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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: June 15, 2017

SUBJECT: MedStar Franklin Square Medical Center
Docket No. 16-03- 2380

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by MedStar Franklin Square Medical Center (MFSMC).

MFSMC proposes to replace its current surgical facilities, which the applicant describes as outdated. This project will replace the hospital's 16 operating rooms (ORs) and support areas -- which are currently located in two separate areas on the second floor of the hospital -- with a 14-OR surgical suite in a new two-story building that will connect to its inpatient tower.

This project is Phase II of MFSMC's Master Facility Plan (MFP), developed in 2005 to address the age of the hospital plant and its outmoded infrastructure. (Phase I of the MFP included the replacement of the hospital's facilities for inpatient and emergency services in a new inpatient tower.) Upon completion the project will result in an OR complement consisting of: twelve (12) mixed-use general purpose ORs, one (1) hybrid OR, and one (1) interventional pulmonology room.

The primary objectives of the proposed project are to modernize outdated surgical facilities and consolidate services for efficiency. MFSMC's surgical facilities have an average age of 35 years, and none of the ORs meet the current industry standard of 600 square feet ("SF") of clear floor area.

The total project cost is estimated to be $70,000,000. MFSMC anticipates funding the project with $39,670,000 in tax-exempt bonds, $20,000,000 in fundraising, $10,000,000 in cash, and $330,000 in interest income from bond proceeds. (DI #3, Attachment 9) The project is requires a Certificate of Need ("CON") approval because it involves an estimated capital expenditure that

exceeds the current threshold for hospital capital expenditures, which is currently $11,750,000, and MFSMC did not exercise its ability to implement the project without CON approval under the provisions of Health-General §19-120(k)(6)(viii). MFSMC is seeking an adjustment of its global budget revenue that will include the additional capital costs resulting from this project and its anticipated financing method. Obtaining a CON is a necessary prerequisite to obtaining HSCRC approval of a GBR adjustment of the size sought by MFSMC that is related to a capital expenditure that exceeds the current hospital capital threshold used in defining the scope of CON regulation.

Commission staff analyzed the proposed project's compliance with the applicable State Health Plan standards and the other applicable CON review criteria at COMAR 10.24.01.08 and recommends that the project be APPROVED with the following condition:

> *Any future adjustments in rates set by the Health Services Cost Review Commission must exclude $965,687. This figure includes the estimated new construction cost that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.*

IN THE MATTER OF	*	
	*	**BEFORE THE**
MEDSTAR FRANKLIN SQUARE	*	
MEDICAL CENTER	*	**MARYLAND HEALTH**
	*	
DOCKET NO. 16-03-2380	*	**CARE COMMISSION**
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Staff Report and Recommendation

June 15, 2017

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I. INTRODUCTION

A. The Applicant

Franklin Square Hospital Center, doing business as MedStar Franklin Square Medical Center ("MFSMC" or "the Hospital"), is a 353-bed general hospital located at 9000 Franklin Square Drive in Rosedale (Baltimore County). It provides acute inpatient services for medical/surgical, obstetric, pediatric, and acute psychiatric patients. It is one of seven Maryland general hospitals operated by MedStar Health and the largest of these hospitals. MedStar Health operates also operates two general hospitals in the District of Columbia.

B. Background and Project Description

MFSMC proposes to replace its current surgical facilities, which the applicant describes as outdated. This project will replace the hospital's 16 operating rooms (ORs) and support areas -- which are currently located in two separate areas on the second floor of the hospital -- with a 14-OR surgical suite in a new two-story building that will connect to its inpatient tower.

The primary objectives of the proposed project are to modernize outdated surgical facilities and consolidate services for efficiency. MFSMC's surgical facilities have an average age of 35 years, and none of the ORs meet the current industry standard of 600 square feet ("SF") of clear floor area for each OR; in fact, only three of these ORs (ranging between 515 to 530 SF) offer as much as 450 SF of space. Some of the problems associated with the size of these ORs cited by the applicant include:

- Entrance doors are too small, presenting problems, especially for the hospital's bariatric surgery program;
- A lack of clear floor area within the ORs does not facilitate congregating the number of clinicians often needed for a contemporary surgical procedure;
- Space to accommodate the variety of imaging technology and surgical equipment that have become standard in the performance of surgical procedures is lacking. (DI #3, Exhibit 3, p. 48-49).

This project is Phase II of MFSMC's Master Facility Plan (MFP), developed in 2005 to address the age of the hospital plant and its outmoded infrastructure. (Phase I of the MFP included the replacement of the hospital's facilities for inpatient and emergency services in a new inpatient tower.) Upon completion the project will result in an OR complement consisting of: twelve (12) mixed-use general purpose ORs, one (1) hybrid OR, and one (1) interventional pulmonology room.

Finally, the fragmentation of the service into two distinct locations leads to a duplication of staff to cover the pre- and post-operative areas and support spaces, and limits the ability to share staff between these two surgery pods. One pod consists of eleven ORs; the second pod of five ORs was designed for outpatient surgery and is located in a separate section of the hospital.

The project would construct a new 75,000 SF, two-story replacement facility and renovate 600 SF to connect the replacement facility with the the existing hospital on the Ground Level and Level

1. (DI #11, p. 2) The Ground level will serve as the main arrival area for patients, with a lobby for patient drop-off, registration, patient prep, and a recovery area for patients after surgery. The fourteen ORs, and the Post-Anesthesia Care Unit ("PACU") will be located on Level 1.

The project is estimated to cost $70,000,000, including:

- $50,889,648 for the building addition, fixed equipment, site development and building infrastructure costs, fees and permits;
- $180,000 for building renovations; $16,548,501 in other capital costs; $1,588,851 as an inflation allowance; and
- $793,000 in financing costs.

MFSMC anticipates funding the project with $39,670,000 in tax-exempt bonds, $20,000,000 in fundraising, $10,000,000 in cash, and $330,000 in interest income from bond proceeds. (DI #3, Attachment 9) The project is requires a Certificate of Need ("CON") approval because it involves an estimated capital expenditure that exceeds the current threshold for hospital capital expenditures, which is currently $11,750,000, and MFSMC did not exercise its ability to implement the project without CON approval under the provisions of Health-General §19-120(k)(6)(viii). MFSMC is seeking an adjustment of its global budget revenue that will include the additional capital costs resulting from this project and its anticipated financing method. Obtaining a CON is a necessary prerequisite to obtaining HSCRC approval of a GBR adjustment of the size sought by MFSMC that is related to a capital expenditure that exceeds the current hospital capital threshold used in defining the scope of CON regulation.

C. Summary of Staff Recommendation

Staff recommends approval of the project based on its finding that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated. However, staff recommends the following condition be placed on the approval, based on staff's finding that the estimated cost of the project exceeds the benchmark calculated using the Marshall Valuation Service methodology:

> *Any future adjustments in rates set by the Health Services Cost Review Commission must exclude $965,687. This figure includes the estimated new construction cost that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.*

A summary of the basis for this recommendation is as follows:

Criteria/Standard	Conclusions
Need and Capacity	The project will not add surgical services capacity to the hospital or health system, but will modernize and consolidate the surgical facilities that are now spread across separate areas. It will reduce the OR inventory from 16 to 14and make the OR and support space more efficient to use.

Cost Effectiveness	The applicant outlined its goals and considered alternatives for this limited project. The alternative presented by the applicant -- renovation on site -- was deemed cost prohibitive given facility constraints. The applicant demonstrated that constructing a replacement facility best addresses the need to modernize hospital facilities and improve efficiency, and was the most cost effective option to meet project objectives.
Efficiency	By consolidating the two, separate surgical pods into one, the project will reduce staff duplication, resulting in a reduction of 21 full time-equivalent (FTE) staff positions.
Financial Feasibility and Viability	Equity and philanthropy will cover approximately 43% of the total project cost. MFSMC has demonstrated that it has the equity, fund-raising capability, and debt capacity to fund the project as proposed. Its utilization projections and revenue and expense assumptions are reasonable. Although MFSMC is seeking a rate increase to cover interest and depreciation for the project, MHCC staff has concluded that the project is feasible and that MFSMC will continue to be a viable hospital, even if its revenue base is not expanded in response to this project, as the hospital proposes. HSCRC staff has advised MHCC of this same conclusion.
Construction Cost	Applying the analysis outlined in the Marshall Valuation Service methodology yields a conclusion that the estimated project cost is 2% higher than the benchmark calculated by staff ($12.06 per SF above the benchmark of $595.10 per SF calculated by staff). Accordingly, staff recommends that if the project is approved it include a condition excluding the excess cost from any rate increase that might be authorized to cover the capital costs associated with this project.
Impact	The proposed project is a modernization, replacement, and "right-sizing" of the existing facility. It will align MFSMC's surgical services with updated design standards, while reducing the OR complement by two rooms. It should have no negative impact on existing providers or on services for patients. MFSMC has filed a partial rate application with HSCRC for the incremental capital costs related to this project. HSCRC has not yet acted on it. Obviously, if granted, charges would be affected.

II. PROCEDURAL HISTORY

A. Review of the Record

Please see Appendix 1, Record of the Review.

B. Interested Parties in the Review

There are no interested parties in this review.

C. Local Government Review and Comment

No comments were received by local government entities.

D. Community Support

No letters of support for the proposed project were received.

III. REVIEW AND ANALYSIS

The Commission is required to make its decision in accordance with the general Certificate of Need review criteria at COMAR 10.24.01.08G (3) (a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to all relevant State Health Plan ("SHP") standards and policies. The State Health Plan chapters that apply are COMAR 10.24.10, Acute Inpatient Services, and COMAR 10.24.11, General Surgical Services.

A. The State Health Plan

COMAR 10.24.01.08G(3)(a)State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

COMAR 10.24.10 - State Health Plan for Facilities and Services: Acute Care Hospital Services

COMAR 10.24.10.04A — General Standards.

(1) <u>Information Regarding Charges.</u> ***Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:***

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

In its application, MFSMC stated that the Financial Counseling Department and Finance Department provide information concerning charges as well as information concerning the range and types of services provided to the public, individually and upon request. (DI #3, p. 19)

Responding to Commission Staff's request that the applicant provide more information regarding its compliance with COMAR 10.24.10.04A(1)(a), MFSMC responded that it would update its hospital's policy to reflect this requirement and would ensure that a list of charges for a representative selection of hospital services would be available to the public and on the hospital's web site by January 20, 2017. (DI # 13. p. 1)

Staff subsequently verified that the MFSMC web site includes a page titled "Estimated Average Charges for Common Procedures" with a working link to a PDF that includes a list of representative charges. The web page is dated April 25, 2017.[1] The applicant included a copy of its recently updated and approved policy regarding the provision of information to the public concerning charges for its services with the application. (DI #22, p. 11)

(2) Charity Care Policy ***Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.***

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

MFSMC stated that it provides medical services to all patients regardless of their ability to pay and provided relevant sections of its Corporate Financial Assistance Policy, which includes a responsibility to "provide a financial assistance probable and likely eligibility determination to the patient within two business days of the initial financial assistance application." (DI #3, Attachment 19, p.141)

Additionally, MedStar Health's policy states that MedStar Health will provide public notices yearly in local newspapers serving the hospital's target population. (DI #3, Attachment 19, p.3). MFSMC provided a copy of its notice to provide financial assistance (DI #11, Attachment CQ 7, p. 28), which it states in both English and Spanish at the hospital's primary access points, including the

[1] https://www.medstarfranklinsquare.org/our-hospital/estimated-average-charges-for-common-procedures/?_ga=1.156215419.1960317805.1489671628#q={}
MFSMC states that the Finance Department will update this list on a quarterly basis, which would be consistent with COMAR 10.24.10.06B(29).

main patient entrance, the Woman's Pavilion entrance, the ambulatory services entrance, the emergency department entrance, and all admitting/registration areas. (DI #3, p. 20) MFSMC also provided a copy of the individual notice it provides to patients regarding the hospital's financial assistance policy. (DI #3, Attachment 21).

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

According to figures reported in the most recent Health Service Cost Review Commission's FY 2015 Community Benefit Report, MFSMC's level of charity care fell within the bottom quartile of all hospitals for this year, ranking 44th out of 53 Maryland hospitals (for details see Appendix 2), thus the applicant is required to "demonstrate that its level of charity care is appropriate to the needs of its service area population."

MFSMC opened its response to staff's questions seeking this demonstration by providing several years of perspective, as shown in Table III-1 immediately below.

Table III-1 MFSMC Charity Care Ranking Among Maryland Hospitals FY2010-FY2015

CHARITY CARE	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Amount ($000s)	$8,924.3	$10,808.6	$12,654.2	$14,943.9	$13,581.7	$6,028.4
% of Total Expenses	2.3%	2.6%	2.9%	3.3%	2.9%	1.2%
Quartile Rank	2nd	3rd	3rd	3rd	3rd	4th

Source: http://hscrc.maryland.gov/init_cb.cfm

MFSMC pointed out that its charity care increased in both absolute dollars and as a percentage of total operating expenses in each year between FY2010 and FY2013, before declining on both of these measures in FY2014 and FY2015.

MFSMC states, "A primary reason for the decline in MFSMC charity care expense as a percentage of total operating expenses is the expansion of the Maryland Medicaid program that began in January 2014..{as a result of}the Affordable Care Act (ACA)… Maryland …expanded its Medicaid program in January of 2014 with the goal of reducing the number of Marylanders without health insurance... prior to the passage of the ACA, there were just over 1 million Marylanders enrolled in Medicaid,..By FY14, there were just over 1.1 million enrollees in these programs, and by FY15 there were about 1.25 million enrollees…an increase of over 200,000 enrollees in the eighteen months after the expansion of the Maryland program." (DI#22, p.7).

To document this hypothesis MFSMC cited data showing that, statewide, Maryland hospitals experienced a 22.6% increase in gross inpatient revenue from Medicaid, while seeing a steep (73.5%) decline in the inpatient revenue associated with self-pay patients and a 30.0% decline in charity care provided by Maryland hospitals, as shown in the table below.

Table III-2: Maryland Hospital Gross Acute Inpatient Revenue Derived From Medicaid and Self Payment by Patients and Value of Inpatient Charity Care FY 2013 – FY 2015 (excludes Normal Newborn Services)

Payer Category	FY2013	FY2014	FY2015	%Variance
Medicaid HMO (All)	$942,838,890	$1,123,614,999	$1,331,002,978	41.2%
Medicaid	$572,441,693	$573,727,712	$526,812,320	-8.0%
	$1,515,280,583	**$1,697,342,711**	**$1,857,815,298**	**22.6%**
Self-pay	$293,270,116	$171,419,807	$77,639,101	-73.5%
Charity/No Charge	$518,234,532	$483,833,108	$362,585,727	-30.0%
	$811,504,648	**$655,252,915**	**$440,224,828**	**-45.8%**

Source: Medicaid and Self-Pay data: HSCRC Discharge Abstract Data, Jul 2012 - June 2015;
Charity Care: HSCRC Website, Maryland Community Benefits Data: http://hscrc.maryland.gov/init_cb.cfm

MFSMC stated that the impact of this expansion of the Medicaid program had a greater impact on it than on the typical Maryland hospital, i.e., MFSMC experienced a 53.6% increase in gross hospital revenue from patients covered by Medicaid, much greater than the 22.6% state average. It also experienced a decline of 59.7% in charity care expense, significantly larger than the 30.0% average decline in charity care in the state.[2]

MFSMC attributed this atypical impact to three factors.

1. MFSMC's Primary Service Area ('PSA") is comprised of communities which skew to the low end of median income distribution among Baltimore County Census Designated Places. Three of the four lowest median income communities in the county are in MFSMC's PSA, while the fourth is in MFSMC's secondary service area (Dundalk, Essex, Parkville, Middle River).
2. Eastern Baltimore County has a very active coalition of organizations called the Baltimore County Southeast Area Network (BCSAN), which focuses on improving the quality of life and health status of eastern Baltimore County residents and took an active role in informing residents of the change in the eligibility requirements of the Maryland Medicaid program and supporting members of the community with the application process for program enrollment.
3. MFSMC states that it has been committed to identifying uninsured patients who may qualify for insurance under the expanded Maryland Medicaid program and facilitating the enrollment process.

MFSMC states its belief that "these measures have reduced the need for charity care in its community by decreasing the number of uninsured residents and increasing the number of residents with Medicaid insurance" and "…that this factor alone accounts for the decline in charity care provided by the hospital in FY15 and {its} FY15 rank in the bottom quartile for charity care expense as a percentage of total operating expenses among Maryland hospitals…{i.e., that} the decline in charity care it provided to its community in FY15 is the result of a decline in the need for charity care in its community attributable to the factors detailed above."

[2] MFSMC presented data showing that its inpatient Medicaid discharges increased by 40% in FY2015 over FY2013, while they increased by 12% statewide.

Staff concurs with the applicant's view that its charity care ranking in the bottom quartile is explainable by what appears to be a disproportionate gain in insured patients attributable to the ACA Medicaid expansion undertaken by Maryland and the demographics of its service area, and recommends that the Commission find that this standard has been satisfied.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;
(ii) Accredited by the Joint Commission; and
(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

The Applicant documented its DHMH licensure, Joint Commission accreditation, (DI #3, Attachments 23 and 24), and compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

MFSMC stated that it collects and reviews its quality performance data monthly to monitor and improve its performance. These measures include Serious Safety Events, Acute Care Core Measures, and Patient and Employee Safety Measures. See the MFSMC's CON Application Attachment 22 for a fuller description of MFSMC's approach to Quality and Safety. http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_medstar_franklin.aspx

Staff notes that subpart (b) of this standard has become outdated, as currently written. There is still a Maryland Hospital Performance Evaluation Guide ("HPEG"), which is the hospital consumer guide component of the MHCC web site, and a set of "quality measures" are included as a component of that guide. However, in the eight years since this standard was adopted, the HPEG has been substantially expanded to include many more measures of hospital quality and performance and the specific format of the "quality measures" component of the HPEG no longer consists of a set of measure values that conform with the format of this standard, in which each measure is scored as a compliance percentage.

Currently, there are 37 "quality measures" listed in the HPEG derived from the CMS Process Measures file for the fiscal year that ended on March 31, 2016 and the CMS Outcome Measures file for Mortality and Readmission for the fiscal year that ended June 30, 2014. Performance for most of these measures (32 of the 37) is now, in a comparative context, expressed as "Below Average,"

"Average," or "Better than Average." Sufficient data was available from MFSMC to express a rating or other value for 35 of these 37 measures.

For the 30 measures with an actual MFSMC comparative performance rating, MedStar Franklin Square scored "Better than Average" on six measures, "Average" on 22 measures, and "Below Average" on two measures. Those two measures were the "immunization for influenza" prevention measure and the "aspirin at arrival" measure. The first measures how well the hospital does in immunizing patients likely to get influenza. The second measures how well the hospital does at providing aspirin to heart attack patients arriving at the hospital.

MHCC recently expanded its reporting of performance measures on an updated Maryland Health Care Quality Reports website. In its quality reports, MHCC now focuses on two priority areas: (1) patient experience, as reported by the Centers for Medicare and Medicaid Services (CMS) in its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; and (2) healthcare associated infections, as tracked by CDC's National Healthcare Safety Network ("NHSN"). Staff will recommend amendments to the Acute Care Hospital Services chapter of the State Health Plan to reflect these changes when that chapter is updated. Appendix 8 of this report provides an overview of MFSMC's performance on the broader array of quality measures now used by MHCC in its public reporting on hospital quality of care.

COMAR 10.24.10.04B-Project Review Standards

(1) Geographic Accessibility ***A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.***

The project does not propose establishment of a new acute care general hospital or the relocation and replacement of an acute care general hospital on a new site. This standard is not applicable to this proposed project.

(2) Identification of Bed Need and Addition of Beds

This project does not involve changes in bed capacity. This standard is not applicable.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit

The Applicant does not seek to establish a new pediatric unit. This standard is not applicable.

(4) Adverse Impact

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

MFSMC stated that it plans to pursue a partial rate application or Global Budget Revenue modification with HSCRC to fund at least the incremental depreciation and interest costs of the project. MFSMC states that its average charge per ECMAD is 0.32% below its peer group. (DI #3, p. 25).

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

The proposed project will reduce the OR inventory at the hospital from 16 to 14 rooms. Comprehensive data on ambulatory surgical case volume for the primary service area is not available. However, the Applicant submitted historical and projected surgical case volume for the hospital as evidence that this reduction will not inappropriately diminish the availability or accessibility to care. (DI #3, p. 25) MFSMC experienced a 12.6% decline in surgical volume from FY 2014 to FY 2016. The Applicant does not believe that volume declines will continue at the same rate and is forecasting moderate growth. (DI #3, Attachment 26). Based on current trends and projections, it is unlikely that the proposed downsizing would diminish availability of OR space at MFSMC. Similarly, OR utilization at hospitals statewide declined between CY 2010 and CY 2015, while the use of non-hospital operating rooms increased.[3] Considering these trends, the proposed reduction of two operating rooms at MFSMC would be unlikely to diminish the availability and accessibility to surgical services at MFSMC for the patient population.

With regard to the impact of this project on other services, the project will require relocation of the Eastern Family Resource Center (EFRC), one of four health centers in Baltimore County and part of the Health Care for the Homeless Health Centers Network. EFRC currently occupies the space where the proposed project will be built. The applicant states that Baltimore County, in partnership with MedStar Health, is constructing a replacement Center, scheduled to be completed in by the end of 2017. At that time, the building will be vacated and demolished. (DI #3, p. 16)

Staff concludes that the proposed project complies with this standard and will not have an unwarranted adverse impact on charges for, availability of, or access to services.

[3] MHCC's COMAR 10.24.11 Draft for Informal Public Comment

(5) <u>Cost-Effectiveness</u>

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;
(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and
(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That it has considered, at a minimum, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);
(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;
(ii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and
(iii) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

The proposed project involves limited objectives including the modernization and "right-sizing" of MFSMC's surgical services department. Thus, the Applicant is required to address subpart (b) and demonstrate that there is only one practical approach to achieving the project's objectives. MFSMC identified the following project goals. (DI #8, Attachment CQ 8).

1. Bring the hospital's ORs into compliance with all appropriate standards for the delivery of surgical services without compromising the hospital's ability to maintain a sufficient inventory of ORs to meet the current and projected need for surgical services in the hospital's service area;
2. Design and renovate/construct the facility at the most efficient project cost, in the shortest, most efficient period of time, and with the least disruption to delivery of services during the renovation/construction period, and
3. Consolidate two OR pods into one more efficient OR suite that reduces the cost of providing surgical services at MFSMC.

The applicant considered one alternative to the proposed new construction project: renovating in place rather than constructing a building additon. Cost estimates were constructed by a team made up of an architect, a construction contractor, a real estate developer, and engineers. The renovate-in-place alternative was deemed more cost prohibitive and time consuming compared to the proposed project. The cost for the selected new construction option is estimated at $70,000,000. The cost for renovating 14 ORs in the existing space was estimated to be $97,000,000 (DI #3, Attachment 27).

The most prohibitive feature of renovating the existing space to comply with contemporary industry standards is the department's location on the second floor, below the roof. The current floor-to-floor height is 12 feet. To achieve the recommended floor-to-floor height of 18 feet would require removal of the roof, addition of longer support columns, and roof replacement. (DI #11, p. 12). Additionally, the cost of renovating alongside a functioning OR would significantly lengthen the project timeline, increase the expense of the project, and would not achieve the desired consolidation. (DI #11, Attachment CQ 8). MFSMC concluded that the proposed project was the only practical approach to adequately provide 14 modernized ORs with a minimum of 600 SF of clear floor space, and achieve consolidation of surgical space, along with the cost efficiencies associated with creating a single surgical suite. (See Appendix 3 for MFSMC's *Comparison of MFSMC Replacement of Surgical Services Options*.)

MFSMC also stated that the hospital and MedStar Health spent significant planning time to determine the best location for new surgical services and the appropriate number of ORs. The proposed location and size is projected to meet the needs of inpatients and also provides the convenience, accessibility, and efficiency of an ambulatory surgery center. (DI #11, pp. 12-13).

Staff concludes that the applicant provided details on its decision-making process and alternatives, and recommends a finding that the Applicant meets this standard.

(6) Burden of Proof Regarding Need

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Staff addresses the need demonstration made for this project in its analysis regarding COMAR 10.24.11.05B.2, the surgical services chapter's Project Review Standard for Need, and in its review of the Need criterion. In summary, staff concludes that the Applicant has carried its burden of proof regarding project need.

(7) Construction Cost of Hospital Space

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

This standard requires a comparison of the project's estimated construction cost, adjusted for specific construction characteristics of the proposed project, with a benchmark, an index cost, (i.e., an "expected cost") derived from the Marshall Valuation Service ("MVS"). The benchmark cost is developed using an MVS methodology that begins with the base cost for the construction of a general hospital of Class A, good quality construction from the calculator section of the MVS guide.[4] The MVS methodology allows for a variety of adjustment factors related to the specific circumstances of the project, e.g., timing of the project, the locality, the number of stories, height per story, shape of the building (e.g., the relationship of floor size to perimeter), and departmental use of space. For a more complete explanation of MVS, as well as its application to this project, see Appendix 4.

Calculation of a Benchmark

For this project, MFSMC arrived at an MVS benchmark cost for the new construction portion of the project of $600.99 per SF. MFSMC adjusted the base costs for Class A good quality hospital construction for factors such as the sprinkler system, the fact that the project is primarily the construction of expensive surgery department space (departmental differential cost factor), the average perimeter, the average wall height, current cost, and local costs as detailed in Appendix 4. (DI #3, Attachment 28, pp. 161-163).

Commission Staff calculated its own MVS benchmark of $595.10 per SF for the new construction (see Appendix 4). This MHCC-calculated benchmark is only $5.89 per SF lower than that calculated by the applicant. The reason for this lower MVS benchmark calculation is use of a lower local multiplier by staff than that used by the applicant (1.01 vs. 1.02). Local multipliers are

[4] From Section 15, page 24 of the Marshall Valuation Service guide

meant to adjust national averages for local conditions and are updated quarterly. The applicant did not specify the date of the local multiplier it used but they must have been prior to the application submission date of August 5, 2016. The applicant also did not specify the specific location of the multiplier used. MHCC staff used the latest available local multiplier from April 2017 for Baltimore, Maryland, which is the local multiplier available for the area closest to the project location.

Comparisons of Project Costs to MVS Benchmark

In comparing its estimated costs to the $600.99 per SF MVS benchmark, MFSMC made adjustments for items that it considered to be excluded from the MVS base costs such as:

- Site demolition, rough grading, paving, storm drains, jurisdictional hook-up fees and landscaping, and walls that are explicitly excluded from the MVS calculator costs; and
- Extraordinary costs that it considered to be over and above the costs captured by the MVS calculator methodology. These adjustments included the costs of: achieving LEED silver equivalency, waterproofing and groundwater mitigation, remote utility connections, and enhanced structural support to accommodate future vertical expansion and to enable such expansion to proceed without impacting OR operations; and
- Franklin Square allocated a portion of the architects and engineering fees to each of the items identified in the previous bullets and allocated capitalized interest expenses to selected items. (DI #3, Attachment 28, p. 165).

After these adjustments MFSMC arrived at an adjusted estimated project cost of $42,501,310, which comes out to $566.68 per SF for comparison to the MVS benchmark. (DI #3, Attachment 28, p. 165 and DI #24, page 7)). This is $34.31 per SF below the MVS benchmark of $600.99 per SF calculated by MFSMC.

Staff compared its calculated MVS benchmark of $595.10 per SF to the estimated cost of the new construction as adjusted for costs that are not included in MVS, and accepted the applicant's adjustments described above with the exception of the full adjustment for remote utility connection. The adjustment classified as remote utility connection totaling $3,795,000 includes the cost of upgrading an existing central utility plant and extending services via underground trenching through existing parking lots to the new building addition. The costs include $1.35 million for a new chiller and cooling tower and associated piping designed to serve 260,000 SF. The remaining $2,445,000 is for building services such as electrical service and steam to the building addition as well as providing emergency power. (DI #24, p. 7 and DI #26)

Staff does not accept the full adjustment of almost four million dollars because MVS base costs include the cost of utility connections from lot line for typical setback and the services described above are typical of any hospital construction and, therefore, included in the MVS base.

However, to the extent the capacity of the chiller and cooling tower exceed the capacity needed to serve the 75,000 SF addition such cost should not be included in the comparison of the MVS benchmark. Thus, staff considers the $960,577[5] attributable to the capacity to serve the additional 185,000 SF[6] to be an extraordinary cost for purposes of comparing to an MVS benchmark for the 75,000 SF addition.

The following table shows Franklin Square's comparison of its estimated cost for constructing the project as adjusted to the MVS benchmark it calculated to MHCC staff's comparison of estimated cost of construction as adjusted to the staff calculated MVS benchmark.

Table III-3: Comparison of MedStar Franklin Square Medical Center's Estimated New Construction Cost To the MVS Benchmarks Calculated by MFSMC and MHCC Staff

Project Budget Item	MFSMC Estimate	MHCC Staff Estimate	Explanation of any Variance
Building	$39,863,917	$39,863,917	
Fixed Equipment	2,547,768	$2,547,768	
Site Preparation	2,783,886	$2,783,886	
Architectural Fees	4,740,077	$4,740,077	
Permits	954,000	$954,000	
New Construction Subtotal	**$50,889,648**	**$50,889,648**	
Allocated Capitalized Construction Int. & Financing Costs	**$3,763,593**	**$3,057,299**	MFSMC allocated these costs before making adjustments for project costs it considered to not be included in MVS. MHCC staff calculated the allocation after all adjustments.
Project Cost for MVS Comparison Before Adjustments	**$54,653,241**	**$53,946,947**	
Adjustments to Budget for Comparison to MVS Benchmark			
Adjustments to Site & Building Costs	$10,446,347	$7,611,425	Lack of MHCC staff acceptance of most of the adjustment MFSMC claimed for so called "remote utility connections".
Proportional Adjustment to A & E fees	$1,095,605	$798,280	This variance is also explained by differences in the size of the adjustment for remote utility connections.
Adjustment for Cap. Int. for selected cost adjustments	$609,979	$0	MFSMC subtracted costs for capitalized interest on selected cost items claimed to be extraordinary costs. MHCC staff calculated the allocated cap int. & fin. Cost as described above.
Total Adjustments	**$12,151,931**	**$8,409,705**	

[5] $1,350,000-((75,000/260,000)*$1,350,000)= $960,577.

[6] 260,000-75,000=185,000

Adjusted Total for MVS Comparison	**$42,501,310**	**$45,537,242**	
Total Additional Square Footage	75,000	75,000	
Adjusted Project Cost Per SF	**$566.68**	**$607.16**	
MFSMC and MHCC calculated MVS Benchmark Cost Per SF.	**$600.99**	**$595.10**	See table above
Total Over (Under) MVS Benchmark	**($34.31)**	**$12.06**	

Data Sources: MFSMC CON Application, Attachment 28 and April 21, 2017 and May 1, 2017 response to additional information questions: Commission Staff calculations

Conclusion

This leaves the estimated project cost higher than the benchmark by $12.06 per SF (2.0%).

This standard requires that any rate increase proposed by the hospital related to the capital cost of the project "shall not include the amount of project construction costs that exceeds the MVS benchmark and those portions of the contingency allowance, inflation allowance and capital construction interest that are based on the excess construction cost." Staff has apportioned the amounts budgeted by MFSMC for the contingency and future inflation by calculating the excess cost as a percentage of total current capital cost (1.34%) and multiplying the amounts budgeted for those line items by that percentage as shown in the following table. No apportionment of capital construction interest is necessary because such costs are already accounted for in the MVS base costs.

Table III-4: Calculation of Excess Cost

Construction cost exceeding benchmark ($12.06 x 75,000 SF)	$904,5000
Total estimated current capital cost before Inflation & finance costs	$67,618,149
Costs exceeding benchmark as percent of total current capital costs	1.34%
The portion of the contingencies that should be excluded ($2,985,346 x 1.34%)	$39,934
The portion of future inflation that should be excluded ($1,588,851 x 1.34%)	$21,253
Total to be excluded from any rate increase proposed by the hospital related to the capital cost of the project	**$965,687**

Sources: CON Application Exhibit 1, Table E and MHCC calculations

Based on this analysis, staff recommends that approval of the project should be accompanied by the following condition:

Any future adjustments in rates set by the Health Services Cost Review Commission must exclude $965,687. This figure includes the estimated new construction cost that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

(8) Construction Cost of Non-Hospital Space

The project does not involve changes to non-hospital space. This standard is not applicable.

(9) Inpatient Nursing Unit Space

The project does not propose any changes to inpatient nursing unit space. This standard is not applicable.

(10) Rate Reduction Agreement

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

This standard is no longer applicable because the rate reduction agreements referenced by the standard have been replaced by the Global Budget revenue model. Staff will consider the ongoing validity and/or revision of this standard in its next iteration of COMAR 10.24.10, the SHP chapter used in the review of general hospital projects.

(11) Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

MFSMC provided a description of the ways in which the design of the proposed project will have a positive impact on operational efficiency. In summary, those features fall under the

following themes: (DI #3, p. 29).

- A reduction in OR inventory from 16 rooms to 14 rooms, and corresponding reduction in staff expenses;
- Consolidation of surgical services into one location, and corresponding consolidation of pre-operative, post-operative, and administrative staff expenses; and
- Improved design and layout of ORs and improved work flow and staff and equipment sharing efficiencies.

Currently, MFSMC must duplicate staff to cover two pre- and post-operative areas and support spaces. The proposed project will consolidate the surgery department and reduce the applicant's OR inventory by two rooms. MFSMC projects that this will allow a staff reduction of 21 FTEs resulting in an expense savings of $2,000,000, with these cost savings realized beginning in FY 2020. (DI #3, p. 29, Attachment 11, p. 68).

Combined with a projected modest increase in surgical minutes, the staff reduction results in a 20% increase in productivity per surgical FTE (68.6 cases/FTE vs. 57.4 cases/FTE), as depicted in Table III-5 below.

Table III-5: Current and Projected Surgical Services Staffing
MedStar Franklin Square Medical Center

	FY 2016	FY 2022
Number of ORs	16	14
Projected Surgical Cases	12,055	12,969
FTEs	210	189
Surgical Cases/FTE	57.4	68.6

Source: DI #3, Attachment 26 and DI #11, p. 15-16.

Staff concludes that the applicant has provided a credible analysis of projected efficiencies, premised on eliminating the current necessity for duplications in its staffing pattern for two distinct and separate surgical suites through consolidating of the two suites and recommends a finding that the applicant has met this standard.

(12) Patient Safety

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

MFSMC states that patient safety played a central role in the planning and design of the proposed replacement surgical services facility, incorporating best practices in facility design for inpatient and outpatient surgical care. Noted safety features include: (DI #3, pp. 29-30)

- 12 general purpose ORs with a minimum clear area of 600 SF, a hybrid OR with a clear area of 800 SF, and a bronchoscopy OR with a clear area of 700 SF per the Facility Guidelines Institute (FGI) Guidelines for Design and Construction of Hospitals and Outpatient Facilities minimum area requirement;
- Floor to floor height dimension of more than 16 feet, faciliting proper positive air flow;
- Space to accommodate advanced surgical technologies, that promote high quality outcomes and patient safety, and the number of clinicians often required in advanced surgery;
- Clear floor area that contributes significantly to infection control, eliminating "room crowding" that increases the possibility of breakdown in sterile technique;
- Standardized room layout with all equipment in the same location, to reduce errors and improve safety;
- Sterile and semi-sterile areas designed with access control features;
- Peripheral support areas of the surgical suite, including storage areas, equipment rooms, and scrub sink areas located off a semi-restricted corridor;
- Clean core directly connects to every operating room, only accessed by authorized personnel and patients;
- A Phase I post-anesthesia care unit and a Phase II recovery areas that meet the minimum clear area guidance of the FGI Guidelines and have a separating wall to allow for more patient privacy and an enhanced patient care and experience; and
- A Phase I post-anesthesia care unit that meets the 1.5 post-anesthesia patient care stations per operating room guidance of the FGI Guidelines.

Staff concludes that the applicant provided evidence that indicates patient safety issues were considered in the design of the replacement surgical services department, and recommends a finding that the applicant has met this standard.

(13) Financial Feasibility

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

MFSMC provided the assumptions underlying its financial projections. For revenue, these include an assumption for inflation (2% annually for the capital project, 1.5% annually for professional fees); an assumption that professional fees will increase in line with growth in casevolume; and that contractual allowance, bad debt, charity care, and uncompensated care will be proportional to overall revenue modeled on the projected proportions for FY 2017. For expenses, salaries and wages are assumed to increase by 3% annually, with benefits equivalent to 20% of

salaries; the inflation assumption for other expense categories ranges between 1.5 to 3% per annum; and certain expenses for supplies will vary in relation to volume changes. (DI #3, Attachment 11)

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

With respect to the proposed project, there is not a projection for operating room need in the State Health Plan and accurate historical outpatient data is not available. For the hospital as a whole, selected historical and projected volume, revenue and expenses are shown below: (DI #3, Table F & G) The applicant projects less than 1% annual growth in inpatient days and outpatient case volume for most of the projected time period. Uninflated patient services revenue is, of course, projected to increase at this same rate. Uninflated operating expenses are projected to decline from FY 2018 to FY 2022 due, for the most part, to hospital-wide cost-savings and efficiency improvements, while staffing expense levels increase slightly as a percent of these operating expenses. Overall, MFSMC projected revenues to exceed expenses for the hospital as a whole, in line with historic performance.

Table III-6:Selected Current (FY 2014- FY 2016) and Projected (FY 2017 – FY 2022) Utilization and Financial (Current Year Dollars) Statistics
MedStar Franklin Square Medical Center, All Operations

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Inpatient Days	92,906	93,342	92,299	85,726	86,685	86,906	87,257	87,257	87,257
Annual Change		0.5%	-1.1%	-7.1%	1.1%	0.3%	0.4%	0.0%	0.0%
Outpatient Visits	394,187	440,761	437,103	440,679	443,482	446,391	448,460	448,460	448,460
Annual Change		11.8%	-0.8%	0.8%	0.6%	0.7%	0.5%	0.0%%	0.0%
Patient Services Revenue (Uninflated)	$476,855	$492,874	$508,466	$520,732	$521,010	$520,909	$524,400	$525,745	$525,709
Annual Change		3.4%	3.2%	2.4%	0.1%	0.0%	0.7%	0.3%	0.0%
Total Operating Expenses (Uninflated)	$468,801	$487,721	$511,828	$515,126	$512,060	$510,116	$510,093	$506,892	$501,655
Annual Change		4.0%	4.9%	0.6%	-0.6%	-0.4%	0.0%	-0.6%	-1.0%
Staffing/ Contractual Expenses (Uninflated)	$255,835	$263,468	$278,805	$284,810	$285,848	$286,023	$285,502	$282,830	$280,034
Annual Change		3.0%	5.8%	2.2%	0.4%	0.1%	-0.2%	-0.9%	-1.0%
% of Operating Expenses	54.6%	54.0%	54.5%	55.3%	55.8%	56.1%	56.0%	55.8%	55.8%
Net Income (Uninflated)	$21,744	$17,473	$9,532	$16,998	$19,617	$21,160	$24,674	$29,220	$34,421
Net Income (Inflated)	$21,744	$17,473	$9,532	$16,999	$15,353	$12,624	$11,592	$11,542	$11,758

Source: MedStar Franklin Square CON Application, DI #3, Attachments 10,12-13

Staff recommends a finding that the project is financially feasible and will not jeopardize the long-term financial viability of the hospital and that the applicant has met this standard.

(14) Emergency Department Treatment Capacity and Space
(15) Emergency Department Expansion

Neither of these standards is applicable. The project does not involve changes in MFSMC's emergency department facilities.

(16) Shell Space

The project does not include construction of shell space. This standard is not applicable.

COMAR 10.24.11 State Health Plan for Facilities and Services: General Surgical Services

.05A. General Standards.

The General Surgical Services chapter of the SHP, COMAR 10.24.11, guides CON reviews involving non-specialized surgical facilities and services. Hospital applicants are required to address all standards applicable to their proposed project in both the acute care hospital services and the general surgical services chapters of the SHP; however, COMAR 10.24.11 states that: "A hospital is not required to address standards in this Chapter that are completely addressed in its responses to the standards in COMAR 10.24.10."

MFSMC currently has 16 ORs located in two separate areas of the hospital. Fourteen rooms are mixed-use general purpose ORs and two are mixed-use special purpose. The proposed project would replace and relocate the surgical services facilities from the second floor of the main building to a newly constructed, attached building. The new surgical services would consist of 14 mixed-use general purpose ORs, 1 hybrid OR, and 1 OR designed for bronchoscopy.

The standards in the *General Surgical Services* chapter that duplicate standards from the *Acute Care Hospital Services* chapter, and are addressed in the preceding section of this report, are COMAR 10.24.11:

- **.05A(1)*, Information Regarding Charges***
- **.05A(2)*, Charity Care Policy***
- **.05A(3)*, Quality of Care***
- **.05B(6)*, Patient Safety***
- **.05B(7)*, Construction Costs***
- **.05B(8)*, Financial Feasibility*.**

Analysis of these standards will not be repeated here.

(4) <u>Transfer Agreements.</u>

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.

MFMSC stated that "it provides a full range of inpatient and outpatient services and maximizes coordination of patient care services and healthcare providers across the continuum. The appropriate type and level of care are provided according to the patient's assessed bio-psycho-social needs." MFSMC stated that it "maintains informal clinical relationships with tertiary care providers

in the area (University of Maryland Medical Center and The Johns Hopkins Hospital) for any case it receives that is outside its capabilities." (DI #11, p. 7). MFMSC also notes that emergent cardiac surgery cases are stabilized and transferred within the MedStar system to MedStar Union Memorial Hospital in Baltimore City.

MFMSC provided its policies and procedures guiding that inter-hospital transfer of patients (DI #11, Attachment CQ9, pp. 30-54) and a copy of the form that would be completed and sent with a transferred patient. (DI #3, Attachment 25). MFMSC noted that the intake of any such transferred patients is usually through the emergency department and the transfer is governed by these inter-hospital transfer policies and procedures.

Staff concludes that MFSMC's policies and procedures comply with the requirements of Health-General Article §19-308.2 – which is referenced in the standard -- and the implementing OHCQ regulations (10.07.01.23), and recommends that the MHCC find that MFSMC meets this standard.

Among the remaining applicable standards are two that prescribe policies, facility features, and staffing and/or service requirements that an applicant must meet, or agree to meet prior to first use. Staff has reviewed the CON application and confirmed that the applicant provided information and affirmations that demonstrate the proposed replacement of MFSMC's surgical services complies with these standards, **Standard .05B(4), Design Requirements** and **Standard .05B(5), Support Services.**

Regarding design requirements, the applicant states that "all project building plans (will) comply" with the applicable design requirements in Section 2.2 of the FGI Guidelines. (DI #3, p. 40), which are incorporated by reference in this SHP chapter. Regarding support services, MFSMC provides laboratory, radiology, and pathology services as part of its normal clinical operations, and has stated it will continue to provide these services through its internal staff and external contractual relationships. (DI #3, p.40). The text of these standards, as well as the location within the application where compliance is documented, is attached as Appendix 5.

.05B. Project Review Standards.

(1) <u>Service Area.</u>

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

The applicant proposes to reduce the total number of operating rooms from 16 to 14. This application is neither a proposal to establish a new hospital providing surgical services nor a proposal to expand the number of operating rooms at an existing hospital, and thus this standard is not applicable.

MFSMC identified the area from which the top 80% of its discharges originated with a map and a list of zip code areas. This service area includes eastern Baltimore City, eastern Baltimore County, and southern Harford County. (DI #3, pp. 37-38)

(2) Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospitals likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

Background

Currently MFSMC has 16 ORs split between two separate locations in the hospital. This complement includes 14 mixed-use general purpose ORs and two mixed-use special purpose ORs. The proposed project will consolidate the department, and reduce the OR complement by two rooms, configured as follows: 12 ORs for mixed-use general purpose, one hybrid OR, and one bronchoscopy OR. The project will replace the existing facilities with updated ORs, pre-and post-operative spaces, support spaces, and mechanical infrastructure in a new two-story building attached to the existing hospital. Table III-5 below shows the current and proposed OR complements.

Table III-7: Existing and Proposed Changes to Operating Room Inventory, MedStar Franklin Square Medical Center

Room Type	Current OR Inventory	Proposed OR Inventory
Mixed-Use General Purpose	14	12
Mixed-Use Special Purpose	2	
Hybrid		1
Bronchoscopy		1
Total	**16**	**14**

Needs Assessment

Historical and Projected Case Volume

MFSMC's historic and projected surgical case volume is shown in the following table.

Table III-8: MFSMC Surgical Volume

	Actual					Estimated	Projected				
Fiscal Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Surgical Cases*	14,509	14,619	13,786	12,908	11,980	11,450	12,558	12,777	12,969	12,969	12,969

* Excludes procedures that take place outside of the operating rooms (DI#28)

MFSMC's surgical volume declined by 17% between FY 2012 and FY 2016 – from 14,509 to 11,980 cases-- with a continuing slight decline forecast for 2017. The applicant states that this decline was driven by departures from the hospital's medical staff, primarily in the specialties of urology and vascular surgery. In its CON application the applicant stated that it has or it will replace the staff vacancies that led to the decline over this period, an assumption that led MFSMC to express confidence that it will recapture some of this lost volume. Franklin Square specifically reported that MFSMC has recruited five new surgeons for FY2018 to replace the departures it has experienced. (DI#28).

Looking forward, MFSMC projects that, by 2022, it will result ramp up surgical case volume to the approximate level it experienced in FY 2015 (DI #3, Attachment 26, p. 155)

OR Utilization and Projected Need for ORs

In forecasting total OR time, the applicant assumed: an average of 120 minutes for general purpose cases, 82 minutes for endovascular cases, and 88 minutes for interventional pulmonology cases. All of these estimates include turnaround time. (Based on a review of selected CON application materials from other hospitals responding to this standard, the minutes per case presented by the applicant compare favorably to most of the CON applications reviewed, i.e., historical minutes per case reported by MFSMC were less than the average minutes per case reported by other hospitals in earlier CON applications.)[7]

MFSMC used these assumptions and the optimal capacity assumptions of the State Health Plan for hospital ORs to project a need for 12.5 mixed use general purpose ORs, 0.5 endovascular special purpose ORs, and 0.4 interventional pulmonology special purpose operating rooms.

[7] The Staff recommendation on CON 15-15-2368 for Suburban Hospital included a projection of 152 minutes plus 25 minutes of turnaround time for inpatient cases and 101 minutes plus 25 minutes of turnaround time for outpatient cases based on data through 2014. CON 12-24-2332 for Mercy Medical Center included a projection of 160.3 minutes for inpatient cases and 69.1 minutes for outpatient cases, not including turnaround time. CON 09-02-2292 for Baltimore Washington Medical Center included a projection of 102 minutes of surgery time plus 30 minutes of turnaround time per case based data through 2009.

MFSMC projected a need for more than 12 general purpose operating rooms, plus one additional OR based on its experience with endovascular surgery and one additional OR based on its experience with interventional pulmonology surgery. The additional special purpose ORs would both be used at less than optimal capacity of 114,000 minutes (1,900 hours) per year, the SHP's assumed "optimal capacity" for hospital ORs of this type. In total, the projected OR need generated using these assumptions totals approximately 13.4 ORs by 2022. The detail behind these calculations is shown in Appendix 6.

Considering that the applicant is proposing to reduce its current OR inventory, it is worth noting here that the number of inpatient surgical cases in Maryland hospitals is estimated to have declined approximately 16% and 3% for outpatients between CY 2010 and CY 2015. In contrast, the number of OR cases performed at physician outpatient surgery centers and ambulatory surgical facilities is estimated to have increased about 7.5% over the same time period. The rate of outpatient surgery performed in operating rooms in all settings declined from an estimated 95 to 91 surgical cases per thousand population, and the rate of inpatient surgery declined from 30 cases to 24 cases per thousand population.[8].

The projections of caseload and OR time are reasonable in the context of the hospital's historic experience and the information provided on changes that have occurred and are projected to occur in the hospital's medical staff. Considering that the proposed project involves replacement of essential hospital facilities for purposes of modernization rather than a new or expanded facility, staff concludes that the case for fourteen operating rooms at MFSMC meets the requirements of this standard.

The case for the need to modernize and replace the facilities in a new building are covered under the discussion on the need criterion that follows.

B. <u>COMAR 10.24.01.08G(3)(b) Need</u>

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.

This Staff Report and Recommendation has considered the applicable need analysis under **COMAR 10.24.11.05B(2) Need – Minimum Utilization for Establishment of a New or Replacement Facility** immediately above, and recommended a finding of consistency with the standard. This project concerns the need to *modernize* and *relocate* the surgical facilities of the hospital.

[8] MHCC's COMAR 10.24.11 Draft for Informal Public Comment.

Need to Modernize

FGI guidelines for hospital surgical services indicate that operating rooms should have a minimum clear floor area of 400 SF, and operating rooms for image guided surgery or surgical procedures that require additional personnel or large equipment should have a minimum clear floor area of 600 SF. At MFSMC, most of the existing ORs (11 out of 16) have less than 400 SF of clear floor area, and none of the existing 16 ORs have 600 SF standard. (DI #3, Attachment 26, p. 47).

MFSMC described the following deficiencies that led to the proposal to replace the department: (DI #3, Attachment 3, DI #11, p. 12).

- The existing surgical facilities cannot be renovated to create the number of larger ORs (with 400 to 600 SF of clear area) desired;
- The average age of the existing ORs is approximately 35 years;
- Entrance doors are too small, especially for bariatric surgery;
- The clear floor area does not facilitate the number of clinicians necessary for surgical procedures;
- The layout does not facilitate the necessary mobility of clinicians within the ORs;
- The space and layout possibilities for the existing space are not ideal for accomodating contemporary intra-operative and imaging technology and for implementing minimally invasive surgical approaches;
- The existing floor to floor height on the second (top) floor of the surgical services department is 12 feet. Achieving the recommended floor to floor height of 18 feet necessary to accommodate modern equipment used in advanced surgery would require removing the roof and adding longer support columns; and
- The existing facilities are inefficient to use of ORs and the in-room "crowding" that occurs in smaller rooms presents challenges for the maintenance of sterile technique and increases risks for surgical site infection.

Need to Relocate

In its analysis of alternatives MFSMC examined the option of renovating in place. While such an option would allow some deficiencies to be addressed, as noted, renovations to bring the ORs up to 600 SF and to address the deficient floor to floor height were seen as cost prohibitive, and more disruptive of operations.

In addition, renovating in place would leave the department fragmented, in two separate pods in the hospital, forcing continued duplication and inefficiency. (DI #3, Attachment 3, DI #11, p. 12) (DI #11, p.13)

The proposed project will bring the hospital's ORs up to standard for operating room space, and will resolve other space and layout problems. The proposed project is also less expensive when

compared to the alternative of renovating in place. Replacement and relocation of the facilities is clearly the best option for both modernization and efficiency gains.

In summary, MFSMC has demonstrated the need for the proposed project by its service area population.

C. COMAR 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.

Staff has already considered the applicable cost effectiveness analysis under COMAR 10.24.10.04B(5) – Cost-Effectiveness, and recommended a finding of consistency with this standard based on the applicant's demonstration that the proposed project to replace and relocate MFSMC's surgical services department was the only practical approach to achieve the project's objectives.

It should also be noted that non-hospital surgical settings tend to have lower costs and charges than hospitals, given the high overhead expenses usually involved in building and operating a hospital.[9] Regarding this, MFSMC states that many surgical cases that are appropriate for an ambulatory surgery setting have already migrated out of MFSMC to stand-alone centers. (DI #11, p.13)

While a portion of the surgeries conducted at MFSMC could possibly be performed elsewhere at non-hospital settings for lower costs, the hospital would still need to modernize its existing facilities. The Applicant's proposal to reduce the number of hospital ORs and the cost savings associated with the proposed project also help to ensure that the proposed project will create a more cost effective setting than the existing surgical facilities of MFSMC.

The applicant has reasonably demonstrated that the project is a cost effective approach to modernizing and consolidating its surgical services department.

D. COMAR 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.

Availability of resources necessary to implement the project

The estimated cost of the project is $70 million, itemized in Table III-9 below. MFSMC proposes to fund this expense with:

- A cash contribution of $10 million;

[9] MHCC's COMAR 10.24.11 Draft for Informal Public Comment

- $20 million in philanthropic contributions;
- Debt in the amount of $39,670,000; and
- Interest income (from invested bond proceeds) of $330,000.

Cash equity and fundraising will amount to more than 40% of the total required funds. The applicant reported that it has a history of meeting and surpassing its fundraising goals in campaigns for capital improvements to the hospital and cited MFSMC's recent campaign to upgrade its neonatal intensive care facilities, in which philanthropy covered 38% of the total cost. (DI #11, p. 14)

Speaking to its ability to secure tax-exempt bonds on favorable terms, MedStar Health stated that it has shared its financing plan with rating agencies and investment banks, and states that it has the following favorable ratings outlooks:

- Moody's Investors Service A2, Positive outlook;
- Fitch Ratings A, Stable outlook; and
- Standard and Poor's A, Positive outlook. (DI #11, p.14-15).

Table III-9 : MFSMC Project Budget

Use of Funds	Total
1. Capital Costs	
b. New Construction	
Building	$ 39,863,917
Fixed Equipment	2,547,768
Site and Infrastructure	2,783,886
Architect/Engineering Fees	4,740,077
Permits (Building, Utilities, etc.)	954,000
Subtotal	$ 50,889,648
c. Renovations	
Building	180,000
Subtotal	$ 180,000
d. Other Capital Costs	
Movable Equipment	9,596,155
Contingency Allowance	2,985,346
Gross Interest during Construction Period	3,967,000
Subtotal	$ 16,548,501
Total Current Capital Costs	67,618,149
e. Inflation Allowance	1,588,851
Total Capital Costs	$ 69,207,000
2. Financing Cost and Other Cash Requirements	
Loan Placement Fees	614,000
Bond Discount	179,000
Subtotal	$ 793,000

TOTAL USES OF FUNDS	**$ 70,000,000**
Sources of Funds	
Cash	$ 10,000,000
Philanthropy	20,000,000
Authorized Bonds	39,670,000
Interest Income from Authorized Bond proceeds	330,000
TOTAL SOURCE OF FUNDS	**$ 70,000,000**

Source: DI #3, Attachment 9

Availability of resources necessary to sustain the project

The applicant projects that the hospital will generate excess revenue over expenses in FY 2020, the first full year of operation after completion of the project. Embedded in that projection is an assumption that MFSMC's global budgeted revenue will be increased so that higher charges can offset the depreciation and interest expense resulting from the project. HSCRC staff does not view this additional revenue increment as necessary to implement the project, as outlined in its memorandum of June 5, 2017 (Appendix __). HSCRC staff conclude that, if the revenue adjustment requested by MFSMC, described as $4.7 million effective November 2019, is not authorized "MFSMC's projected profit margin for FY 2022 would decrease from the 6.4% assumed in the CON to a revised 5.5%." HSCRC staff stated its belief that "MedStar Health, Inc. may have the capacity, on a system-wide basis, to reduce its existing excess volumes and fixed expenses sufficiently to absorb this estimated cost increase" and denial of the requested rate increase associated with this project will not have "a material impact on the viability of the project."

Table III-10 below projects MFSMC's revenues and expenses for FY 2014 through FY 2022.

Table III-10: MFSMC Revenue & Expense Statement, Uninflated - Entire Facility, FY 2014 thru FY 2022

	Two Most Recent Years		Current Year	Projected Years					
	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022
Revenue									
a. Inpatient Services	$ 355,074	$ 342,280	$ 346,037	$ 357,938	$ 358,480	$ 358,578	$ 360,759	$ 361,560	$ 361,539
b. Outpatient Services	325,220	321,486	345,100	351,370	351,464	351,138	353,230	354,017	353,996
Gross Patient Service Revenues	*680,294*	*663,766*	*691,137*	*709,308*	*709,945*	*709,717*	*713,990*	*715,577*	*715,934*
c. Allowance for Bad Debt	18,522	18,511	24,476	25,801	25,824	25,816	25,971	26,029	26,028
d. Contractual Allowance	174,400	149,425	151,549	155,810	156,139	156,022	156,607	156,776	156,771
e. Charity Care	10,517	2,956	6,646	6,965	6,971	6,969	7,011	7,027	7,026
Net Patient Services Revenue	*476,855*	*492,874*	*508,466*	*520,732*	*521,010*	*520,909*	*524,400*	*525,745*	*525,709*
f. Other Operating Revenues	13,341	12,281	12,894	11,392	10,667	10,367	10,367	10,367	10,367
Net Operating Revenue	***$ 490,196***	***$ 505,155***	***$ 521,360***	***$ 532,124***	***$ 531,677***	***$ 531,276***	***$ 534,767***	***$ 536,112***	***$ 536,076***
									Expenses
a. Salaries & Wages (including benefits)	$ 252,303	$ 258,764	$ 274,010	$ 280,213	$ 281,247	$ 281,422	$ 280,899	$ 278,255	$ 275,502
b. Contractual Services	3,532	4,704	4,795	4,597	4,601	4,601	4,603	4,575	4,532
c. Interest on Current Debt	9,586	8,916	7,640	7,966	8,137	8,057	7,840	7,762	7,684
d. Interest on Project Debt							1,983	1,950	1,914
e. Current Depreciation	24,345	24,281	22,768	23,614	23,504	23,364	21,744	21,167	20,748
f. Project Depreciation							1,378	2,756	2,756
g. Current Amortization									
h. Project Amorization					26	26	26	26	26
i. Supplies	76,019	75,260	74,060	73,026	70,924	69,002	67,916	67,471	66,767
j. Other Expenses	61,397	71,457	82,581	89,241	89,212	89,222	89,247	88,691	87,829
k. Purchased Services	41,619	44,339	45,974	36,469	34,409	34,422	34,457	34,239	33,897
Total Operating Expenses	***$ 468,801***	***$ 487,721***	***$ 511,828***	***$ 515,126***	***$ 512,060***	***$ 510,116***	***$ 510,093***	***$ 506,892***	***$ 501,655***
									Income
a. Income from Operation	***$ 21,395***	***$ 17,434***	***$9,532***	***$ 16,998***	***$ 19,617***	***$21,160***	***$24,674***	***$ 29,220***	***$ 34,421***
b. Non-Operating Income	349	39							
Net Income	***$ 21,744***	***$ 17,473***	***$9,532***	***$ 16,998***	***$ 19,617***	***$ 21,160***	***$ 24,674***	***$ 29,220***	***$ 34,421***

Source: DI #3, Attachment #12.

Conclusion

The applicant has demonstrated that it has the resources to implement this project and the assumptions made with respect to utilization, revenues, and expenses in modeling performance and impact of the project are reasonable. There are no substantive concerns with the financial feasibility of the project or the ongoing viability of MFSMC, whether or not the associated increase in budgeted revenue is approved by HSCRC.

E. COMAR 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.

MHCC has issued two CONs to MFSMC in the past 15 years. Both were completed in compliance with all terms and conditions of approval.

The first was a CON issued on July 20, 2006 (D.N. 05-03-2173) that approved the construction of a five-story addition which was Phase I of a master facilities plan to modernize the hospital. The approved cost of the project was $224,878,180. The project was subsequently redesigned and the last Quarterly Report submitted to MHCC on October 25, 2010 identified estimated total cost of $193,368,591. On December 10, 2010, MHCC determined that the project was complete and had been implemented consistent with the terms of the July 20, 2006 CON, and issued First Use Approval on this date.

The other CON was issued on September 18, 2008 (D.N. 08-03-2250) authorizing the hospital to convert its child psychiatric unit to an adolescent psychiatric unit. The Commission approved the project with a condition requiring MFSMC to file post-implementation reports with MHCC focused on the disposition of children and adolescents who presented with psychiatric symptoms. The project was executed satisfactorily.

Staff concludes that the application is consistent with this criterion.

F. COMAR 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 service area, 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.

Impact On Existing Providers

MFSMC stated that since the proposed project is a replacement of its existing surgical services facilities and reduces the number of ORs it operates, it anticipates no impact on the volume of services provided by other existing health care providers, on costs of those services, or on access to those services in the health planning region. It has assumed it will increase its charges to cover the depreciation and interest expense associated with the project and is seeking an adjustment of its revenue base by HSCRC to allow these higher charges. (DI #3, p. 18).

Impact On Geographic And Demographic Access To Services

Because the surgical facilities will remain on the same hospital campus, there should be no negative impact on geographic or demographic access to surgical services at MFSMC. The reduction in the number of operating rooms is in line with changing patterns of use. The project willimprove availability of more appropriately equipped rooms for certain surgical procedures at MFSMC through updating the facility to accommodate modern surgical technology.

Impact On Costs and Charges of Other Providers, and to The Health Care Delivery System

Because the hospital is not expanding its OR capacity and is designing its new OR facility to meet expected demand, it anticipates no impact on the volume of services provided by other existing health care providers. While its capital costs will increase, operating costs are projected to decline for the surgical program due to the more efficient staffing pattern that the new facilities will make possible. Charges will increase if the applicant's assumed revenue adjustment(equaling $4.7 million in the first complete year after project implementation) to offset the annual depreciation and interest expense resulting from the project is granted. HSCRC has not yet acted on this request.

Staff recommends that the Commission find that this project's impact on the health care delivery system is positive.

III. SUMMARY AND STAFF RECOMMENDATION

Based on its review and analysis of the Certificate of Need application, Commission staff recommends that the Commission find that the proposed capital project complies with the applicable State Health Plan standards, is needed, is a cost-effective approach to meeting MFSMC's objectives, is viable, is proposed by an applicant that has complied with the terms and conditions of previously issued CONs, and will not have a negative impact on service accessibility, cost and charges, or other providers of health care services.

Accordingly, Staff recommends that the Commission **APPROVE** the application of MedStar Franklin Square Medical Center for a Certificate of Need for a 75,000 square foot building addition to house replacement surgical facilities and renovation of approximately 600 square feet of existing space, at an approved capital cost of $70,000,000.

IN THE MATTER OF	*	
	*	**BEFORE THE**
MEDSTAR FRANKLIN SQUARE	*	
MEDICAL CENTER	*	**MARYLAND HEALTH**
	*	
DOCKET NO. 16-03-2380	*	**CARE COMMISSION**
	*	

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FINAL ORDER

Based on the analysis and findings in the Staff Report and Recommendation, it is this 15th day of June 2017:

ORDERED, that the application for A Certificate of Need by MedStar Franklin Square Medical Center, Docket No. 15-15-2368 for a project that will replace its surgical facilities, at an estimated project cost of $70,000,000, be **APPROVED**, with the following condition.

> *Any future adjustments in rates set by the Health Services Cost Review Commission must exclude $965,687. This figure includes the estimated new construction cost that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.*

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1

Record of the Review

Record of the Review

Docket Item #	Description	Date
1	Samuel E. Moskowitz, President of MedStar Franklin Square Medical Center ("MFSMC") and Senior Vice President, MedStar Health, submitted a Letter of Intent ("LOI") seeking Certificate of Need approval for construction of a new facility to upgrade and consolidate a total of 16 operating rooms ("ORs") and relocate the hospital's perioperative services. MHCC staff acknowledge receipt of the LOI on June 3, 2016.	6/2/16
2	Samuel E. Moskowitz submits amendment to LOI by reducing the number of operating rooms ("ORs") after project completion from 16 to 14.	8/5/16
3	Samuel E. Moskowitz submits a Certificate of Need ("CON") application on behalf of MFSMC for the replacement of its surgical services and support areas.	8/5/16
4	MHCC staff acknowledges receipt of application by letter.	8/9/16
5	MHCC staff requests *The Sunpaper* publish notice of receipt of the CON application.	8/9/16
6	Staff requests that the *Maryland Register* publish notice of receipt of the CON application.	8/9/16
7	*The Baltimore Sun* sent confirmation that a Notice of Receipt of the CON Application was published on August 18, 2016.	8/18/16
8	MHCC staff requested additional information for completeness.	8/29/16
9	Commission staff and Applicant agreed to deadline for completeness response of 9/19/16 by email.	9/6/16
10	Commission staff and Applicant discuss "relevance" of question #14 in completeness review by email.	9/8/16
11	Commission staff received Applicant's responses to the August 29, 2016 request for completeness and additional information.	9/30/2016
12	Commission staff requested second round of completeness information.	11/15/16
13	Commission staff received Applicant's responses to the November 15, 2016 request for completeness information.	11/21/16
14	Commission staff informed the applicant regarding notification of docketing for the application in the *Maryland Register* on December 9, 2016.	11/28/16
15	Commission staff requests publication of notification for the formal start of review in *The Baltimore Sun*.	11/28/16
16	Commission staff requests publication of notification for the formal start of review in the *Maryland Register*.	11/28/16
17	Commission staff sends a copy of the CON application to Gregory Branch, M.D., Health Officer for the Baltimore County Health Department for review and comment.	11/18/16
18	Notice of formal start of review is published on December 12, 2016 in *The Baltimore Sun.*	12/12/16
19	Kathy Talbot, MedStar Health sends copy of request sent to Dennis Phelps, Health Services Cost Review Commission, formally requesting a rate adjustment to fund the incremental capital costs from HSCRC.	12/23/16
20	Commission staff requests additional information regarding applicant's	3/23/2017

	compliance with two standards in the *General Surgical Services Chapter* of the State Health Plan addressing: *Information Regarding Charges*; and *Charity Care Policy*.	
21	Commission staff requests additional information regarding the applicant's compliance in *Acute Hospital Services* chapter of the State Health Plan addressing *Construction Cost of Hospital Space*.	3/30/2017
22	Commission staff received Applicant's responses to the March 23, 2017 request foradditional information.	4/6/2017
23	Commission staff submitted memo to Donna Kinzer and Jerry Schmith, HSCRC, requesting their review and comment on the MFSMC CON application addressing two State Health Plan standards. .	4/13/2017
24	Commission staff received Applicant's responses to the March 30, 2017 request for additional information addressing Marshall Swift Valuation Service.	4/21/2017
25	Commission staff received email from Applicant regarding additional information addressing two State Health Plan standards.	4/24/2017
26	Email correspondence between MHCC staff and Franklin Square Medical Center regarding information related to the MVS analysis.	4/25/17
27	Commission staff requesting HSCRC comments on the project.	5/10/17
28	Email correspondence between MHCC staff and Franklin Square Medical Center regarding updated surgical volumes.	5/26/17
29	HSCRC comments regarding the project.	6/5/17

Appendix 2

Percentage and Ranking of Charity Care Provided by Hospitals, FY 2015

Percentage and Ranking of Charity Care Provided by Hospitals, FY 2015

Ranking	Hospital Name	Total Charity Care as % of Total Operating Expense	Reported Charity Care
1	Dimensions Laurel Regional Hospital	45.06%	$ 4,726,000
2	Dimensions Prince Georges Hospital Center	28.96%	$ 15,079,327
3	UM Midtown	19.97%	$ 13,771,000
4	Adventist Washington Adventist*	16.94%	$ 9,217,136
5	UM Shore Medical Chestertown	16.59%	$ 1,230,831
6	UMMC	15.25%	$ 52,771,969
7	Holy Cross Hospital	14.89%	$ 29,924,630
8	Calvert Hospital	13.48%	$ 3,943,515
9	Mercy Medical Center	13.46%	$ 17,927,395
10	Western Maryland Health System	12.71%	$ 9,705,306
11	UM Shore Medical Dorchester	12.50%	$ 1,542,184
12	UM St. Joseph	11.43%	$ 8,002,483
13	Adventist Rehab of Maryland*	11.18%	$ 2,086,400
14	Atlantic General	11.18%	$ 2,952,568
15	UM Charles Regional Medical Center	10.06%	$ 1,464,645
	Average Charity Care, all hospitals	**10.05%**	**$ 362,585,727**
16	MedStar Harbor Hospital	9.97%	$ 2,859,045
17	Shady Grove*	9.81%	$ 10,238,461
18	UM Harford Memorial	9.60%	$ 3,080,091
19	Johns Hopkins Bayview Medical Center	9.51%	$ 16,531,000
20	Johns Hopkins Hospital	9.45%	$ 30,276,000
21	UM Shore Medical Easton	9.30%	$ 4,177,836
22	Adventist Behavioral Health at Eastern Shore*	9.24%	$ 32,069
23	Peninsula Regional	8.90%	$ 6,622,800
24	Doctors Community	8.88%	$ 10,947,888
25	UM Rehabilitation and Ortho Institute	8.67%	$ 877,000
26	Bon Secours	8.66%	$ 2,390,079
27	Garrett County Hospital	8.61%	$ 2,561,792
28	Frederick Memorial	8.40%	$ 10,472,000
29	St. Agnes	8.34%	$ 17,827,208
30	Suburban Hospital	8.10%	$ 4,093,000

31	UM Baltimore Washington	8.10%	$	8,041,930
32	MedStar Union Memorial	7.94%	$	4,022,477
33	Adventist Behavioral Health Rockville*	7.85%	$	818,860
34	Anne Arundel Medical Center	7.82%	$	2,703,700
35	Howard County Hospital	7.80%	$	3,169,655
36	Holy Cross Germantown	7.69%	$	2,108,744
37	LifeBridge Sinai	7.30%	$	4,172,967
38	Lifebridge Northwest Hospital	7.29%	$	3,226,996
39	Meritus Medical Center	7.14%	$	4,027,266
40	MedStar St. Mary's Hospital	7.08%	$	1,782,643
41	Carroll Hospital Center	6.90%	$	1,228,796
42	MedStar Good Samaritan	6.87%	$	3,151,845
43	UM Upper Chesapeake	6.30%	$	4,942,659
44	MedStar Franklin Square	6.14%	$	6,028,378
45	Sheppard Pratt	5.36%	$	4,858,679
46	Union Hospital of Cecil County	5.09%	$	833,308
47	MedStar Montgomery General	4.87%	$	3,172,151
48	MedStar Southern Maryland	4.61%	$	2,514,686
49	Ft. Washington	4.50%	$	1,455,012
50	GBMC	4.12%	$	1,674,433
52	McCready	3.39%	$	278,769
53	Mt. Washington Pediatrics	3.03%	$	109,595

Source: HSCRC's 2015 Maryland Hospital Community Benefit Report
* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis, which allows them to more accurately reflect their true activities during the Community Benefit Cycle.

APPENDIX 3

Comparison of MedStar Franklin Square Medical Center Replacement of Surgical Services Options

Comparison of MFSMC Replacement of Surgical Services Options

	Option 1: Renovate in Place*	Option 2: New Construction
GOAL 1: Bring the hospital's operating rooms into compliance with all appropriate standards for the delivery of surgical services without compromising the hospital's ability to maintain a sufficient inventory of ORs to meet the current and projected future need for surgical services in the hospital's service area.		
Correct current OR physical plant deficiencies related to FGI/ Industry Norms.	**Does Not Achieve Project Goal 1**	**Achieves Project Goal 1**
(1) Current facility lacks the square footage to accommodate the 14 ORs MFSMC projects it will need in one consolidate location with a minimum of 600 SF of clear floor area. (See also Goal 3).	Available square footage of footprint does not provide an area necessary for 14 ORs with a minimum 600 SF of clear floor area in one location	Provides space for 14 ORs with a minimum 600 SF of clear floor area.
(2) Current facility does not meet Standard of 16 FT floor to floor space	This deficiency cannot be mitigated. Changes necessary to increase the floor to floor space are cost prohibitive.	Provides Standard 16 FT floor to floor space in all rooms
GOAL 2: Design and renovate/construct the facility at the most efficient project cost, in the shortest, most efficient period of time, and with the least disruption to the delivery of services during the renovation/construction period.		
2a. Project Cost	**Does Not Achieve Project Goal 2a $97M****	**Achieves Project Goal 2a $70M**
	Renovations in place incur costs associated with demolition, infrastructure upgrades, etc., that are both time consuming and costly. Moreover, one impact of a long project schedule is the additional expense associated with cost inflation in later project years.	Achieves efficient project cost
2b. Project Timeline	**Does Not Achieve Project Goal 2b 75 Months**	**Achieves Project Goal 2b 24 Months**
	Because the project would entail ongoing OR functioning and construction/renovation in the same location, there will a repeated sequential process of room closure - renovation - room re-opening. This will significantly lengthen the project duration.	New construction on a separate site, unencumbered by mixing ongoing services with simultaneous renovations, provides the shortest project timeline.
2c. Disruption of Services During Renovation/Construction	**Does Not Achieve Project Goal 2c Significant Disruption to Current Services**	**Achieves Project Goal 2c No Disruption to Current Services**
	A renovation in place project produces significant disruptions to currently surgical services and other related services: (1) Significant noise disruptions in the OR (2) Heightened risk to sterile climate (3) Significant scheduling and access disruptions (4) Department displacements	New construction on a separate site eliminates disruption to current services.
GOAL 3: Consolidate two OR pods into one more efficient OR Suite that reduces the cost of providing surgical services at MFSMC.		
Improved Operational Efficiency	**Does Not Achieve Project Goal 3 Limited Oppurtunity for Expense Reduction**	**Achieves Project Goal $2.0M/Year Expense Reduction 3**
	The deficiency in existing square footage noted in A(1) prevents the consolidation of all surgical services into one location. This limits the opportunity for expense reduction associated with the eliminating the current duplication of series (pre-op, post-op, etc.)	Provides full consolidation of surgical services and full potential for expense reductions. Consolidating the hospital's two currently separate locations will create staffing efficiencies through the elimination of duplicated services and the streamlining of existing services through improved design and adjacencies.

*This option assumes renovation of the existing OR space in the central core of the original hospital and an expansion into other adjacent spaces that are currently housing other hospital functions. The space available for renovation does not yield enough square footage to achieve the proscribed 600 SF clear floor area in its ORs.

**Excludes escalation

APPENDIX 4

Marshall Swift Valuation Service Review

The Marshall Valuation System – What It Is and How It Works

In order to compare the cost of a proposed construction project to that of similar projects, a benchmark cost is typically developed using the Marshall Valuation Service ("MVS"). MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses, including hospitals.

The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs do not include costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, or general contingency set asides for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[10]

MVS allows the applicant and staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide.

In developing the MVS benchmark costs for a particular project the base costs are adjusted for a variety of factors using MVS adjustments such as including an add-on for sprinkler systems, the presence or absence of elevators, the number of building stories, the height per story, and the shape of the building (the relationship of floor area to perimeter). The base cost is also adjusted to the latest month and the locality of the construction project.

Developing an MVS Benchmark for This Project

MedStar Franklin Square Medical Center calculated the benchmark to be $600.99. MHCC staff has calculated its own MVS benchmark of $595.10 per square foot for the building addition proposed by MFSMC based on the information submitted in the CON Application (Docket Number 16-03-2380) and information obtained from the MVS guide. The following table identifies selected building characteristics and compares the staff calculation of the MVS benchmark to the calculations submitted by the applicant.

[10] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2014).

Comparison of Maryland Health Care Commission Staff and MedStar Franklin Square Medical Center's Calculation of Marshall Valuation Service Benchmark

Building Characteristics		
Construction Class/Quality	Class A/Good Quality	
Number of Stories	2	
Square Feet	75,000	
Average Perimeter	874	
Weighted Average Wall Height	16.0	
Average Area Per Flor	37,500	
Marshall Valuation Service Benchmark Calculations		
	MHCC Staff Calculations	**MFSMC Calculations**
Base Cost per SF (11/2015)	**$365.78**	**$365.78**
Adjustment for Dept. Cost Differences	1.58848	1.588
Adjusted Base Cost per SF	**$581.03**	**$581.04**
Multipliers		
Perimeter Multiplier	0.906	.90568
Story Height Multiplier	1.092	1.09188685
Multi-Story Multiplier*	1.000	1.000
Refined Cost per SF	**$574.59**	**$574.59**
Sprinkler Add-on per SF	$3.07	$3.07
Adjusted Refined Square Foot Cost	**$577.66**	**$577.66**
Update/Location Multipliers		
Current Cost Multiplier	1.02	1.02
Location Multiplier	1.01	1.02
Final Benchmark MVS Cost per SF	**$595.10**	**$600.99**

Source: MedStar Franklin Square Medical Center CON Application (pages 161-167) and Marshall Valuation Service®, published by Core Logic and Commission Staff Calculations

*Multi-story multiplier is .5% (.005) per floor for each floor more than three stories above the ground.

Both MHCC staff and MFSMC started with the based cost for hospital class A good quality construction last updated by MVS in November 2015. Then both staff and applicant adjusted the base costs for the departmental uses proposed by MFSMC as detailed in the application. (DI #3, Attachment 28, p. 163) and the space planning guide in MVS (Section 87, p. 8) and for the building shape (perimeter multiplier) and the story height using essentially the same adjustment factors. The same cost of sprinklers was then added.

The final proposed cost after adjustments for specific building characteristics described above were then adjusted by applying the current cost and local multiplier to bring the MVS benchmark up to date. The applicant did not specify the date of the update factors it used but they must have been prior to the application submission date of August 5, 2016. The applicant also did not specify the local multiplier that was used. MHCC staff used the latest available multipliers, current cost

multiplier for May 2017 and the local multiplier from April 2017 for Baltimore, Maryland, which is the closest local multiplier available.

Applying MVS Analysis to this project

In comparing its estimated costs to the $600.99 per SF MVS benchmark, MFSMC made adjustments for items that it considered to be excluded from the MVS base costs such as:

- Site demolition, rough grading, paving, storm drains, jurisdictional hook-up fees and landscaping, and walls that are explicitly excluded from the MVS calculator costs; and
- Extraordinary costs that it considered to be over and above the costs captured by the MVS calculator methodology. These adjustments included the costs of: achieving LEED silver equivalency, waterproofing and groundwater mitigation, remote utility connections, and enhanced structural support to accommodate future vertical expansion and to enable such expansion to proceed without impacting OR operations; and
- Franklin Square allocated a portion of the architects and engineering fees to each of the items identified in the previous bullets and allocated capitalized interest expenses to selected items. (DI #3, Attachment 28, p. 165).

The adjustment classified as remote utility connection totaled $3,795,000 includes the cost of upgrading an existing central utility plant and extending services via underground trenching through existing parking lots to the new building addition. The costs include $1.35 million for a new chiller and cooling tower and associated piping designed to serve 260,000 SF. The remaining $2,445,000 is for building services such as electrical service and steam to the building addition as well as providing emergency power. (DI #24, p. 7 and DI #26)

MHHC staff accepts the adjustments made by the applicant as described above with the exception of the full adjustment for remote utility connection. Staff does not accept the full adjustment of almost four million dollars because MVS base costs include the cost of utility connections from lot line for typical setback and such services are typical of any hospital construction and, therefore, included in the MVS base. However, to the extent the capacity of the chiller and cooling tower exceed the capacity needed to serve the 75,000 SF addition such cost should not be included in the comparison of the MVS benchmark. Thus, staff considers the $960,577[11] attributable to the capacity to serve the additional 185,000 SF[12] to an extraordinary cost for purposes of comparing to an MVS benchmark for the 75,000 SF addition.

The following table shows Franklin Square's comparison of its estimated cost for constructing as adjusted to the MVS benchmark it calculated to MHCC staff's comparison of estimated cost of construction as adjusted to the staff calculated MVS benchmark.

[11] $1,350,000-((75,000/260,000)*$1,350,000)= $960,577.
[12] 260,000-75,000=185,000

Comparison of MedStar Franklin Square Medical Center's Estimated New Construction Cost To the MVS Benchmarks Calculated by MFSMC and MHCC Staff

Project Budget Item	MFSMC Estimate	MHCC Staff Estimate	Explanation of any Variance
Building	$39,863,917	$39,863,917	
Fixed Equipment	2,547,768	$2,547,768	
Site Preparation	2,783,886	$2,783,886	
Architectural Fees	4,740,077	$4,740,077	
Permits	954,000	$954,000	
New Construction Subtotal	**$50,889,648**	**$50,889,648**	
Allocated Capitalized Construction Int. & Financing Costs	**$3,763,593**	**$3,057,299**	MFSMC allocated these costs before making adjustments for project costs it considered to not be included in MVS. MHCC staff calculated the allocation after all adjustments.
Project Cost for MVS Comparison Before Adjustments	**$54,653,241**	**$53,946,947**	
Adjustments to Budget for Comparison to MVS Benchmark			
Adjustments to Site & Building Costs	$10,446,347	$7,611,425	Lack of MHCC staff acceptance of most of the adjustment MFSMC claimed for so called "remote utility connections".
Proportional Adjustment to A & E fees	$1,095,605	$798,280	This variance is also explained by differences in the size of the adjustment for remote utility connections.
Adjustment for Cap. Int. for selected cost adjustments	$609,979	$0	MFSMC subtracted costs for capitalized interest on selected cost items claimed to be extraordinary costs. MHCC staff calculated the allocated cap int. & fin. Cost as described above.
Total Adjustments	**$12,151,931**	**$8,409,705**	
Adjusted Total for MVS Comparison	**$42,501,310**	**$45,537,242**	
Total Additional Square Footage	75,000	75,000	
Adjusted Project Cost Per SF	**$566.68**	**$607.16**	
MFSMC and MHCC calculated MVS Benchmark Cost Per SF.	**$600.99**	**$595.10**	See table above
Total Over (Under) MVS Benchmark	**($34.31)**	**$12.06**	

Data Sources: MFSMC CON Application, Attachment 28 and April 21, 2017 and May 1, 2017 response to additional information questions: Commission Staff calculations

APPENDIX 5

Excerpted CON standards for General Surgical Services From State Health Plan Chapter 10.24.11

Excerpted CON standards for General Surgical Services
From State Health Plan Chapter 10.24.11

Each of these standards prescribes policies, services, staffing, or facility features necessary for CON approval that MHCC staff have determined the applicant has met. Bolding added for emphasis. Also included are references to where in the application or completeness correspondence the documentation can be found.

STANDARD	**APPLICATION REFERENCE (Docket Item #)**
(4) Design Requirements. Floor plans submitted by an applicant **must be consistent with the current FGI Guidelines.** (a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines. (c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.	DI #3, p. 40
(5) Support Services. Each applicant **shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services**.	DI #3, p. 40

APPENDIX 6

Operating Room Use Projections

MedStar Franklin Square Medical Center's Historic and Projected Utilization for Mixed-Use General Purpose Operating Rooms, FY 2014 – FY 2022

Fiscal Year	General Purpose Cases	Average Minutes per Case	Total Surgery Minutes	Number of General Purpose ORs Needed at Optimal Capacity
2014	11,956	120	1,430,408	12.5
2015	11,335	123	1,395,580	12.2
2016	11,142	123	1,365,983	12.0
2017	11,358	121	1,374,318	12.1
2018	11,589	120	1,390,680	12.2
2019	11,718	120	1,406,160	12.3
2020	11,779	121	1,425,711	12.5
2021	11,779	121	1,425,711	12.5
2022	11,779	121	1,425,711	12.5

Source: DI#3, Attachment 26, p. 157

MedStar Franklin Square Medical Center's Historic and Projected Utilization for Endovascular Special Purpose Operating Rooms, FY 2014 – FY 2022

Fiscal Year	General Purpose Cases	Average Minutes per Case	Total Surgery Minutes	Number of General Purpose ORs Needed at Optimal Capacity
2014	1,278	83	106,690	0.9
2015	984	83	81,214	0.7
2016	402	82	33,145	0.3
2017	435	74	32,051	0.3
2018	480	75	36,228	0.3
2019	540	77	41,798	0.4
2020	660	80	52,938	0.5
2021	660	80	52,938	0.5
2022	660	80	52,938	0.5

Source: DI#3, Attachment 26, p. 157

MedStar Franklin Square Medical Center's Historic and Projected Utilization for Interventional Pulmonology Special Purpose Operating Rooms, FY 2014 – FY 2022

Fiscal Year	General Purpose Cases	Average Minutes per Case	Total Surgery Minutes	Number of General Purpose ORs Needed at Optimal Capacity
2014	552	90	49,549	0.4
2015	589	88	51,556	0.5
2016	511	86	43,834	0.4
2017	511	87	44,319	0.4
2018	519	87	45,119	0.4
2019	519	87	45,119	0.4
2020	530	87	46,219	0.4
2021	530	87	46,219	0.4
2022	530	87	46,219	0.4

Source: DI#3, Attachment 26, p. 157

APPENDIX 7

HSCRC Opinion Letter

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

June 5, 2017

To: Kevin McDonald
Chief – CON, MHCC

From: Gerard J. Schmith
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Review of financial projections for MedStar Franklin Square Medical Center CON for Surgical Facilities Replacement Project

This memo is in response to your memo dated May 10, 2017 where you requested that HSCRC staff provide an opinion as to whether MedStar Franklin Square Medical Center' (MFSMC) CON project for replacing its surgical facilities would still be viable if the staff did not approve the MFSMC's rate request to fund the project.

In staff's review of the project we noted that MFSMC assumed that the staff would approve a rate request of $4.7 million effective November 2019 which was equal to the incremental depreciation and interest expense associated with the project. The rate request that MFSMC recently submitted to the HSCRC for the project requested an effective date of July 1, 2017, which is more than 2 years earlier than the effective date of the increase assumed in the CON.

The uninflated projected financial statements included as part of the CON assumed annual profits ranging from $16,998,000 in FY 2017 to $34,421,000 in FY 2022. The inflated projected financial statements included as part of the CON assumed annual profits ranging from $16,999,000 in FY 2017 to $11,758,000 in FY 2022. The reason for the wide discrepancy in projected future profits in the uninflated projections versus the inflated projections was that MFSMC assumed in the inflated projections that net revenues would increase by approximately 1.8% per year while non-capital expenses would increase by about 3.0% per year causing the lower projected profits in the inflated projections.

Based on staff's experience over the last 40 years, hospitals have been able to historically manage their expenses in line with their allowed rate increases so staff believes that the larger profits projected by MFSMC under the uninflated financial statements are more representative of what will actually occur. If staff does not approve MFSMC's recent rate request there will be no impact on MFSMC projected financial statements in the CON for FY 2017 through 2019 because MFSMC did not assume it would receive a rate increase for the project until November

2019. If the $4.7 million rate request assumed by MFSMC in the projected financial statements in the CON is not granted, MFSMC's projected profit margin for FY 2022 would decrease from the 6.4% assumed in the CON to a revised 5.5%.

On a system-wide basis MFSMC's parent, MedStar Health Inc., generated significant net revenue during the year ended June 30, 2016. The HSCRC staff believes that MedStar Health Inc. may have the capacity, on a system-wide basis, to reduce its existing excess volumes and fixed expenses sufficiently to absorb this estimate cost increase.

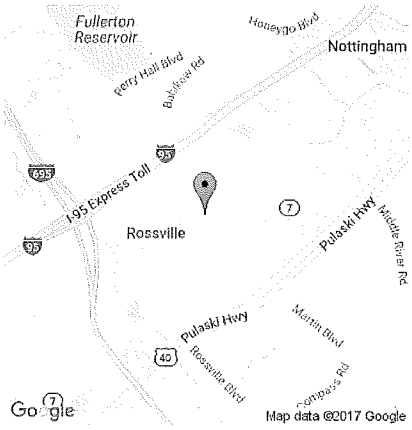
Staff does not believe that the denial of MFSMC's assumed rate increase associated with the CON for the replacement of surgical facilities will have a material impact on the viability of the project.

APPENDIX 8

Quality Report: Summary of MedStar Franklin Square Medical Center

Summary of Hospital Information: MedStar Franklin Square Medical Center

9000 Franklin Square Drive
Baltimore, MD 21237



Website: http://www.medstarfranklinsquare.org/

Phone Number: 443-777-7000

This hospital is accredited by the Joint Commission

Total Beds: 364

Hospital Type: General

Are maternity services provided? Yes

Are pediatric services provided? Yes

Are pediatric ICU services provided? No

Is cardiac catheterization lab service provided? Yes

Does this hospital perform Percutaneous Coronary Intervention (PCI) procedures? Yes

Does this hospital perform cardiac surgery? No

Provides Trauma Center Services: No

Provides Emergency Department Services: Yes

Find Another Hospital

Quality Ratings | Clinicians with Admitting Privileges

Compared To:
Maryland Hospitals Average

Consumer Star Rating

Ratings for Health Conditions and Topics
Ratings shown here are compared to State Average

COPD-Chronic Obstructive Pulmonary Disease

Results of care	Rating	Risk-Adjusted Rates
Dying within 30-days after getting care in the hospital for chronic obstructive pulmonary disease (COPD)	Average	7.1 (5.8 - 8.6)
Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	Average	20.1 (18.2 - 22.2)

Childbirth

Practice patterns	Rating	Risk-Adjusted Rates
Percentage of births (deliveries) that are C-sections	Average	30.8422 (29.0422, 32.6422)
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	Better than average	15.8854 (12.2293, 19.5416)
How often babies in the hospital are delivered using cesarean section when this is the mother's first birth.	Average	21.3054 (19.5725, 23.0382)
How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	Average	14.9770 (11.6196, 18.3343)
Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	Better than average	0%

Combined Quality and Safety Ratings

Deaths	Rating	Risk-Adjusted Rates
Patients who died in the hospital after having one of six common conditions.	Average	0.8491 (0.6823, 1.0159)

Patient safety	Rating	Risk-Adjusted Rates
How well this hospital keeps patients safe based on eleven patient safety problems	Average	0.5826 (0.3823, 0.7829)

Consumer Ratings

Communication	Rating	Risk-Adjusted Rates
How often did nurses always communicate well with patients?	Better than average	80%
How often did doctors always communicate well with patients?	Average	78%
How often did staff always explain about medicines before giving them to patients?	Better than average	64%
Were patients always given information about what to do during their recovery at home?	Better than average	87%
How well do patients understand their care when they leave the hospital?	Below average	43%

Environment	Rating	Risk-Adjusted Rates
How often were the patients' rooms and bathrooms always kept clean?	Below average	59%
How often did patients always receive help quickly from hospital staff?	Below average	58%
How often was patients' pain always well-controlled?	Better than average	71%
How often was the area around patients' rooms always kept quiet at night?	Below average	54%

Satisfaction overall	Rating	Risk-Adjusted Rates
How do patients rate the hospital overall?	Average	66%
Would patients recommend the hospital to friends and family?	Better than average	68%

Emergency Department (ED)

Wait Times	Rating	Risk-Adjusted Rates
How long patients spent in the emergency department before leaving for their hospital room	Below average	462.0
How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Below average	185.0
How long patients spent in the emergency department before being sent home	Below average	242 minutes

Wait Times	Rating	Risk-Adjusted Rates
How long patients spent in the emergency department before they were seen by a healthcare professional	Below average	64 minutes
How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	Below average	80 minutes
Patients who left the emergency department without being seen	Below average	4%

Flu Prevention

Protecting patients	Rating	Risk-Adjusted Rates
Patients in the hospital who got the flu vaccine if they were likely to get flu	Below average	96%

Heart attack and chest pain

Recommended care - Outpatient	Rating	Risk-Adjusted Rates
How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	Not enough data to report	-
Patients with a heart attack who received aspirin on arrival to the hospital	Below average	97%
How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	Average	10%

Results of care	Rating	Risk-Adjusted Rates
How often patients die in the hospital after heart attack	Average	7.2917 (4.6919, 9.8915)
Dying within 30-days after getting care in the hospital for a heart attack	Average	13.1 (11.1 - 15.4)
Returning to the hospital after getting care for a heart attack	Average	17.1 (14.8 - 19.8)

Heart failure

Results of care	Rating	Risk-Adjusted Rates
How often patients die in the hospital after heart failure	Average	2.2830 (1.0193, 3.5466)
Dying within 30-days after getting care in the hospital for heart failure	Average	10.9 (9.3 - 12.6)
Returning to the hospital after getting care for heart failure	Average	20.9 (19.0 - 22.9)

Heart surgeries and procedures

Recommended care	Rating	Risk-Adjusted Rates

Recommended care	Rating	Risk-Adjusted Rates
How often the hospital uses a procedure to find blocked blood vessels in the heart on both sides of the heart instead of on only one side.	Better than average	0.0000 (0.0000, 0.0000)

Results of care	Rating	Risk-Adjusted Rates
Death rate for CABG	Not enough data to report	
Rate of unplanned readmission for CABG	Not enough data to report	

Hip or knee replacement surgery

Results of care	Rating	Risk-Adjusted Rates
Returning to the hospital after getting hip or knee replacement surgery	Average	6.2 (4.6 - 8.3)
Complications after hip or knee replacement surgery	Average	3.7 (2.4 - 5.5)

Imaging

Practice patterns	Rating	Risk-Adjusted Rates
Contrast material (dye) used during abdominal CT scan	Better than average	0%
Contrast material (dye) used during thorax CT scan	Better than average	0%
Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	Average	3.6%
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	Better than average	1.9%

Patient safety

Results of care - Complications	Rating	Risk-Adjusted Rates
How often the hospital accidentally makes a hole in a patient's lung	Average	0.1806 (0.0000, 0.5697)
How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Average	1.0387 (0.2444, 1.8331)
Number of patients who get a blood transfusion and have a problem or reaction to the blood they get	Not enough data to report	-
Returning to the hospital for any unplanned reason within 30 days after being discharged	Average	15.5 (14.8 - 16.1)
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	Better than average	0%

Results of care - Complications	Rating	Risk-Adjusted Rates
Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not enough data to report	1

Results of care - Deaths	Rating	Risk-Adjusted Rates
How often patients die in the hospital after bleeding from stomach or intestines	Average	3.3410 (1.7649, 4.9171)
How often patients die in the hospital after fractured hip	Average	5.5712 (1.8654, 9.2770)
How often patients die in the hospital while getting care for a condition that rarely results in death	Average	0.2771 (0.0000, 0.8248)

Pneumonia

Results of care	Rating	Risk-Adjusted Rates
How often patients die in the hospital while getting care for pneumonia	Average	1.6532 (0.0000, 3.8228)
Dying within 30-days after getting care in the hospital for pneumonia	Average	9.6 (7.8 - 11.6)
Returning to the hospital after getting care for pneumonia	Average	16.4 (14.5 - 18.6)

Stroke

Results of care	Rating	Risk-Adjusted Rates
How often patients who came in after having stroke subsequently died in the hospital.	Average	6.5286 (4.2241, 8.8331)
Death rate for stroke patients	Average	19 (16, 22.2)
Rate of unplanned readmission for stroke patients	Average	12.1 (9.9, 14.7)

Surgeries for Specific Health Conditions

Practice patterns	Rating	Risk-Adjusted Rates
Number of surgeries to remove part of the esophagus	Not enough data to report	3
Number of surgeries to remove part of the pancreas	Not enough data to report	10
Number of surgeries to fix the artery that carries blood to the lower body when it gets too large	Not enough data to report	34

Results of Care – Deaths	Rating	Risk-Adjusted Rates
How often patients die in the hospital during or after surgery on the esophagus	Average	0.0000 (0.0000, 23.7565)

Results of Care – Deaths	Rating	Risk-Adjusted Rates
How often patients die in the hospital during or after pancreas surgery	Average	0.0000 (0.0000, 15.2472)
How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Average	41.1582 (23.4552, 58.8611)

Surgical patient safety

Results of care	Rating	Risk-Adjusted Rates
How often surgical patients die in the hospital because a serious condition was not identified and treated	Average	119.3226 (64.0943, 174.5510)
How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	Average	3.3838 (0.0000, 7.5082)
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	Better than average	2.1183 (0.3445, 3.8921)
How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Average	1.0387 (0.2444, 1.8331)
Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not enough data to report	1

Healthcare Associated Infections (HAI)

Surgical Site Infections (SSI)

Central Line-Associated Blood Stream Infections (CLABSI)

Health Care Worker Vaccinations (HCW)

Clostridium Difficile Infections (CDI)

Methicillin-Resistant Staphylococcus Aureus Infections (MRSA)

Catheter-Associated Urinary Tract Infections (CAUTI)

Common Medical Conditions and Charges

Conditions and Charges