we want to see happen here.'"

Last November, a MHCC staff memo cavalierly dismissed the modest City of Takoma Park effort to expand the FMF CON exemption to include the reuse of a former hospital facility vacated by a relocating hospital, without revealing the role of the MHCC staff in damping down a Takoma FMF application. The misleading memo states that "proposing changes in the [FMF] standard to fit a specific project that the hospital in question is not sponsoring at this time but that the City is eager to support."

Ironically, while the proposed Takoma Park waiver encourages the retention of emergency services, the special interest legislation recommended by the MHCC staff is primarily written by hospitals that wish to downsize, shedding their inpatient responsibilities and cherry picking remaining services. The one-sided measure primarily was authored by the Maryland Hospital Association (MHA), to stave off competing bills providing greater local control of hospital decisions. Perversely, the regulations reward hospitals for eliminating their inpatient services through downsizing and provide nothing to relocating hospitals that are continuing to serve as general hospitals. To avoid precipitating an unsustainable race to the bottom, the FMF regulations should encourage the founding of integrated emergency and urgent care centers.

Comprehensive Hospital Relocation Planning is Desperately Needed

The State Health Plan should require the comprehensive resolution of all issues regarding the provision of medical services relating to a hospital relocation. The absence of a precise methodology for providing sustainable services at the former sites of general acute care hospitals invites continued *ad hoc* planning and rank speculation resulting in hollowed out medical facilities that are doomed to fail. Unless dual medical campuses are incorporated into the comprehensive CON process for hospital relocations, prudent jurisdictions should oppose relocations and consolidations hammer and tongs, avoiding the more collaborative Takoma approach which resulted in an unsustainable campus.

The current draft regulations, and the example set by the White Oak CON proceeding, encourages hospitals to leave FMFs out of vaguely configured second campuses in order to simplify the decision-making process. Hospitals should not be permitted to game the CON process by transforming existing medical campuses into Potemkin wellness villages serving as unsustainable temporary place markers to facilitate approval of the move of an acute care general hospital. WAH reported to an appointed Takoma Park advisory committee that it did not include a FMF in its relocation proposal because it was advised by MHCC staff that inclusion would have jeopardized approval of the entire application.

It is disturbing that the regulations make it appear that the MHCC learned nothing from a decade of dealing with the White Oak move, the fallout of which included placing a final nail in the coffin of Laurel Regional Hospital. The segmented planning is contrary to the planning goals of the CON process, but consistent with the blind eye that the state cast toward LRH's deteriorating financial condition, and the White Oak reviewer's practical invitation for WAH to abandon the Takoma campus after five years led the City of Takoma Park to conclude that the decision "appears to envision a dying campus" and that WAH "appears to envision a campus at risk." Takoma Response, p. 5.

The other flimsy condition mandated by the MHCC is a requirement that the proposed Takoma "urgent care center must be open 24 hours a day. Adventist Healthcare, Inc may not eliminate this urgent care center or reduce its hours of operation without the approval of the" MHCC. *Id* at 180. However, the 24/7 hours might be a short-lived and illusory benefit doomed to fail since overnight demand for urgent care, as distinguished from emergency care, is likely to be light, and since the decision invites further change by providing that "operating hours would be reassessed over time, based on usage." *Id* at 27. "The Mayo Clinic Emergency and Urgent Care Center writes that “[o]ccasionally 'urgent care services' are needed in the middle of the night, for example, a baby crying with an earache. This isn't a medical emergency, but may feel like one to the anxious parents."

WAH's relocation was approved despite the MHCC reviewer's serious articulated reservations about the financial fitness of the Takoma behavioral hospital, which is a fiscal house of cards due substantially to the projected loss of Medicaid funds from emergency admissions. Rejecting calls for a FMF to address the fundamental issue, the reviewer passed the buck by instead mandating a future audit of the financially impaired behavioral unit following its fourth year of operation, warning that WAH might "have to reassess its ability to continue to viably serve all acute psychiatric patients in need of service and this reassessment would undoubtedly focus on bringing psychiatric beds back to within the general hospital setting." White Oak Decision II, p. 36.

It remains unclear whether the MHCC even has legal authority to impose conditions on urgent care services. The irresponsible failure of the decision to address this critical question is particularly unsettling since the 2012 MHCC decision recommending rejection of the earlier White Oak CON lamented that while it would be "tempting to condition any approval on the establishment" of Takoma urgent care services, "the Commission does not have an adequate enforcement mechanism to ensure the implementation of such services outside the hospital." Recommended Decision No 09-15-2295, p 39. In the absence of such authority, the MHCC should eschew prescribing urgent care centers and rescue the dysfunctional Takoma Park campus.

Holy Cross argued to the MHCC that state law ostensibly treats urgent care clinics as large doctor's offices, which are free of requirements regarding hours and staffing. Similarly, exceptions filed by Montgomery General Hospital assert that the "urgent care conditions are unenforceable" and "illusory" because the MHCC has "no ongoing enforcement authority under the CON after licensure and first use. Further, nothing in the law requires WAH to obtain MHCC approval before changing the hours of operation of an urgent care center or before shutting down the center altogether." MGH. p. 16. The MHCC should require integrated EUCCs or declare a moratorium on approval of unregulated urgent care centers pending the passage of regulatory legislation.

With the hospital preparing to move in 20 months, the consequences of the absence of comprehensive planning is evidenced by the absence of any provision for bolstering the supply of city ambulances to accommodate trips that will be six to ten times longer than existing ambulance trips. Additionally, Takoma ambulances will be burdened by world-class gridlock afflicting both the White Oak and Silver Spring Holy Cross hospital sites. Moreover, at this eleventh hour, no provision has been made to add paramedic capability to the Takoma Park firehouse, which is only one of two Montgomery County firehouses without a paramedic.

It is not in the best interests of residents of the State for Maryland for the MHCC to cover up the consequences of the hospital move, leaving behind a sham Potemkin village that is doomed to fail in five years. WAH's lack of engagement regarding Takoma emergency issues was painfully evident at an April 5, 2016, open house where it was necessary for several city officials to educate several top WAH executives about the limited paramedic capabilities of the Takoma Park fire station. It was particularly shocking that this education was taking place in the wake of the recent culmination of a second lengthy CON proceeding. WAH's blissful ignorance of such basic information, known to many residents in the audience, calls into question the assurance of both WAH and the MHC that city emergency services will be adequate to deal with the White Oak relocation.

Hospitals should be held to a higher standard regarding their CON filings. Moreover, Maryland residents should be provided with independent sources of medical data and emergency care that are needed to participate in a meaningful public discussion. Independent studies of the impact of major hospital moves should be prepared as a matter of right, rather than based upon divide and conquer lobbying presided over by the Maryland Hospital Association which also, according to a highly reliable source, pulled the plug on extending the exemption to the Takoma Park campus. It is disgraceful that two White Oak CON hearings took place without any testimony being requested from Takoma Park emergency professionals.

Hospital Impact Studies Should be Routinely Mandated

The regulations should provide a means to integrate into the CON process studies of the impact of proposed radical changes to hospital services. The MHCC should lead the way to enactment of legislation to provide for objective medical impact studies of any community facing a proposal to radically alter its existing medical services. The credibility of Maryland healthcare planning is undercut by reliance on special interest legislation to accommodate particular communities while ignoring similarly situated equally deserving communities. Perhaps county governments can share in the cost of such studies in return for a role comparable to the role that the regulations designate for the Maryland Institute for Emergency Medical Service Systems (MIEMSS). See discussion MHCC February 18, 2016, Meeting, at 1:34:48).

The current Chesapeake Rural Health Workgroup is likely to be afflicted by "groupthink" because its "Easton-centric" membership does not include physicians, nurses, patients, or caregivers, and because its regional preoccupation might inherently prejudice the study against retention of the Chestertown hospital, particularly because the membership does not contain any Kent County physicians with practical knowledge delivering local medical services. Moreover, the "political" study left out Western Maryland's two rural counties, which share many medical issues with the study area.

The integrity of the Maryland hospital regulatory process is undermined by the ad hoc politically motivated amendment of last winter's FMF legislation to establish an isolated moratorium on Eastern Shore conversions pending the outcome of a $500,000 medical needs study. Impact studies should be mandated routinely for all similarly situated communities faced with hospital closings or downsizings, including equally deserving residents of Hartford County, who lobbied in vain to secure passage of a last-minute amendment that would have added their community to the moratorium and study that is limited to their neighbors. All Maryland residents deserve hospital impact studies.

The State of Maryland should mandate an even-handed process requiring studies of the impact of any proposed hospital closing or downsizing. With lives in the balance, special interest legislation should not dictate the availability of critical objective information needed by any Maryland community contending with a changing hospital landscape. Jurisdictions concerned about proposed hospital closings, relocations, and downsizings should be working together rather than falling prey to divide and conquer manipulations engineered by the MHA.

The absence of an independent study and an evidentiary hearing facilitated the White Oak reviewer's erroneous travel time analysis which utilized 2013 software. The incompetent utilization of the existing 2,709 population rather than the projected 8,500 residents projected by the 2014 White Oak Master Plan underscored the fallacious MHCC finding that any "marginal improvement in the economic well-being of the service area population that can be logically assumed for the replacement WAH at White Oak is incidental to the project rather than a strategic objective of the project," in response to the contention that WAH was "abandoning the indigent and uninsured populations that it currently services."

Preparing for the master plan process, the Montgomery Planning Board staff found that the construction of 7,351 White Oak residences would result in only 817 Moderately Priced Dwelling Units (MPDUs), 429 affordable units, and zero subsidized units replacing the existing 2,709 residences which include 2086 affordable units and 120 subsided units. The analysis concluded that "[i]ncreasing density poses a risk that redevelopment will result in rent increases that will eliminate market affordable housing options." See White Oak Science Gateway Master Plan Staff Draft, Affordable Housing Analysis, March 8, 2013. The White Oak decision is divorced from reality, and revised regulations should establish exacting policy prohibiting moving forward with plans that are socially unjust and discriminatory.

White Oak Gridlock Is Being Denied

County planners and consultants uniformly forecast that existing levels of White Oak gridlock will worsen following construction of three planned megaprojects, despite extensive planned transportation improvements. In 2014, a MOCO Council Staff report projects that the New Hampshire Avenue and Route 29 intersection will remain a "choke point," the intersection at New Hampshire Avenue and Powder Mill Road will fail totally, and extreme Lockwood Drive congestion would be complicated further by the commingling of BRT buses and cars. Recently, the intersections were ranked the second and fourth worst bottlenecks in the county, respectively, by the Montgomery Planning Board. (pp 68, 70, 71.).

A recent analysis by a team of county traffic consultants made similar findings but added that even some smaller internal intersections and roadways that presently enjoy acceptable traffic levels, including the intersection of Tech Road and Broadbirch Drive, near the hospital, will be dragged down to Levels E and F. (pages 656-657) WAH White Oak, which is expected to have 2,200 employees, will be flanked by a Viva White Oak megaproject that is planning about 5,000 residential units and by the massive campus of the United States Food and Drug Administration (FDA), which recently announced plans to add 5,900 employees by 2020 to its present White Oak workforce of 10,000.

In February, the Planning Board issued its 2017 Mobility Assessment Report, which concluded that "Bethesda and Silver Spring are home to seven of the Montgomery County's 10 most congested transportation corridors," according to a Bethesda Magazine summary. The study identified "severe congestion" on Colesville Road rivaling the Rockville Pike gridlock that prompted the founding of the Shady Grove Adventist Germantown Freestanding Emergency Center. Evenings, northbound "heavy to severe congestion" on New Hampshire Avenue south of the Beltway took 76% longer than ordinary driving conditions and morning southbound traffic takes 47% longer than usual.

For the area of New Hampshire Avenue north of the Beltway (I-495), drivers will be delayed by the gridlock 34% and 48% respectively which will worsen due to additional traffic from the FDA, and the Hillandale and White Oak Shopping Center megaprojects. Mobility pp 32, 34. The intersections of New Hampshire with Colesville Road and Powder Mill are ranked by the recent report as the second and fourth worst bottlenecks in the county, respectively. Mobility pp 68, 70, 71. Moreover, despite extensive transit improvements the former is predicted to remain a "choke point" and the latter will continue to "fail," according to a Council Report. (p. 7.) Rounding things out, travel time between Steward Drive and the Beltway on 29 (2.7 miles) might take as long as 79 minutes, despite the introduction of an extensive transit system.

Please change the regulations to encourage the establishment of integrated emergency and urgent care centers (EUCCs), to demand documentation of the efficacy of any urgent care centers, to require comprehensive hospital relocation planning to ensure sustainable facilities, to mandate the routine preparation of hospital impact studies, to provide for meaningful information hearings, to incentivize use of FMFs to provide patients with more choices, and to designate a role for local governments that follows the deferential model that already has been reserved for MIEMSS.

Thank you for your attention.

Sincerely,

David B. Paris, Takoma Park
Co-Chair, Washington Adventist Hospital Land Use Committee (which sunset in March 2013) (identified for affiliation only)