Robert E. Moffit, Ph.D.
CHAIRMAN

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION
4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MEMORANDUM

TO: Commissioners

Anne Arundel Medical Center, Inc.
University of Maryland Baltimore Washington Medical Center

FROM: Cassandra B.Y. Tomarchio
Commissioner/Reviewer

RE: Recommended Decision
Application for Certificate of Need
Anne Arundel Medical Center Mental Health Hospital
Docket No. 16-02-2375

DATE: March 26, 2018

Enclosed is my Recommended Decision in my review of a Certificate of Need ("CON") application by Anne Arundel Medical Center, Inc. ("AAMC") for a Certificate of Need to establish a 16-bed special hospital-psychiatric to be known as Anne Arundel Medical Center Mental Health Hospital. It is proposed to be constructed on a site approximately two miles from AAMC, the general hospital, and adjacent to Pathways, an alcoholism and substance abuse treatment facility, at Riva Road & Harry S. Truman Parkway in Annapolis, MD, at a total project cost of $24,984,795.

I have considered the entire record in this review and conducted a site visit and have determined that this application complies with applicable standards in the State Health Plan for Facilities and Services ("State Health Plan") and the CON review criteria. Thus I recommend that the Commission **APPROVE** this application, as modified, with a condition.

Interested Parties

The University of Maryland Baltimore Washington Medical Center ("BWMC") is an interested party in this review. While BWMC stated that it does not oppose the addition of inpatient psychiatric beds by AAMC, it argues that the new service and bed capacity should be added in the existing acute care hospital, which it asserts would be a more cost-effective way to achieve the objective of increasing inpatient psychiatric services in Anne Arundel County.

Background

The CON application for this project was initially filed on March 29, 2016. Corrections to the Table Package of that application were filed on April 1, 2016; a revised space program and cost estimates were filed on August 1, 2016; and the application was docketed on October 14, 2016. A revision of the funding plan was submitted on March 17, 2017.

Project Description

Anne Arundel Medical Center proposes to establish a special hospital–psychiatric adjacent to Pathways, an affiliated facility that offers inpatient and outpatient substance abuse treatment. The proposed 16-bed adult special hospital-psychiatric, to be known as Anne Arundel Medical Center Mental Health Hospital, will also provide outpatient and partial hospitalization programs for adults and for children and adolescents. It will include 56,236 square feet of space on four levels. The estimated cost is just under $25 million and will be funded with approximately $15 million in cash and borrowed funds of $10 million.

Review Criteria and Standards

I recommend that the Commission approve AAMC's application, with a condition, because the proposed project is consistent with applicable State Health Plan standards and with Certificate of Need review criteria.

I found that the applicant made a strong case that its proposed 16-bed facility is needed, and also that its decision to locate the unit in a freestanding facility adjacent to Pathways was well supported. I believe that this option will address the needs of the patients in its service area for greater availability and accessibility to psychiatric hospital services. I also believe there is merit in development and operation of a behavioral health campus, combining inpatient and outpatient facilities and programs for mental disorders and substance abuse treatment. This approach has the potential to enhance collaboration and synergy among clinicians and programs.

The applicant is strong financially and has the resources to implement the project, for which it projects a modest but self-sustaining operating margin. The project has garnered a high level of community support.

I find that the impact on other providers and the health care system will be positive. The project will have a positive impact on geographic access to mental health services, especially inpatient services. The significant number of patients presenting at AAMC's emergency department who need hospitalization are subject to lengthy delays and are often referred to facilities that are up to an hour's travel time from Annapolis, presenting difficulty for the patient and family at the time of hospitalization, and making continuing care far less seamless than it would be if this project were to be implemented. The proposed special psychiatric hospital will improve the regional health care system. The proposed project also promises lower charges and cost savings to the health care delivery system, as its projected aggregate charges are below those of current alternatives.

Review Schedule and Further Proceedings.

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on April 19, 2018, beginning at 1:00 p.m. at 4160 Patterson Avenue in Baltimore.

The Commission will issue a final decision based on the record of the proceeding. As provided under COMAR 10.24.01.09B, the applicant and the interested party may submit written exceptions to the enclosed Recommended Decision. As noted below, exceptions must be filed electronically no later than 1:00 p.m. on Wednesday, April 4, 2018, with 25 paper copies of the exceptions submitted at the Commission's offices by noon on Thursday, April 5, the day following the filing deadline. Written exceptions must specifically identify those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based.

Responses to exceptions must be filed no later than 1:00 p.m. on Wednesday, April 11, 2018. Copies of exceptions and responses must be sent in pdf format by email to MHCC and all parties by the filing deadline. Twenty-five paper copies of the response to exceptions must be submitted at the Commission's offices by 3:00 p.m. on Thursday, April 5, 2018.

Oral argument during the exceptions hearing before the Commission will be limited to 10 minutes for the interested party and 15 minutes for the applicant, unless extended by the Chair or the Chair's designated presiding officer. The schedule for the submission of exceptions and any response to exceptions is as follows:

Submission of exceptions	April 4, 2018 No later than 1:00 p.m.
Submission of response	April 11, 2018 No later than 1:00 p.m.
Exceptions hearing	April 19, 2018 1:00 p.m.

IN THE MATTER OF	*	BEFORE THE
ANNE ARUNDEL MEDICAL	*	MARYLAND
CENTER MENTAL HEALTH	*	HEALTH CARE
HOSPITAL	*	COMMISSION
Docket No. 16-02-2375	*	

* *

Reviewer's Recommended Decision

April 19, 2018

(released March 26, 2018)

TABLE OF CONTENTS

I. INTRODUCTION

A. The Applicant

The applicant, Anne Arundel Medical Center, Inc. ("AAMC"), is a 385–bed general hospital located in Annapolis, Anne Arundel County. AAMC provides inpatient medical/surgical services, obstetric and gynecological services, pediatric services, and, through a subsidiary, addiction treatment services. AAMC also provides an array of outpatient diagnostic and treatment services. It was the fourth largest general hospital in Maryland by acute inpatient volume in the twelve months ending March 31, 2017.

AAMC provides alcoholism and substance abuse treatment services, including medically-monitored intensive inpatient detoxification and treatment, through Anne Arundel General Treatment Services, Inc., d/b/a Pathways ("Pathways"), a facility that is located on a separate campus from AAMC's general hospital facilities.

AAMC is a wholly-owned subsidiary of Anne Arundel Health System, Inc. ("AAHSI"), which is identified as the owner of the proposed mental health hospital.[1] AAHSI also operates physician practices and outpatient facilities in AAMC's service area. Appendix 1 shows the corporate structure of Anne Arundel Health System, Inc.

B. The Project

AAMC proposes to establish a special hospital-psychiatric in a new building to be constructed on a site approximately two miles from its general hospital and adjacent to Pathways. Programmatically, the proposed hospital would be comprised of: a 16-bed inpatient psychiatric unit for adults; an ambulatory outpatient mental health clinic; and a psychiatric partial hospitalization program for both adults and adolescents. The applicant describes the building project as follows:

> **Site Features:** The proposed facility will be adjacent to the existing Pathways building, separated by a courtyard, and with a separate entrance. The courtyard area will be secured, providing an opportunity for staff and patients to utilize outdoor space while maintaining privacy and security.
>
> **Parking:** Existing parking is sufficient to support both buildings . . ..
>
> **The Hospital Building:** The proposed facility will have 56,236 -square feet ("SF") of building space on four levels. Three stories are above grade on the courtyard and main entrance sides of the building, and four stories are above grade on the service entrance side of the building.

[1] Prior to docketing of its application, pursuant to COMAR 10.24.01.07D(1), the applicant designated Anne Arundel Mental Health Services, Inc. (at that time a to-be-formed subsidiary of AAMC) as the intended licensee of the mental health hospital under a "doing business as" name that would be determined later. (DI #18, p. 1 & Exh. 18; DI #19).

Basement Floor: The basement will house the building's basic infrastructure and support functions (centralized mechanical and electrical systems, loading dock, kitchen, soiled and clean laundry storage, and supply and dietary storage). Also on this floor is a secure enclosed ambulance bay leading to an intake and holding area where patients will be examined by an Intake Coordinator before being admitted to the inpatient unit on the second floor.

First Floor: This floor contains the main entrance to the building, with elevators adjacent to the lobby for appropriate secure access to the inpatient unit on the second floor. A service elevator is located at the rear of the building, with some storage space adjacent to it. The floor will contain the mental health partial hospitalization program with separate areas for adolescent patients, adult patients, and staff support functions. A multi-purpose room will provide space for outside group meetings. The first floor is proposed to contain 3,421 SF of shell space to which AAMC plans to relocate its existing outpatient mental health clinic services for children and adolescents from leased space when the lease expires in 2021.

Second Floor: This floor will house a 16-bed adult inpatient unit in two wings of single occupancy patient rooms. At the center of the floor, there will be common areas for patients with views into the secure courtyard and other parts of the site. Staff support areas are also located in the center of the building, with sight lines directly down each patient corridor from the nursing station. The occupational therapy program will be located at the rear of the building, along with storage space and the service elevator.

Third Floor: The third floor consists of 11,908 SF of shell space, which will house: the adult outpatient clinic when relocated from space on Riva Road upon expiration of the lease; a planned after-school intensive outpatient mental health program for children and adolescents with disorders of opposition/defiance or acting out behaviors; and an outpatient pain management program. Alternatively, the applicant holds out the possible use of the space for future expansion of inpatient psychiatric services, particularly for adolescent patients.
(DI #24, pp. 78a, 78b).

The estimated capital cost of the project is $24,984,795. The applicant plans to fund the project with $14,984,795 in cash and $10 million in borrowing, as shown on Table I-1 below. . (DI #40).

Table I-1 Project Budget Estimate

Uses of Funds	
Capital Costs	
New Construction	
Building and Fixed Equipment	$16,080,433
Site Preparation / Infrastructure	2,770,763
Architect/Engineering Fees	1,373,350
Permits	23,757
Subtotal-New Construction	**$20,248,303**
Other Capital Costs	
Contingency Allowance	$1,600,000
Commissioning/Testing	375,000
Movable Equipment	900,000
IT/Integration	700,000
Exterior Courtyard/Hardscaping	500,000
Subtotal-Other Capital	**$4,075,000**
Total Current Capital Costs	**$24,323,303**
Inflation Allowance	$511,492
Total Capital Costs	**$24,834,795**
Financing Cost and Other Cash Requirements	
Financing Transaction Costs	$150,000
Total Uses of Funds	**$24,984,795**
Sources of Funds	
Cash	**$14,984,795**
Debt	**$10,000,000**
Total Sources of Funds	**$24,984,795**

(DI #40).

C. Background: Acute Inpatient Psychiatric Care in Maryland, in Anne Arundel County, and at AAMC

Acute Inpatient Psychiatric Care in Maryland Hospitals

There are currently 29 general hospitals in Maryland that have acute psychiatric units, with a total of 747 licensed acute psychiatric beds. There are four private special hospitals for acute psychiatric care licensed for 586 beds, 508 of which were reportedly staffed in 2016.[2] Long-term inpatient care for psychiatric disorders is primarily handled by five special-psychiatric hospitals operated by the State of Maryland's Department of Health.

Acute inpatient admissions have declined approximately nine percent (9%) between 2011 and 2016. However, the average length of stay for acute care patients has increased by approximately 11% over this same period, resulting in a very slight increase in the average daily statewide census of acute psychiatric patients (961.7 in 2016 compared with 960.1 in 2011).

In 2011, there were five freestanding special psychiatric hospitals in Maryland that

[2] MHCC, Annual Report on Selected Maryland General and Special Hospital Services, FY2017.

accounted for 27.7% of the psychiatric discharges and 41% of total acute psychiatric patient-days.[3] By 2016, the freestanding hospitals' share of discharges grew to 30.1% while their share of patient-days remained at 41%. During the period from 2011 to 2016, the average length of stay in special hospitals, at 10.5 days, was longer than that experienced in psychiatric units of general hospitals, at six days.

Table I-2: Key Statistics: Total Acute Inpatient Psychiatric Hospitalization, CY 2011-2016

	2011	2012	2013	2014	2015	2016
Discharges	49,963	49,839	48,725	48,198	46,489	45,231
Patient Days	350,681	353,740	347,462	356,788	353,415	352,010
Average Length of Stay (days)	7.0	7.1	7.1	7.4	7.6	7.8

Sources: HSCRC Discharge Database Inpatient and Psychiatric Files.[4]

Acute Inpatient Psychiatric Care in Anne Arundel County

Anne Arundel County's population was estimated to be approximately 568,000 in July 2016, making it the fifth most populous jurisdiction in Maryland. At present the only psychiatric hospital beds operated in the jurisdiction are located at the University of Maryland Baltimore Washington Medical Center ("BWMC") in Glen Burnie. BWMC presently operates 14 adult psychiatric beds and is renovating space to accommodate ten additional beds.

Tables I-3 and I-4, below, show the trends in adult acute psychiatric hospitalization of Anne Arundel residents aged 18 and older, as well as where services were received over the last six years. I note that, during this period,

- Psychiatric discharges of Anne Arundel County residents rose 10.2%, and the average daily psychiatric census of County residents rose 19.6%.
- Sheppard Pratt increased its dominance as the provider of psychiatric inpatient services to Anne Arundel residents, with its market share growing from 27% in 2010 to 37% in 2014, and to 35% in 2016.
- BWMC's market share dropped from 25% in 2010 to 20% in 2016.

[3] Adventist Behavioral Health-Eastern Shore was a small psychiatric hospital specializing in the treatment of children and adolescents. It temporarily delicensed its 15 beds and suspended its operation in November 2016; these beds expired on February 28, 2018.

[4] I note that in the data contained in this and the two tables immediately following (i.e., Tables I-2, I-3, and I-4), *psychiatric services* in general hospitals are defined based on CMS Major Diagnostic Category (MDC), coded as Mental Diseases and Disorders (MDC="19"); for private psychiatric hospitals, all discharges are psychiatric services.

Table I-3: Anne Arundel Residents' Utilization of Acute Inpatient Psychiatric Services

Key statistics	2011	2012	2013	2014	2015	2016
Discharges	2,825	3,207	3,221	2,978	3,147	3,114
Patient-days	20,270	22,426	21,756	21,092	23,411	24,466
Average length of stay	7.2	7.0	6.8	7.1	7.4	7.9
Average Daily Census	56	61	60	58	64	67

Source: HSCRC Discharge Database, Inpatient and Psychiatric Files

Table I-4: Maryland Hospitals Used by Anne Arundel Adults for Acute Inpatient Psychiatric Services

Hospital	Location	2012		2014		2016	
		Patients	Market Share	Patients	Market Share	Patients	Market Share
Sheppard Pratt	Towson & Ellicott City	978	30%	1,087	37%	1,092	35%
UM Baltimore-Washington	Glen Burnie	745	23%	661	22%	631	20%
Laurel Regional	Laurel	176	5%	109	4%	180	6%
MedStar Franklin Square	Roseville	32	1%	119	4%	158	5%
Bon Secours	Baltimore City	228	7%	110	4%	102	3%
Adventist Behavioral Health	Rockville	68	2%	49	2%	97	3%
University of Maryland	Baltimore City	131	4%	138	5%	66	2%
UMMC-Midtown	Baltimore City	102	3%	63	2%	48	2%
Other	-	747	23%	642	22%	740	24%
Total		**3,207**	**100%**	**2,978**	**100%**	**3,114**	**100%**

Source: HSCRC Discharge Database, Inpatient and Psychiatric Files

Behavioral Health Programming at AAMC

AAMC states that it has developed or is in the process of developing several components of its vision to provide an integrated array of mental health services, as described below.

- **Ambulatory outpatient clinic**. In 2014, AAMC opened an outpatient clinic in which a team of board-certified psychiatrists, nurse practitioners, and other clinical professionals provide comprehensive mental health evaluation and treatment services for adults and children (from the age of three). Specific services include psychiatric evaluations, medication management, and individual and group psychotherapy. The clinic team offers services for life challenges, relationship issues, child and teen behavioral issues, depression, anxiety, trauma, and persistent mental illness. (DI #6, p.14).

- **Screening and referral in the primary care setting**. In FY 2015, AAMC introduced a screening tool and early intervention model across eight primary care and obstetrical and gynecology practice sites to identify individuals experiencing mental health or substance use problems and to provide early intervention. Drawing on nine community mental health and substance use providers who collaborate with AAMC and accept referrals within 48 hours, a recovery navigator provides referral and follow-up to patients. AAMC

plans to expand this program to the communities of northern Anne Arundel County in conjunction with BWMC. (DI #6, p.14).

- **Embedding mental health clinicians in the primary care setting.** The applicant discussed its plans to pilot a primary care integration model that will incorporate interventions for both mental health and substance use disorders in AAMC's primary care practice sites. The applicant noted that it had placed a bilingual therapist at AAMC's Forest Drive Community Clinic, which provides primary care to the uninsured and underserved community, and also acts as a medical home for patients in need of preventive, acute, and/or chronic care. The therapist can address the mental health and substance use needs of the clinic's patient population. The applicant also points to its placement of a Licensed Clinical Social Worker in a primary care office in Centreville, Maryland. It states that, between mid-January 2017 and early April 2017, the office treated 52 individuals for mental health and/or substance related issues that might have otherwise been seen in the ED. The applicant states that data from this pilot will be used in planning the expansion of this integration into other AAMC primary care practices in the future. (DI#6, p.15, DI #40, p.2).

- **Psychiatric partial hospitalization program.** In July 2016, AAMC opened a psychiatric partial hospitalization program with a capacity to serve up to 12 adults and 12 adolescents at any one time. (DI #40). The applicant states that this program is intended to "offer a lower-cost, community-based alternative to the inpatient setting for a significant percentage of patients… [who would be] referred by the ED or directly by community providers as an alternative to inpatient care, or by inpatient facilities as a step-down level of care." It notes that, between its July 2016 opening and March of 2017, the program provided services to 163 unique patients, with a total of 1,943 patient encounters. (DI #40). The applicant plans to relocate the program to the proposed facility.

D. Summary of Reviewer's Recommendation

I recommend that the Maryland Health Care Commission APPROVE this CON application based on my findings that the proposed project: complies with the applicable State Health Plan standards; has been demonstrated to be needed; is a cost-effective alternative for meeting the need; and will be viable. I have found that the project's impact on other providers and the health system will be, on balance, very positive and that the potential negative impact posited by the interested party is primarily theoretical, and would be obviated by a condition that the applicant be prohibited from adding any beds, even "waiver beds" (as addressed at COMAR 10.24.01.02A(3)) without obtaining required approval from MHCC, For this reason, I recommend that the Commission approve this project with the following condition:

> Anne Arundel Medical Center Mental Health Hospital shall not increase its bed capacity without obtaining required approval from MHCC.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 2, Record of the Review.

B. Interested Parties and Participating Entities in the Review

I recognized the University of Maryland Baltimore Washington Medical Center ("BWMC") as an interested party in this review. BWMC stated that it "does not oppose the addition of inpatient psychiatric beds at AAMC, but the new capacity should be added in the existing acute care hospital." (DI #34, p. 1). BWMC views "AAMC's proposal . . . [as] not the most cost effective alternative to achieve the objective of increasing inpatient psychiatric services in Anne Arundel County." It requests that the Commission: (1) deny the proposed project as presented; and (2) urge AAMC to modify its application to establish an inpatient psychiatric unit within the existing general hospital. If the Commission approves the proposed project, BWMC requests that "AAMC not be permitted to add beds, and thus be subject to the federal exclusion for adult Medicaid patients in an Institution for Mental Disease ("IMD"),[5] and should not be permitted to include shell space that comprises one-third of the building's space, without express Commission approval." (DI #34, p. 2).

C. Local Government Review and Comment

The Anne Arundel County House Delegation provided a letter of support for this project, as did the County Executive.

D. Community Support

The Maryland Health Care Commission received a number of written expressions of support for the project from various individuals and organizations. I have summarized the filings, categorizing correspondents in order to provide useful information on the nature and character of the expressions of support.

The following government officials submitted letters in support of the proposed AAMC Mental Health Hospital:

- Honorable John P. Sarbanes, U.S. House of Representatives, 3rd District, Maryland
- Honorable Michael E. Busch, Speaker of the House, Maryland House of Delegates, 30th Legislative District, Anne Arundel County
- Honorable John C. Astle, Senate of Maryland, 30th Legislative District, Anne Arundel County

[5] The "IMD exclusion" refers to a federal policy that prohibits participation by the federal government in funding, through Medicaid, psychiatric services provided to patients between the ages of 21-64 in what federal statute defines as an "Institute for Mental Disease," which is, essentially, a freestanding psychiatric hospital with more than 16 beds (not a unit in a general hospital).

- Honorable Edward R. Reilly, Senate of Maryland, 33rd Legislative District, Anne Arundel County
- Honorable Herb McMillan, House of Delegates, Legislative District 30A, Anne Arundel County
- Honorable Theodore J. Sophocleus, Chair, Anne Arundel County House Delegation
- Steven R. Schuh, County Executive, Anne Arundel County
- Adrienne Mickler, Executive Director, Anne Arundel County Mental Health Agency, Inc.
- Honorable Michael Pantelides, (Former) Mayor, Annapolis
- Pamela M. Brown, Ph.D., Executive Director, Anne Arundel County Partnership for Children, Youth and Families

(DI #6, App. 3C).

In addition, the Anne Arundel County Council passed a resolution, and the County Commissioners of Queen Anne's County also submitted their support for AAMC's proposed project. (DI #6, App. 3C).

The following organizations submitted letters that support AAMC's proposed project:

- CareFirst BlueCross BlueShield (Chet Burrell, President & CEO)
- Johns Hopkins Health System and The Johns Hopkins Hospital (Ronald R. Peterson, President)
- Sheppard Pratt Health System (Steven S. Sharfstein, M.D., President and Chief Executive Officer)
- Calvert Memorial Hospital (Dean A. Teague, President & CEO)

(DI #6, App. 3G & 3H).

Nine persons on AAMC's Board of Trustees each submitted a letter expressing individual support for the proposed inpatient psychiatric hospital. (DI #6, App. 3B). A total of 25 physicians or mental health providers affiliated with AAMC submitted their written support for the proposed inpatient mental health program. (DI #6, App. 3F). Finally, a total of 35 individuals and community organizations from Anne Arundel County submitted their support for AAMC's inpatient mental health proposal. (DI #6, App. 3D & 3E).

III. REVIEW AND ANALYSIS

The Commission is required to make its decisions in accordance with the general CON 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 standards and policies.

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.

The relevant State Health Plan chapter is COMAR 10.24.07: Psychiatric Services ("Psychiatric Services Chapter").

COMAR 10.24.07 State Health Plan for Facilities and Services: Overview, Psychiatric Services, and Emergency Medical Services

Since the Psychiatric Services Chapter was written there have been changes in the role and scope of State-operated psychiatric hospital facilities. There have also been substantial changes in use of acute psychiatric beds. Because of these changes, some of the standards in the Chapter are out of date. In particular, Standards AP 1a-d (which reference an obsolete bed need methodology) are no longer applicable.

A number of other standards do not apply in this review:

- AP 2a, 2b, 2c, and AP 3c are not applicable because all refer to psychiatric units in acute general hospitals, and the applicant seeks to establish a mental health hospital that would be licensed as a special hospital by the Maryland Department of Health ("MDH")
- AP 3b, AP 9, and AP 12c reference inpatient child and adolescent programs, which are not within the scope of the proposed project.
- AP 4b requires physical separation and clinical/programmatic distinctions between two or more age-specific acute psychiatric groups; this proposed project does not include distinct age-specific programming.
- AP 10 is not applicable because it speaks to the expansion of an existing hospital, which is not what is being proposed.

Among the still-relevant and applicable standards are several that prescribe policies, facility features, and staffing and/or service requirements that an applicant must meet, or agree to meet prior to first use. I note that BWMC, the interested party in this review, did not state that the applicant failed to comply with any of the following standards for which I have reviewed the information and affirmations provided by the applicant and find that the applicant demonstrated compliance:

AP 3a, Array of services
AP 5, Availability of services
AP 6, Quality assurance programs, program evaluations, and treatment protocols
AP 12a, Supervision by a psychiatrist
AP 12b, Staffing requirements
AP 13, Discharge planning

The text of these standards is in Appendix 3.[6] My determination of the applicant's

[6] The applicant's responses to these standards can be found at pages 20 to 32 of its application and in its May 25, 2016 response to MHCC staff's completeness questions. (DI #6; DI #20). Specific docket item and page numbers for responses to each standard are referenced in Appendix 2. The application can be accessed on the MHCC website at:

compliance with each of the above standards means that I find that the proposed mental health hospital will operate with the appropriate procedures for:

- Screening and evaluating patients' psychiatric problems on intake;
- Admitting patients;
- Arranging for transfer of patients when appropriate;
- Planning for the discharge of patients with appropriate referral for post-hospital treatment; and
- Emergency psychiatric assessment and treatment.

My determination of compliance with each of the above standards also means that I find that the AAMC Mental Health Hospital will:

- Provide the minimally-required array of services, which includes drug therapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies; and
- Maintain separate written quality assurance programs, program evaluations and treatment protocols for the adult patient populations it plans to serve.

Finally, my findings regarding each of these standards means that the applicant has demonstrated that the proposed special hospital-psychiatric will have:

- Clinical service provision supervised by a qualified psychiatrist;
- Hospital staff that will include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment; and
- Staff who will provide inpatient treatment services to patients seven days per week.

Standard AP 4a

A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

AAMC seeks to establish an inpatient psychiatric hospital that will only serve adults.

Standard AP 7

An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

AAMC states that "the mental health hospital will routinely accept patients who are admitted as involuntary patients." (DI #6, p. 109). The applicant submitted a draft copy of its admissions criteria, which includes the procedures on hearings for involuntarily admissions, as an attachment to its CON application. (DI #6, Exh. 16).

---

http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_aamc_mental_health.aspx

I find that AAMC complies with this standard.

Standard AP 8

All acute general and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12-month period.

AAMC projects that the mental health hospital's level of uncompensated care, as a percentage of gross patient revenue, will be 9.7 percent. (DI #12, Tables J & K). For purposes of comparison, AAMC showed the aggregate bad debt, charity care, and uncompensated care data for all 24 hospitals in the Central Maryland Region in 2015. AAMC calculated the average percentage of total uncompensated care for all services was 4.1%, while AAMC's was 3.04%. (DI #6, pp. 109-110, Chart 44).

Reviewer's Analysis and Findings

The purpose of this standard appears to be to ensure that *private freestanding psychiatric hospitals* provide an appropriate level of charity and uncompensated care relative to that provided by general acute care hospitals.

I compiled and reviewed the most recently available iteration of revenue and uncompensated care data (2016) maintained by the Health Services Cost Review Commission ("HSCRC") for all Central Maryland acute general hospitals. It is displayed in Table III-1, below, and shows results very similar to what AAMC reported for 2015 in its response to this standard.

Table III-1: Acute General Hospitals in Central Maryland, FY 2016
Hospital Uncompensated Care and Gross Patient Revenue

Hospital	Jurisdiction	Total Uncompensated Care (UCC) ($000s)	Gross Patient Revenues (GPR) ($000s)	UCC as % of GPR
UMMC Midtown	Baltimore City	$18,528	$226,817	8.2%
UM-Harford	Harford	6,426.0	104,106.1	6.2%
UM Rehabilitation & Orthopaedic.	Baltimore City	7,254.4	118,766.8	6.1%
MedStar Harbor	Baltimore City	11,195.4	194,368.9	5.8%
St. Agnes	Baltimore City	24,889.1	432,204.4	5.8%
LifeBridge-Northwest	Baltimore Co.	14,575.6	257,944.7	5.7%
UM-BWMC	Anne Arundel	23,239.0	413,064.2	5.6%
Mercy Medical	Baltimore City	27,253.3	513,599.6	5.3%
JH Bayview	Baltimore City	32,847.0	643,455.4	5.1%
MedStar Good Samaritan	Baltimore City	14,558.6	289,108.8	5.0%
MedStar Franklin Square	Baltimore Co.	22,427.1	505,736.1	4.4%
Levindale	Baltimore Co.	2,615.2	60,312.8	4.3%
MedStar Union Memorial	Baltimore City	18,071.4	426,343.8	4.2%
UM-St. Joseph	Baltimore Co.	16,456.0	402,082.7	4.1%
University of Maryland	Baltimore City	54,173.1	1,345,458.4	4.0%
LifeBridge-Sinai	Baltimore City	28,586.9	732,671.6	3.9%
Bon Secours	Baltimore City	3,965.3	106,732.3	3.7%
UM-Upper Chesapeake	Harford	11,900.0	330,967.0	3.6%
Howard County General	Howard	9,809.0	297,946.2	3.3%
Carroll	Carroll	7,317.3	254,064.5	2.9%
Greater Baltimore	Baltimore Co.	11,490.2	439,684.2	2.6%
Anne Arundel	Anne Arundel	14,649.1	576,313.3	2.5%
Johns Hopkins	Baltimore City	47,821.5	2,282,683.4	2.1%
Total	-- -- --	$ 430,048	$ 10,954,432	**3.9%**

Source: HSCRC Report: Disclosure of Hospital Financial and Statistical Data: Fiscal Year 2016, pages 62-64. This Report can be accessed on HSCRC's website at http://www.hscrc.maryland.gov/Documents/pdr/ar/HSCRC-Disclosure-Report-FY-2016.pdf

The uncompensated care total projected by the applicant is well above the average level of uncompensated care (3.9% of gross patient revenues) for all hospital services reported by the 23 acute general hospitals in central Maryland for FY 2016. In fact, in its comments HSCRC staff noted that 9.7% "appears high compared to other Maryland psychiatric hospitals." (DI# 65, pp. 3,4).

The applicant's projections show an intent and expectation to carry its fair share of uncompensated care. Although the applicant's projected uncompensated care may be higher than will actually occur, I find that the applicant has complied with this standard by projecting an uncompensated care percentage that exceeds the average level of uncompensated care provided by the 23 acute general hospitals in Central Maryland.

Standard AP 11

Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

AAMC stated that it "compared its projected charge per case to the age and case-mix adjusted charge per case to general acute care psychiatric units in its local health planning area" (defined as Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County and Howard County) and presented it on Chart 45 in its application. (DI#6, pp. 111,112 and Chart 45). AAMC's analysis included a calculation of an FY2015 average charge per case (with charges inflated 2.4% for the FY16 update factor) of $9,164. AAMC compared that to its projected charge per case of $7,644, stating that its analysis shows AAMC to be "a lower-cost alternative for patients within AAMC's service area." DI#6, pp. 111).

Reviewer's Analysis and Findings

I undertook a validation of the data AAMC submitted, running my own calculations of average cost in the defined health planning area and ran my own calculations (Table III-2 below). I found that AAMC's estimated charge per case of $9,164 would indeed be lower than the average of the other facilities in the planning region, which averaged $9,975 in FY2015 and $11,170 in FY2016. Thus I find that the applicant has met this standard.

Table III-2: Average Charge per Case in the Jurisdictions of Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County and Howard County, FY15-FY17

	Psych Discharges*			Total Charges			Average Charge per Case		
AGE	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017	FY2015	FY2016	FY2017
0-4	8	8	6	$168,653	$621,868	$84,263	$21,082	$77,733	$14,044
5-14	845	759	763	$10,307,481	$9,836,561	$10,405,555	$12,198	$12,960	$13,638
15-44	9,261	8,748	8,785	$82,155,747	$82,588,875	$84,683,735	$8,871	$9,441	$9,640
45-54	3,715	3,369	2,945	$35,460,757	$34,210,275	$32,988,345	$9,545	$10,154	$11,201
55-64	2,200	2,104	2,090	$26,549,341	$27,628,702	$29,379,931	$12,068	$13,132	$14,057
65-74	727	869	815	$10,585,519	$17,036,422	$16,592,523	$14,561	$19,605	$20,359
75-84	385	430	510	$5,220,609	$8,169,020	$12,279,936	$13,560	$18,998	$24,078
85+	257	357	335	$3,091,801	$5,819,623	$6,162,229	$12,030	$16,301	$18,395
Total	17,398	16,644	16,249	$173,539,907	$185,911,346	$192,576,517	$9,975	$11,170	$11,852

* Note: Psychiatric discharge defined as Major Diagnostic Code (MDC) 19, Nature of Admission Not Rehabilitation

Source: HSCRC Inpatient Files

Acceptability

Standard AP 14

Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);
(iii) the Department of Health and Mental Hygiene; and
(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

AAMC submitted a copy of a letter from the Secretary of the Maryland Department of Health and Mental Hygiene, acknowledging notification of the proposed project. (DI #16, Exh. 21). The applicant included many letters of support, including letters from the requisite agencies and organizations cited in this standard, as represented by Jinlene Chan, M.D., M.P.H., (Formerly) Health Officer, Anne Arundel County Department of Health and Adrienne Mickler, Executive Director, Anne Arundel County Mental Health Agency, Inc.: (DI #6, App. 3C, 3D, 3G, & 3H)

I find that AAMC meets this standard.

B. Need

COMAR 10.24.01.08G(3)(b) Need.
The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Applicant's Response

AAMC organized its response to the Need standard into sections, in which it addressed: the County's need for psychiatric care resources; projected bed need for the proposed mental health hospital; and the need for proposed shell space.

AAMC: Anne Arundel County's Need for Psychiatric Care Resources

In its overview of mental health needs of Anne Arundel County residents, AAMC discusses the demand for mental health services presenting at AAMC, including data on: the volume of inpatient discharges with a primary psychiatric diagnosis for residents of Anne Arundel County; the volume of emergency department ("ED") visits to AAMC's ED with a psychiatric diagnosis; and the number of transfers for psychiatric admission made by AAMC. See Table III-3, immediately below. The applicant states that its patient counts were based on patients who received a mental health diagnosis as a primary diagnosis, and that its counts do not include patients with substance use/alcohol-related disorders as the primary diagnosis. (DI #6, pp. 12, 32, 36).

Table III-3: Anne Arundel Co. Adult Residents - ED and Inpatient Mental Health Discharges

	FY'13	FY'14	FY'15	Source in Application
ED Visits with psychiatric diagnosis, any hospitals	5,056	5,014	5,120	Chart 2, p. 33
AAMC ED Visits with psychiatric diagnosis	1,765	1,713	1,837	Chart 2, p. 33
Inpatient psychiatric discharges	3,558	3,214	3,265	Chart 7, p. 39
Transferred from AAMC for psychiatric admission to unit outside Anne Arundel County (pediatric and adult)			1,173	p. 36
AAMC-eligible patients transferred from AAMC for psychiatric admission * [7]			946[8]	Chart 5, p. 37

* AAMC reports that more than 50% of these patients waited 24-48 hours in the AAMC Emergency Department for transfer, and had an average wait time 28 hours. (DI#6, p.12).
Source: (DI #6, pp. 12, 39, citing HSCRC Abstract Dataset).

AAMC points out that Anne Arundel County, with over 550,000 residents, has only one hospital, BWMC, that has an inpatient psychiatric unit, which has a consistently high bed occupancy rate, "operat[ing] at above 90 percent occupancy through CY 2014 and through most of CY 2015."[9] (DI #6, p. 33). The applicant states that it was not able to transfer any of its psychiatric patients to BWMC in FY 2015 because of BWMC's consistently high bed occupancy rate. AAMC notes that BWMC itself had to transfer 530 adult cases to other hospitals for admission to a psychiatric unit. (DI #6, p.40). AAMC states that 77% of Anne Arundel County residents who are hospitalized with a psychiatric diagnosis are hospitalized outside the county. (DI #6, p.71).

AAMC states that its psychiatric patients who require admission are typically transferred to a hospital located at least 40 miles from AAMC. In FY2015, 75% of the 946 adult patients transferred from AAMC's ED with a psychiatric diagnosis were sent to Sheppard Pratt. Table III-4, below, shows the distribution of AAMC's psychiatric referrals.

Table III-4 - Transfers from AAMC to Acute Psychiatric Units, FY2015

County of Residence	Patients Transferred	Proportion of Patients Transferred	Location of Referral	
			Sheppard Pratt	Other General Hospitals
Anne Arundel	674	71%	514	160
Prince George's	62	7%	45	17
Queen Anne's	36	4%	23	13
Other	174	18%	138	36
Totals	**946**	**100%**	**720**	**226**

Source: DI #6, Chart 29, p.64.

[7] "AAMC-eligible patients" are defined by the applicant as those patients with psychiatric diagnosis codes, that the AAMC Mental Health Hospital, based on patient cohorts, does not expect to serve. See, Technical Notes for diagnosis codes. (DI #6, p.37).

[8] AAMC states that transfers went to 22 different hospitals, the vast majority (75%) to Sheppard Pratt. Bon Secours, at 4%, received the second-most transfer. None went to BWMC.

[9] BWMC operated 14 psychiatric beds in 2014 and 2015, but received authorization in July of 2016 for a project that will expand psychiatric bed capacity to 20, a project that is not yet completed. In CY2013 and 2014, the 14-bed unit operated at average annual occupancy rates of 102% and 94% respectively, based on licensed beds allocated to acute psychiatric services. MHCC, Annual Report on Selected Maryland General and Special Hospital Services (FY 2015; FY 2016).

In addition to this hard data, AAMC presents a variety of facts and figures to show the County's need for psychiatric resources. The applicant notes that, among Maryland jurisdictions, Anne Arundel County has the fifth highest number of psychiatric discharges and the fourth highest number of ED visits for psychiatric diagnoses.[10] AAMC further notes that Anne Arundel County has experienced an intensified need for mental health services to combat addiction rates and overdose deaths (DI #6, p.34). It states that the County's Crisis Operations Call Center and Mobile Crisis Teams saw very large increases in activity between 2014 and 2015. (DI #6, p. 47). AAMC points out that Anne Arundel County had the third highest count of drug and alcohol-related intoxication deaths in the State of Maryland in 2014, with 101 drug and alcohol-related deaths, representing a 29 percent increase over the number of deaths in 2013 and an 80 percent increase since 2010. (DI #6, pp. 47, 48). It further notes that the County's 2015 Community Health Needs Assessment, 2015 concluded that

> [t]he rise in mental health issues and the lack of appropriate services and service providers were the major concern for almost every participant in the needs assessment," which showed an 18% increase in the number of people served by a public mental health service in Anne Arundel County between 2012 and 2014. (DI #6, Exh. 1).

AAMC: Projected Bed Need for AAMC's Mental Health Hospital

AAMC notes that the bed need projections for its proposed psychiatric hospital contain five major assumptions: (1) the primary market area will be Anne Arundel and Queen Anne's Counties; (2) the hospital will achieve a service area market share of 25%; (3) the region's psychiatric hospitalization use rate will decline; (4) the average acute psychiatric length of stay will shorten; and (5) patient volume originating from beyond its defined service area will be equal to 15% of the patient volume originating from the service area. The applicant addresses each assumption, as shown below.

1. *AAMC: The primary market area will be Anne Arundel and Queen Anne's Counties.*
   The applicant notes that patients from these two counties represented 75% of the 946 total transfers from AAMC to acute psychiatric units in Maryland in FY 2015. (DI #6, p. 64). The applicant states that: "HSCRC data indicates that AAMC is the first point of hospital contact for more than 20 percent of acute psychiatric patients who were admitted from Anne Arundel County and more than 20 percent of acute psychiatric patients who were admitted from Queen Anne's County." (DI #6, p.65).

2. *AAMC: The proposed psychiatric hospital will achieve a 25% service area market share.*
   AAMC posits that, if the 946 transferred patients had been able to receive inpatient treatment at AAMC, they would have represented a market share of 21% of psychiatric admissions from Anne Arundel and Queen Anne's Counties. (DI #6, p.72). Based on this history, AAMC projects a 25% market share from this target market area for the

[10] I note that Anne Arundel County also has the fifth largest jurisdictional population. See discussion page 4 *supra*.

proposed hospital. To support this assumption, AAMC noted that its ED currently serves 36 percent of Anne Arundel County's adult mental health visits to hospital emergency rooms and 24 percent of Queen Anne's County's adult mental health visits to hospital emergency rooms and that a 25% market share in this region is lower than the market share achieved by several AAMC service lines. (DI # 6, p. 9 and pp.71-73).

3. *AAMC: Acute psychiatric hospitalization use rate will decline.*
The applicant projects that psychiatric discharges per thousand population from this region would decline from a baseline of 7.73 in 2016 to 6.94 in the assumed first year of the project (2019) and to 6.43 in 2022.[11] It expects that this reduction will result from "reliance on the partial hospitalization program, improved community care integration, and peer support programs." (DI #6, p. 75).

4. *AAMC: The acute psychiatric average patient stay will shorten.*
AAMC projects a length of stay that decreases from a current 7.67 days (for its ED psychiatric transfers) to 6.14 days at its proposed psychiatric hospital based on the rationale that AAMC providers will make greater use of the partial hospitalization setting, maintain continuity of care with patients, and accelerate the discharge planning process through greater familiarity/working relationships with local community-based agencies (DI #6, pp. 74,75).

5. *AAMC: Patient volume originating from beyond the defined service area will be equal to 15% of the patient volume originating from the service area.*
The applicant notes that approximately 25% of the its ED psychiatric transfers currently come from outside the projected defined primary market of Anne Arundel and Queen Anne's Counties. It expects that the new hospital in Prince George's County and the reconstituted Laurel Regional facility will serve a large percentage of Prince George's County residents needing psychiatric care. (DI #6, pp. 65, 74).

AAMC states that it calculated admission projections by applying the use rate projection to the projected population of the defined service area, allocating the assumed market share to this total service area demand, and adjusting for the assumed patient volume originating from outside its defined service area. It states that this model yields a projection of 862 and 892 discharges over the first four years of the special hospital's operation. The assumed average length of stay ("ALOS") of 6.14 days yields a projected average daily census of 14.5 to 15.0 patients for the proposed 16-bed unit hospital. (DI #6, p.76).

AAMC also points out that its ED patient transfer volume alone (1,173 patients in FY2015, 946 of whom had diagnoses AAMC reports it could treat in its inpatient psychiatric beds) would justify a hospital of the size proposed. (DI #6, p.36). Specifically, it projects that, if it retained 90 percent of the 946 patients with an ALOS of six days, this patient volume would produce 5,108 patient days, an average daily census of 14 patients. AAMC's calculation assumes that 15% to 20% of the patients could be treated in a partial hospitalization program rather than as inpatients.

[11] Adult psychiatric discharges/1000 from FY2013 through FY2015 were 8.67, 7.70, and 7.72 respectively. (DI #6, Chart 8, p. 40, citing the HSCRC Abstract Dataset and Nielsen, Inc. as sources).

AAMC: Need for Shell Space

AAMC's proposed hospital building includes areas of shell space. On the first floor, it proposes approximately 3,421 SF of shell space that is anticipated for eventual use for child and adolescent outpatient mental health programs. AAMC notes that it currently operates an outpatient mental health clinic for adults and a program for children, aged three and older, at off-campus leased space on Riva Road, 2.4 miles from the AAMC campus. The applicant states that this program has grown, noting that, despite its extension of evening and weekend hours, there is a lengthy waiting list for services. AAMC plans to relocate outpatient mental health clinic services for children and adolescents from the leased space to the first floor of the new mental health hospital, allowing this program and the adult program (which will remain in the leased space until the lease expires in 2021) to grow to meet demonstrated community need. AAMC's expected timeframe to fit out the shell space is three-to-five years. (DI #25, pp.4-6).

The planned third floor at the proposed psychiatric hospital will consist of approximately 11,908 SF of shell space. AAMC anticipates that this space will be used for intensive outpatient mental health programs for children and adolescents, adult outpatient services, and pain management services. As with the outpatient mental health clinic services for children and adolescents, AAMC plans to relocate the adult outpatient clinic from leased space (6,600 SF) on Riva Road to the third floor of the new building upon expiration of the Riva Road lease. AAMC plans to introduce an after-school intensive outpatient mental health program for children and adolescents with disorders of opposition/defiance or acting out behaviors, using approximately 2,600 SF of the shell space, and an outpatient pain management program (approximately 2,700 SF) "to respond to... patients with chronic pain who [are]...best served by an integrated approach to pain management." (DI #24, p. 78a).

AAMC states that the planned after-school child and adolescent program is needed for patients who are being referred to AAMC's partial hospitalization program, but who cannot be treated there because this cohort "cannot appropriately be combined with anxious, depressed and suicidal adolescents in the partial hospitalization program." (DI #25, p.5).

Regarding the space for its pain management program, AAMC states that existing treatment settings for pain management "fail to incorporate psychotherapy intervention and substance use intervention, and that existing mental health and substance use settings do not effectively integrate the somatic management of chronic pain." AAMC states that a "failure to adequately respond to community need in this area continues to lead to tragic outcomes, including the high rates of overdose on prescribed and illicit opiates." AAMC states that it has an opportunity to provide an integrated program that would incorporate specialists in pain management, mental health, and addictions interventions "to provide relief to patients, tackle the frequently intertwined syndromes underlying pain problems, and support long-term emotional and physical well-being." (DI #24, p. 78a).

The applicant initially identified these uses for the shell space, but also provided alternative plans for an eight-bed adolescent inpatient unit on the third floor, stressing that the alternative would only be considered if Maryland is granted a waiver or other relief from the IMD exclusion and if "there is demonstrated need at the time." (DI #36, p.16). It states that, if such relief is

granted, the adolescent inpatient unit would result in the adult outpatient clinic not being relocated from the leased space.

Despite this potential use being described only as a possible alternative to the described outpatient uses, AAMC outlined a need analysis, pointing out that: (1) adolescent patients from Anne Arundel County must currently leave the jurisdiction for inpatient care, compromising continuity in mental health care, and making family engagement more difficult; (2) in FY 2015, a total of 526 mental health discharges were reported for Anne Arundel County adolescent residents (ages 10-17 years), with almost 30% of these discharges originating at AAMC's ED; and (3) nearly 90% of Anne Arundel County adolescent patients were admitted to Sheppard Pratt, approximately one hour's drive for Anne Arundel County families, resulting in challenges to the effective coordination of aftercare with community providers.

Table III-5: AAMC: Need Projection for Adolescent Psychiatric Beds

Assumptions and calculations	Result
Start with the 526 discharges of Anne Arundel County youth in FY 2015 as a base and assume a 20% reduction in discharges resulting from greater reliance on partial hospital, intensive outpatient, and traditional outpatient service settings.	526 discharges x 80% = 421 discharges
Assume that 90% of these Anne Arundel County discharges are served at AAMC.	421 x 90% = 379 discharges
Assume an average length of stay of 7 days (current ALOS of Anne Arundel County discharges is 9 days).	379 x 7 = 2653 patient days, and a daily census of 7.3
Assume a 90% occupancy target.	7.3/.9 = 8 beds needed

Source: DI #25, p. 7.

AAMC states that its anticipated timeframe to fit out the shell space will likely be three to five years after the facility's opening. (DI #24, pp. 78a, 78b). Providing further detail about the timing of use of the shell space, the applicant states that

> [t]he portion of the third floor slated for the relocation of the adult outpatient clinic (or a potential eight-bed adolescent inpatient unit if the IMD exclusion is resolved) is proposed as shell space in order to allow for the expiration of the lease [in 2021] for the space in which the clinic is currently operated. The remainder of the space on the third floor and the portion of the first floor slated for the child and adolescent outpatient clinic, the intensive outpatient program, and the pain management clinic is proposed as shell space in order to allow the Applicant to pursue an orderly and efficient phase-in of these programs over 3-5 years rather than strain resources in an attempt to implement these programs at the same time as the new inpatient unit is established and the partial hospitalization program is relocated to the new building.
> (DI #25, p. 8).

Interested Party Comments

BWMC does not object to AAMC's establishment of a 16-bed inpatient psychiatric service capability, but instead believes that the inpatient psychiatric beds should be situated within AAMC, rather than at a separate location. BWMC also objects to the construction of shell space at the

proposed psychiatric hospital, stating that AAMC did not demonstrate a need for more than the 16 beds it seeks in its application. BWMC notes that, after Commission staff asked AAMC to justify the proposed shell space by showing additional need for beds, AAMC "asserted that it may seek to add an adolescent psychiatric unit in the future." (DI #34, p.9). BWMC states that AAMC's statement that there are no adolescent beds in Anne Arundel County and that 90% of adolescent patients in the County are referred to Sheppard Pratt, an hour's drive away, fails to account for the fact that the Commission "recently approved [the] Sheppard Pratt at Elkridge project, which will include a 17-bed adolescent unit (Sheppard Pratt at Elkridge, Docket No. 15-13-2367)." (DI #34, p.9)[12].

Applicant's Response to Interested Party Comments

As will be discussed in more detail in the following section (discussion of the availability of more cost effective alternatives) AAMC states that it rejected the option of constructing this unit within the acute care hospital because it concluded that the only available space was suboptimal, concluding that space at AAMC as it: would not allow for the co-location of outpatient programming; was poorly located within the general hospital with no expansion possible; would consume needed acute care medical surgical beds; and would not allow for behavioral health staffing efficiencies and synergies.

AAMC responds to BWMC's argument against its possible use of its proposed third floor shell space for eight adolescent beds, by noting that it outlined plans to use all of the shell space within the next 3-to-5 years, with none of those planned uses involving additional inpatient beds. The applicant emphasizes that the shell space is included in its proposal to "enable the relocation and expansion of the outpatient clinic for children and adolescents, and eventually the relocation of the adult outpatient clinic program from its current leased space." AAMC states that inclusion of this space will "enable AAMC to deliver a comprehensive and integrated mental health care program on a single campus" incorporating inpatient psychiatric care, psychiatric partial hospitalization, as well as other outpatient mental health programs and referral and care coordination services. (DI #36, p.1).

AAMC stresses that it "identified the possibility of an 8-bed unit for adolescents only as a possible alternative use for a portion of the shell space on the third floor...if the State is granted a waiver or other relief from the IMD exclusion and depending on whether there is demonstrated need at the time." (DI #36, p.16).

Reviewer's Analysis and Findings

The Psychiatric Services Chapter does not have an applicable bed need analysis. Accordingly, AAMC has the burden of proving the need for its proposed 16-bed adult unit. To that end, the applicant provided a well-documented and detailed service area-based analysis. I find that AAMC has demonstrated that a 16-bed psychiatric acute inpatient capability is justified. As

[12] Presumably, the point being made here is that the northern Howard County location of the replacement psychiatric hospital will be substantially closer for most, if not all, Anne Arundel County residents than the Sheppard Pratt facilities located in Ellicott City and Towson.

AAMC has documented, the number of patients with a psychiatric diagnosis that it currently sees in its Emergency Department is indicative of a need for inpatient psychiatric facilities with the bed capacity proposed.

I will address the issue of how and where AAMC proposes to configure its proposed psychiatric hospital capacity in my discussion of the Availability of More Cost-Effective Alternatives, COMAR 10.24.01.08G(3)(c), below. With respect to the shell space being proposed, I find that the applicant has outlined a clear and well-defined plan for use of the proposed space, to be phased in as existing leases expire. BWMC dwells on the potential use of the shell space for beds, and its fear that this would result in classification of the proposed facility as an IMD and the disadvantages this would create for use of this facility to serve Medicaid patients. I believe that the applicant's plans for use of that space for outpatient services are rational and well-documented. I note that, as pointed out by the applicant, any addition of beds (commonly known as "waiver" or "creep" beds) pursuant to current regulations, at COMAR 10.24.01.03E(2), would be limited to one bed every two years for the foreseeable future. Such a slow addition of beds would be very impractical and, thus, unlikely. I agree with the applicant that it would not risk classification as an IMD to gain one additional bed. (DI #36, pp. 19, 20).

AAMC states that the shell space on the first floor will be used to relocate outpatient mental health clinic services for children and adolescents from leased space where it currently operates an outpatient mental health clinic for adults and children. Relocation of child and adolescent services to this shell space will permit the adult outpatient clinic to grow to meet the need for adult services. Upon the lease's expiration in 2021, the applicant states that it plans to relocate the adult outpatient clinic to the shell space on the third floor of the new building. I find that this is a quite reasonable planned use of shell space as part of a rational transition plan to consolidate behavioral health programs space in the future without incurring the cost of early exit from existing lease agreements.

It is third-floor shell space that draws most of BWMC's opposition. The applicant states that the space is slated to house an after-school child and adolescent program targeting those with "disorders of opposition/defiance or acting out behaviors," space to relocate its adult outpatient programming, and a pain management program geared toward integrating pain management and substance abuse treatment to combat the growing problem of addiction that is resulting in overdose fatalities. I find that these services are needed by the population to be served, and that centralizing them in this proposed space is a rational solution. I find that the applicant has demonstrated a practical need for the proposed shell space that make its construction in conjunction with the proposed inpatient psychiatric beds a reasonable choice, in light of both need and cost considerations.

I find that the applicant has demonstrated a need for its proposed project.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3)(c) <u>Availability of More Cost-Effective Alternatives</u>.
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.

Applicant's Response

AAMC states that its primary goals in proposing this project are to: (1) eliminate the delays and barriers to timely inpatient psychiatric care that now result from 946 patient transfers to other facilities, almost all outside of Anne Arundel County; (2) strengthen the quality and continuity of mental health care in Anne Arundel County by establishing a comprehensive and integrated mental health care program that enables coordination with community-based support services; (3) ensure that AAMC's inpatient mental health capacity is available to serve all patients regardless of payor source, including Medicaid patients, without delay; and (4) reduce admission rates and length of stay, and leverage community based resources to the fullest extent possible. (DI #6, p. 80).

AAMC spoke to its consideration of four alternatives: (1) do nothing; (2) convert existing hospital space; (3) establish a freestanding psychiatric hospital on the Pathways campus; and (4) redevelop an existing site. (DI #6, pp. 81-83).

AAMC: Option 1: Do nothing. AAMC states that continuing to rely on existing facilities to meet a demonstrated need additional inpatient psychiatric capacity was "rejected because it maintains the unacceptable status quo for the large volume of patients in need of inpatient psychiatric care who arrive at AAMC's ED and who must be transferred long distances to receive care." (DI #6, p.81).

AAMC: Option 2: Convert existing hospital space. AAMC states that it explored the option of converting two existing acute-care units (approximately 14,326 SF) in the North Hospital Pavilion into 16 psychiatric beds. It estimated a total project cost range of $6.5-$8.5 million. AAMC notes several drawbacks to this option.

AAMC states that these units are the only available options for renovation for this purpose, and that their sixth-floor location is disadvantageous because "elevated floors are not ideal for a mental health locked unit," stating that the adjacencies, access for visitors, and security for patients and visitors "are inferior to those that could be achieved at a consolidated mental health and substance use campus." (DI #6, p. 82). AAMC contends that the advantage of such a consolidated behavioral health campus is its ability to share staff across inpatient and partial hospital programs and that such advantages would be compromised under Option 2. Further, AAMC states that if it needs to add beds or multiple units to meet growing need in the future, the sixth-floor location does not provide that opportunity.

The applicant also states that under the Global Budget Revenue ("GBR") payment model currently in use for regulation of hospital charges, its reimbursement for inpatient psychiatric services – a new service in the hospital – would be subject to a 50 percent variable cost factor, and that the service line would create a negative operating margin. AAMC estimates that, on a stand-alone basis, the psychiatric services would sustain an operating loss of $1.28 million in the third year of operation. It states that this would make the program unsustainable over time. AAMC asserts that this option would also have the undesired effect of increasing costs subject to Maryland's Medicare waiver.

AAMC: Option 3: the proposed construction of a special hospital-psychiatric on the Pathways campus. AAMC states that it selected Option 3 because it would have none of the drawbacks of Option 2's hospital-based unit. The applicant views Option 3 as enabling it to provide a comprehensive and integrated mental health care program at a single location[13] and that a unit located outside of an acute care hospital enables the design team to create "the right 'balance between the safest possible healing environment and a non-institutional appearance that is correct for the unique conditions that exist in each and every facility.'"[14] It notes that it currently leases the proposed site from Anne Arundel County on a long-term basis. (DI #6, p. 82).

AAMC: Option 4: Redevelop an existing site. AAMC states that it explored the option of building a psychiatric hospital on property it could acquire that would have required demolishing an existing building, stating that such a scenario would have the advantage of being owned by the health system, as opposed to the long-term land lease with Anne Arundel County described in Option 3. AAMC states that it reviewed potential sites and conceptual estimates for this alternative, but found that the total capital investment would be in excess of $21 million. AAMC concluded that the "land acquisition, demolition and unforeseeable site conditions make this a less favorable option," which would also create additional ongoing cost "to support another satellite for the health system for couriers, materials management, technology infrastructure, personnel, etc." (DI #6, p. 83). The applicant states that this option was not desirable because capital and ongoing costs would be greater, and it fails to "provide the numerous benefits afforded by co-locating multiple mental health and substance use services on a single site." (DI #6, p.83).

Interested Party Comments

BWMC questions the applicant's conclusion that the most cost-effective option is "to establish a new health care facility... several miles from the hospital, its emergency department (ED), and other important hospital services," (DI#34, P.1) stating that AAMC "rejected the hospital based unit option for several fallacious reasons, and... disregarded several advantages to establishing the inpatient psychiatric unit in the hospital." (DI #34, p.6). BWMC states that a hospital-based unit is more cost effective for several reasons, summarized below.

BWMC: Project Cost and Failure to Consider Alternative Sites within the Hospital

BWMC points out that AAMC estimated the cost of converting existing space to be between $6.5 million and $8.5 million, compared to the $25 million estimated cost of the proposed new facility. It states that AAMC failed to explain why space within the hospital is unsuitable, challenging what it characterizes as AAMC's apparent conclusion that the only available space within the hospital – the sixth floor of the North Hospital Pavilion – is "not ideal for a mental health locked unit, and that access for visitors and security for patients and visitors are inferior to

[13] The applicant states that it will incorporate inpatient psychiatric care, partial hospitalization, intensive outpatient programs, family support services, prevention programs, and referral to and care coordination with community-based support services. This option also supports better integration with community-based activities, including family and self-help programs to strengthen patient engagement, and patient advocacy organizations to encourage active involvement in community health. (DI #6, p.82).

[14] Hunt, James M and David M. Sine, "Design Guide for the Build Environment of Behavioral Health Facilities," Edition 7.0, May 2015. (DI # 6, p.82).

those that could be achieved in a new facility," pointing out that the selected alternative, like a unit at AAMC, "would use elevated floors (the second and third floors) for inpatient capacity ...." BWMC notes that "AAMC does not explain why it cannot make the space in the existing hospital as secure as the inpatient space in the proposed new facility." (DI #34, p.7). It also points out that AAMC failed to provide any information or analysis about other space that may be available within the hospital. (DI #34, p. 9).

BWMC: Staffing Inefficiencies

BWMC also asserts that a hospital-based unit would enhance staffing efficiency. BWMC states that, while AAMC claims that its ability to share staff across inpatient and partial hospital programs would be compromised in the hospital-based option, it failed to describe or quantify the savings it would realize "by taking advantage of the staffing infrastructure of the existing hospital ...." BWMC notes that the proposed separate facility will force AAMC to maintain redundant functions in maintenance, admitting, food service, and materials management staff. Further, BWMC states that a hospital-based option would facilitate clinical staff integration, particularly sharing and coordinating clinical staff with AAMC's ED. On this point, BWMC notes that AAMC based much of its need justification for inpatient psychiatric capacity on visit volume to its ED, yet selected a project option that "divorces the inpatient psychiatric unit from the ED." BWMC points out that AAMC will need to staff its ED with mental health professionals, but the distance between the ED and the proposed inpatient psychiatric hospital would make it impossible to share that staff, while a hospital-based option would permit it. BWMC asserts that AAMC ignored that clinical integration benefit, while focusing instead on the possible benefit of coordinating outpatient and inpatient psychiatric staffing. BWMC questions why the outpatient services could not be moved to the acute care hospital campus rather than be stationed at the proposed new facility. (DI #34, pp.7-8).

BWMC: Financial Feasibility Would not be Threatened by a Hospital-Based Unit

Addressing AAMC's explanation that it rejected the hospital based unit option because the unit would not be sustainable over time due to projected losses (-$1.28 million in Year 3), BWMC notes that the loss is driven by HSCRC policy, i.e., AAMC's reimbursement for inpatient services would be subject to a 50% variable cost factor. Citing information AAMC submitted in the recent Baltimore Upper Shore Cardiac Surgery Review (Docket Nos. 15-02-2360, 15-02-2361), BWMC asserts that such a loss would not be material to the overall financial feasibility of the hospital because the AAMC's submission showed a projected net income of at least $62.7 million in FY 2019. Moreover, BWMC states that "AAMC has asserted that it is proper for it to reallocate revenue from other sources in the hospital to subsidize its proposed cardiac surgery program, which it projects will lose at least $3 million each year (more than twice the projected losses for the inpatient psychiatric service)." (DI #34, p.10). BWMC contrasts its approach to planning to meet the need for additional inpatient psychiatric capacity with that of AAMC.

BWMC points out that other area hospitals have planned projects to meet the need for additional inpatient psychiatric capacity, but unlike AAMC, they are not prioritizing revenue goals. BWMC notes that it recently received a determination from the Commission that a CON is not needed to expand its inpatient psychiatric capacity by ten beds, an expansion project that would

proceed within the next several months. Under the agreement between the University of Maryland Medical System and the HSCRC regarding BWMC's global budget revenue ("GBR"), BWMC will be reimbursed for additional inpatient psychiatric volume at a 50% variable cost factor. Likewise, BWMC points out that Doctors Community Hospital ("DCH") recently applied for a CON to establish a 16-bed inpatient psychiatric unit on its hospital campus that will be regarded by HSCRC as part of the acute general hospital. (DCH CON application, Matter No. 16-16-2386). Like BWMC, DCH will be reimbursed for new services at a 50% variable cost factor. BWMC also notes that MedStar Health announced plans to expand its behavioral health services at MedStar Harbor Hospital, a short distance from Anne Arundel County.[15] As a hospital-based unit, the new MedStar expansion would be subject to the HSCRC's market shift policy. BWMC posits that, if AAMC is permitted to build a new facility at a cost of $18 million rather than using existing space in its acute general hospital based on a revenue enhancement rationale, then future applicants will be encouraged to use AAMC's approach rather than employ the more cost-effective approaches of BWMC and DCH. (DI #34, p.11).

BWMC: Potential Impact of the Federal Law That Limits Medicaid Reimbursement for an IMD

BWMC states that AAMC's analysis failed to address the potential impact of the federal law that limits Medicaid reimbursement for an IMD. BWMC notes that the "IMD exclusion" essentially means that the federal government will not reimburse the State for its portion of the Medicaid payment in mental health and substance abuse disorder residential treatment facilities with more than 16 beds, except for individuals under the age of 21. (DI#34, pp. 11,12). BWMC indicates that AAMC did not take into account the fact that a hospital-based unit is not an IMD, and thus could expand beyond 16 beds without any concern that it may be precluded from receiving Medicaid reimbursement for adult patients, in contrast to the potential impact of expanding the proposed psychiatric hospital. BWMC points out that this is surprising because one of AAMC's stated project goals is to serve all patients regardless of payor source, including Medicaid patients. It notes that AAMC's application, at Table K, projects that a substantial portion (39.4%) of the revenue for the new facility would be generated by Medicaid patients.

BWMC: The Inclusion of 17,132 Square Feet of Shell Space is Not Cost Effective

BWMC opines that, if MHCC approves this project, it should not approve the proposed third floor shell space because AAMC has not shown that the space is needed at all. In addition, BWMC challenges the accuracy of AAMC's net present value analysis which concluded that building the space as part of the initial construction would be less costly than building a third floor addition later. BWMC states that AAMC has not met the test of cost effectiveness.[16] BWMC bases its critique on the assumption in AAMC's estimate that:

---

[15] MedStar proposed and has since implemented the relocation of an acute psychiatric hospital unit from MedStar Union Memorial Hospital to MedStar Harbor Hospital. The move did not change bed capacity in Baltimore City and, thus, cannot be correctly classified as an expansion of the service.

[16] The Acute Hospital Services Chapter, at COMAR 10.23.10.04B(16), provides:

(a) Unfinished hospital space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective…

(b) [T]he applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

the construction of the third floor would cost 100% more based upon the complexity of constructing the space on top of an operating health care facility. AAMC provides a summary explanation for this aggressive assumption, but it provides no support for the accuracy of the complexity factor of 100%. (DI #34, p. 13).

Applicant's Response to Comments

AAMC: Consideration of Alternative Sites within the Hospital

AAMC characterizes BWMC's assertion that locating the 16 beds in AAMC's acute care general hospital is more cost effective than establishing the mental health hospital as "unfounded and incorrect." While AAMC acknowledges that the 16-bed unit could be accommodated within the hospital, where it would be less, it believes that the hospital-based option "fell far short on key objectives for the project." (DI #36, p.9).

AAMC states that an in-hospital placement could not accommodate the partial hospitalization and other outpatient programs that are planned for the new building, and that there is no space on the hospital campus available to co-locate these programs with the inpatient unit to create "the integrated, holistic mental health care program that this project represents." (DI #36, p.9). AAMC notes that the hospital-based option would prevent the achievement of the project's two core goals: (1) improve the quality and continuity of mental health care in Anne Arundel County through the planned comprehensive and integrated mental health program that will enable coordination with community-based support services; and (2) reduce inpatient length of stay and admission rates through leveraging of community-based resources. (DI #36, pp. 9, 10).

AAMC notes that there are significant advantages to be reaped from co-locating the inpatient and outpatient programs. For example, program psychiatrists will work in both venues, "thus easing this transition for patients and avoiding the potential for gaps to arise in communication or appropriate follow-up care." AAMC describes these purported advantages as follows:

> Should an acute episode/relapse occur, physicians will be able to admit patients directly to the acute unit and eliminate the need for an ED visit/evaluation. The ability to accommodate direct admissions from sub-acute care programs...will reduce unnecessary overburdening of acute hospital EDs and inconveniencing patients and families. The integration of self-help programs and family wellness programs into the work-flows and...work spaces of the inpatient program will encourage incorporation of this recovery-oriented approach to mental health problems. Continuity of these self-help programs and family programs across inpatient, partial hospital and outpatient environments will also promote early identification of...and timely intervention to avoid, relapse. The clinical advantages

---

(i) Considers the most likely use identified by the hospital for the unfinished space;
(ii) The time frame projected for finishing the space; and
(iii) Demonstrates that the hospital is like to need the space for the most likely identified use in the projected time frame.

to co-locating the inpatient unit with these outpatient programs also drive the projected two-day reduction in the average length of stay of patients currently being transferred outside of Anne Arundel County. This reduction could not be achieved without establishing the inpatient unit as part of an integrated mental health care program in a single location.
(DI #34, p. 10).

Responding to BWMC's critique that AAMC did not sufficiently consider or explain why it did not consider other spaces within the hospital, the applicant states that it considered any available space that could be repurposed. AAMC notes that there is no existing space at the hospital that could accommodate the combination of inpatient and outpatient services into a comprehensive mental health care program. The sixth floor option (its Option 2) would accommodate an inpatient program only. AAMC asserts that separating the inpatient unit from the partial hospitalization and other outpatient programs "defeats the clinical advantages and shorter lengths of stay associated with co-locating these programs...and would not achieve key objectives of the project." (DI #36, p. 13).

AAMC also points out that using the sixth floor for a 16-bed unit would necessitate taking 25 general medical/surgical beds out of service, noting that having fewer beds available "would have a significant negative impact on AAMC's ability to operate effectively as an acute care general hospital." (DI #36, p. 14). AAMC quoted occupancy and ED diversion statistics for several points in time during FY 2016 to illustrate this point[17].

Responding to BWMC's observation that the inpatient psychiatric beds would be above the first floor at either the proposed special hospital or if located at AAMC, the applicant clarifies that the problem of locating the inpatient psychiatric beds at AAMC is not elevation in and of itself but, rather, the placement within a general hospital. AAMC points out that, if a psychiatric unit is to be located within an acute care general hospital, ideally it would be located on the first floor where safety and security concerns can be met by having a controlled, separate entrance. It notes that, among other concerns, a first-floor location ensures that involuntary psychiatric patients do not need to be transported to an upper floor in elevators used for multiple purposes. Thus, AAMC believes that the only available space in existing physical space at the general hospital is the sixth floor space identified as Option 2, AAMC reiterates that a hospital-based location is less suitable and effective from a safety and security standpoint than the proposed special psychiatric hospital on the Pathways campus.

AAMC: Staffing Considerations

AAMC states that BWMC is incorrect in its assertion that locating the unit within the hospital is more efficient from a staffing perspective, maintaining that the level of mental health clinical staffing is the same whether the unit is in the general hospital or on a freestanding campus, and that there would be no duplication of staff under its chosen option. AAMC points out that the mental health clinicians in the hospital are primarily focused on assessment, and are spread across three shifts covering 24 hours a day, with "no capacity or opportunity for cross-training... to work in an inpatient psychiatric unit focused on therapeutic intervention and recovery." (DI #36, p.11).

[17] I note that AAMC did not provide a large sampling or comprehensive data regarding those measures.

It states that the clinical staff who will most appropriately be cross-trained for the inpatient unit are those who staff the partial hospitalization program and the outpatient and intensive outpatient programs that will be located at the Pathways campus.

The applicant acknowledges that there will be staffing inefficiencies in ancillary clinical services (lab, pharmacy, phlebotomy, etc.), but not with mental health care clinical staff. It states that the efficiencies associated with ancillary and support service staffing are far outweighed by the mental health clinical staff efficiencies associated with the Pathways location. (DI #36, p.12).

AAMC: Financial Feasibility

The applicant agrees with BWMC that the loss projected for a hospital-based unit could be absorbed by AAMC without threatening its financial viability, but clarifies that it did not claim that its general hospital could not absorb an operating loss associated with a hospital-based unit. AAMC states that the loss would make a general hospital-based unit a less cost-effective alternative.

AAMC: Impact of the IMD Exclusion

AAMC states that there is no IMD exclusion risk associated with its proposal because its special hospital would not be an IMD. AAMC notes that it analyzed the impact of a 50% cut in Medicaid reimbursement for adult Medicaid admissions[18] to its special psychiatric hospital and found the effect would be a small annual loss that would still be significantly smaller than the loss associated with operating a hospital-based unit. The applicant concludes that this analysis demonstrates that, even if the proposed new mental health hospital were an IMD, it is still a more cost-effective alternative than locating the unit at the hospital. (DI #36, p.14).

AAMC: The Cost and Effectiveness of the Proposed Shell Space

Responding to BWMC's assertion that AAMC had not proven that its proposed shell space is needed because there is no need for eight additional adolescent beds, the applicant states that BWMC's statement "ignores the outpatient mental health programs for which AAMC plans to use all of the shell space in the next three to five years, none of which involve additional inpatient beds." (DI #36, p. 16). AAMC notes that it presented the idea of an eight-bed adolescent unit "only as a possible alternative use for a portion of the shell space on the third floor...but only if the State is granted a waiver or other relief from the IMD exclusion and depending on whether there is demonstrated need at the time." (DI #36, p. 16).

AAMC also defends its estimate of the cost of adding a floor to an existing, operating psychiatric hospital (the 100% "complexity factor"), which it factored into its net present value calculation that compared the cost of building the shell space now versus adding it when needed at a later date. AAMC refers to opinions from The Whiting-Turner Construction Company[19] and

[18] That is, the level that would hold the State completely harmless from the loss of federal funds for adult psychiatric admissions to IMDs.

[19] AAMC attached a letter from The Whiting-Turner Contracting Company that detailed reasons for increased costs when adding a floor onto an existing occupied building and that stated, "if a 3rd floor is

the architectural and design firm of CRGoodmanAssociates,[20] each of whom saw a substantial cost differential when constructing a building floor after the initial construction and operation of the facility.

Reviewer's Analysis and Findings

At issue here is whether AAMC chose the most cost-effective approach to provide inpatient psychiatric services. I previously found that the applicant demonstrated a need to provide acute inpatient psychiatric services for adults through development of 16 inpatient beds.[21] BWMC does not quarrel with AAAMC's demonstration of need for the service.

BWMC argues that the best place for this service is within AAMC's general hospital, giving a number of reasons for this point, including: a lower initial capital expenditure; an opportunity for staffing efficiencies; and a lower impact on costs and charges. However, its biggest concern is the possibility that AAMC would expand the facility, triggering its recognition as an IMD, a development that BWMC fears would create a disincentive for AAMC to accept adult Medicaid patients, pushing this population, which is often more expensive and less remunerative to treat, onto other hospitals, particularly BWMC.

AAMC acknowledges the larger capital expenditure, but credibly explained that the clinical staffing would be the same whether the inpatient psychiatric capacity is in the general hospital or established in a freestanding special hospital.

Responding to the expansion/IMD issue raised by BWMC because of the inclusion of shell space in the project, AAMC maintains that it would only consider bed expansion if the IMD exclusion is eliminated. Furthermore, AAMC identified likely uses for that space within three years, uses that involve outpatient, rather than additional inpatient, programming.

AAMC presented comparative data (see App.4) showing that its projected charges would be 33% below the statewide average – and 43% lower than Sheppard Pratt (where most of its referrals go now) – resulting in a projected annual savings of $3.3 million by shifting care from higher cost facilities to AAMC's mental health hospital. (DI #36, p. 20; DI #6, pp. 97-99).

The applicant has diligently evaluated alternatives. I find that AAMC's reasons for its choice of location are convincing. While there would be some positive aspects (particularly

---

added to this Mental Health Hospital after the base building construction is completed it will add a substantial cost increase with several patient & staff disruptions." (DI #36, Exh. 4).

[20] CRGoodmanAssociates stated:

> The complexity of constructing a vertical expansion above an occupied psychiatric inpatient unit will add very significant cost. Access to the unit will need to be carefully controlled and limited to certain hours. Major plumbing work as well as work on other systems will need to occur within the second-floor ceiling space. In order to ligature-proof the second-floor patient rooms, non-accessible drywall ceilings will need to be installed. If a future floor were to be added at a later date, these ceilings would have to be demolished, creating further disruption and extended working time in the existing unit. Other issues that complicate future vertical expansion include maintaining the weatherproof integrity of the building throughout the construction period. (DI #36, Exh. 5).

[21] See discussion, pp. 20-21, *supra.*

transport advantages) of locating the hospital emergency department and the inpatient psychiatric beds within the same building or on the same campus, existing options for repurposing space within the general hospital appear limited and less than ideal.[22] Co-locating a special psychiatric hospital with Pathways has the advantage of centralizing a continuum of behavioral health services, including the partial hospitalization and outpatient programming envisioned by AAMC, in one location. I have weighed the advantages to of a behavioral health campus against the disadvantages and find that AAMC's choice of location and consolidation of mental health services will have desirable benefits for the area population.

AAMC's description of the project includes its plan to create a comprehensive mental health evaluation and treatment campus that will enhance continuity and effectiveness of behavioral health care, while perhaps lowering costs through shorter inpatient stays. AAMC has shown that the creation of such a model is unlikely to be accomplished through renovation of existing space on its general hospital campus

It certainly is possible to create a comprehensive mental health evaluation and treatment program without physical co-location of all its various components. Models exist in which high quality care is delivered to patients who must transfer between a hospital's campus (with its ED and inpatient facilities), and its off-campus outpatient services that are well-integrated and carefully coordinated. AAMC's plans for its introduction of inpatient psychiatric services is being planned to allow for a more affordable consolidation of behavioral health services operated by AAMC. Regarding BWMC's view that expanding AAMC proper is a better alternative, I feel it is important to note that this project is not a "greenfield" development, but one that expands AAMC's established institutional campus at Pathways.

The applicant has presented a plan that commits it not to use the introduction of inpatient services to favor inpatient care for patients who can be effectively treated outside the special hospital's inpatient unit. Providing more and better space for outpatient services is a substantial part of the proposed campus expansion. Importantly, the consolidation of program space embodied in this project will make it possible for the inpatient and outpatient programs to share staff, something that cannot be effectively accomplished with the current scattered locations used by AAMC. This presents a positive aspect of this project from a cost perspective. It enhances the ability of the same staff members to work with patients in both settings, improving continuity of care.

While the freestanding option carries a higher capital expenditure, I find this aspect to be more than offset by the operational savings to be realized by ending the use of leased space by the ability to gain clinical staffing efficiencies, and also by the additional effectiveness in patient care and continuity. As discussed under the NEED criterion, I also find that the initial construction of shell space is a prudent plan in light of the planned use of this space, the timing for finishing constructed space, and the avoidance of additional cost and the disruption to patient care.

I find that the applicant has demonstrated that the proposed project is a cost-effective

[22] The in-hospital option considered by the applicant would present the disadvantage of taking medical/surgical beds out of service at a facility that has experienced relatively high occupancy levels of its physical bed capacity in recent years.

approach to meeting identified needs.

D. Viability of the Proposal

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.

Applicant's Response

AAMC estimates that the project will cost $24,984,795. It proposes to borrow $10,000,000 to fund the project through the sale of bonds and will provide the balance from cash reserves. (DI #40, Table E).

The applicant submitted audited consolidated financial statements for Anne Arundel Health System, Inc. and Subsidiaries for 2014 and 2015 as part of its application. This document showed that the system had $99.6 million in cash and cash equivalents as of the end of fiscal year (FY) 2015 and that total assets exceeded total liabilities ($1.054 billion to $639 million). The statement also showed that the applicant generated excess revenue over expenses in FY 2014 and FY 2015, with gains of $14.44 and $25.45 million, respectively. (DI#6, Exh. D-9, Consolidated Financial Statements and Supplementary Information).

The applicant's forecast of use of the proposed hospital and the hospital's projected financial performance are shown in the following table.

Table III-6. AAMC: Projection of Key Operating Metrics

	Operating Year				
UTILIZATION	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Discharges	718	879	886	892	892
Patient days	4,409	5,397	5,440	5,477	5,477
Average length of stay	6.1	6.1	6.1	6.1	6.1
Average annual occupancy rate	75.5%	92.4%	93.2%	93.8%	93.8%
Outpatients (partial hospitalization)	4,299*	5,679	5,718	5,758	5,799
FINANCIAL					
Net Patient Services Revenues	$5,840,989	$7,452,330	$7,649,141	$7,843,577	$8,002,757
Expenses	$6,558,083	$7,118,205	$7,197,331	$7,305,748	$7,401,900
Net income	($717,094)	$334,125	$451,810	$537,829	$600,857

Source: DI #40, Tables I and K.
*Partial hospitalization projection for Year 1 in Table I was entered as 4,699, an error that was corrected in the applicant's response to HSCRC comments dated Feb. 2, 2018. Applicant stated that this entry error was not carried over into the financial projections. (DI#66, p. 1).

The applicant addressed community support for the project by submitting letters of support for the project from members of its Board of Trustees, members of its medical staff leadership, community physicians, several State and federal legislators including Speaker of the House Michael Busch and U.S. Representative John Sarbanes, and County Executive Steven Schuh. Dr.

Jinlene Chan, County Health Officer at the time the application was submitted, wrote a letter of support for the project. Some of the other supporting letters came from:

- Anne Arundel County Mental Health Agency
- Anne Arundel County partnership for Children, Youth, and Families
- The Community Foundation of Anne Arundel County
- United Way of Central Maryland
- Several local churches

Reviewer's Analysis and Findings

This criterion requires consideration of three questions: availability of resources to implement the proposed project; the availability of resources to sustain the proposed project; and community support for the proposed project.

Availability of Resources to Implement the Proposed Project

The applicant's financial statements demonstrate the availability of financial resources to implement the project. The hospital is financially strong. (DI#6, Exh. D-9, Consolidated Financial Statements and Supplementary Information).

Availability of Resources to Sustain the Proposed Project

AAMC projects an ability to reach a high bed occupancy level at the proposed 16-bed hospital by the second year of operation. I find this projection to be credible based on a well-documented market feasibility analysis provided by the applicant. As I noted in my discussion of the Need criterion earlier in this Recommended Decision, the volume of patients currently being transferred from the AAMC emergency department to psychiatric hospital facilities for admission indicate that simply redirecting these patients to the proposed hospital would result in a high bed occupancy rate (87%) at an assumed length of stay of six days.

MHCC requested the Health Services Cost Review Commission ("HSCRC") to review the financial projections provided in the CON application and subsequent filings, and advise MHCC whether the project is financially feasible. HSCRC staff found that the projected inpatient revenue "appears reasonable" but questioned the applicant's projected growth in outpatient visits and the applicant's assumptions with respect to outpatient revenue, observing that AAMC anticipated rates of payment for outpatient services that were approximately 20 to 25% higher than those of existing private psychiatric hospitals in Maryland. HSCRC staff noted that a reduction of outpatient revenue to a level comparable with those of existing private psychiatric hospitals would reduce projected net revenue at the project by approximately $400,000 to $500,000 per year. (DI#65, p.3).

HSCRC staff also expressed concern that the applicant's projection of expenses may be too low, given that a freestanding 16-bed hospital "may not have sufficient economies of scale to provide services effectively or efficiently...and that operating expenses projected in the CON could be too low, based on comparisons to actual revenue and expenses incurred at other private psychiatric hospitals in Maryland." (DI#65, pp.5, 6). HSCRC staff's comments conclude with:

This combination of overstated revenue and understated expenses casts doubt on the projected profits in the CON. The HSCRC staff would closely analyze the projected revenue and expenses when setting the rates for this facility at the time it would open. However, Anne Arundel Medical System has shown a propensity to manage their operations appropriately in the past, and staff expects that they would continue to do so in the future.

At my request AAMC responded to HSCRC's comments and, in summary, its response was as follows:

- Responding to the comment that outpatient rates are high compared to those of other psychiatric facilities in Maryland, AAMC explained that the partial hospitalization program is the only outpatient program that will be provided in the proposed facility until the shell space is completed, at which time the additional outpatient programs will move there. It stated that partial hospitalization is a much more resource intensive service than a simple "clinic" visit, and thus not comparable to the program rates HSCRC cited.[23] AAMC pointed out that its projected charge was lower than the statewide median. (DI# , p. 2). As far as the projected rate of growth in visits, AAMC explained that the partial hospitalization projection is based on an assumption that the current partial hospitalization program would move to the new facility in 2020, into space that is larger than the leased space currently housing the program.

- AAMC provided a detailed response to HSCRC's concerns that expense projections may be understated. It stated that it could achieve these projected levels of

---

[23] In its response to HSCRC comments, AAMC explained that:

> Partial hospitalization serves as a 'step-up' program for patients in outpatient programs who need more intensive treatment and as a 'step-down' program for patients on inpatient units who are transitioning back to outpatient care. Patients arrive in the morning and spend the day involved in individual and group therapeutic activities, attend school on site [if of school age], and then return home each afternoon. The service is designed for both adolescents and adults between the ages of 13-17 and 18-60, and focuses on combining individual therapy, family therapy, behavioral interventions, occupational therapy, medication management, school advocacy, and systems coordination to facilitate keeping the child at home, in school, and in regular outpatient treatment. Intensive aftercare planning is a core component of the program and family participation is a critical element. Staff work with patients and families to optimize a transition back home.
>
> PHP services are longer and more intensive than outpatient clinic visits. For example, PHP visits are 6.5 hours versus one hour for a clinic visit. Accordingly, the inclusion of Sheppard Pratt's data, which includes a combination of partial hospitalization visits *and* mental health clinic visits, and Adventist Behavioral Health clinic visits, to determine a reasonable charge for a distinctly different program is not an appropriate comparison. Given that the same service is offered at acute care hospitals in the State, the Applicant believes that the Statewide median is a better basis for setting a reasonable rate given the significant disparity in volumes and services at the Psychiatric Specialty hospitals.

(AAMC response to HSCRC comments, DI# 66, p. 4).

expenditure by leveraging its existing infrastructure at AAHS, including the Pathways campus, for administrative and dietary support, maintenance and plant operation costs (which can be lower at a brand new facility in the first years of operation, when compared with an existing facility), and insurance costs. Using its existing insurance captive platform will enable it to provide cost effective coverage for malpractice and other insurance. In addition, the applicant pointed out that the cost for clinic and ancillary services varies widely among the existing psychiatric specialty hospitals in Maryland, mainly due to the different mix of services provided at these hospitals.[24]

Summary

After reviewing the applicant's audited financial statements, I have no doubt that the applicant has sufficient financial resources to implement the project. I have also concluded that the applicant demonstrated strong community support for the project. The project is supported by Sheppard Pratt, the hospital that currently receives the majority of patient's initially seen at AAMC who become inpatient psychiatric admissions.

While I appreciate the caution reflected in the HSCRC staff comments, I believe that AAMC has adequately addressed the questions raised about its outpatient revenue projections and its projected expenses. To the extent that HSCRC staff's concern with respect to potentially overstated revenue and understated expenses prove accurate, my perspective on the HSCRC comments indicate that the project is still likely to be feasible, albeit with smaller margins. As noted by HSCRC, the applicant has a strong track record in managing for financial success.

I find that the proposed project is financially feasible and that AAMC can develop the proposed facility for acute psychiatric services on a viable basis.

E. Compliance with Conditions of Previous Certificates of Need

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.***

Applicant's Response

[24] E.g., AAMC noted that the cost per equivalent inpatient day ("EIPD") for clinic and ancillary services ranged from $60 at Washington Adventist Hospital to $129 at Brook Lane. AAMC projected a $90 cost per EIPD. The applicant noted that both Sheppard Pratt and Brook Lane provide inpatient adolescent psychiatric services and offer ancillary services such as electroconvulsive therapy but that AAMHH will only treat an adult population in its inpatient services and will not be providing electroconvulsive therapy. For these reasons, the applicant argues that it is reasonable to expect that AAMHH's costs would be lower than those of Sheppard Pratt or Brook Lane, given the variance in the patient population served and the service offerings. (Source: AAMC Response to HSCRC Memorandum of January 24, 2018, DI# 66, p. 6.)

AAMC states that it has been issued three CONs since 2000 and has complied with all conditions that were attached to the CONs: (1) 2006 – construct nine-story addition to South Tower (Docket No. 04-02-2153); (2) 2010 – finish sixth floor of South Tower addition to add 30 MSGA beds (Docket No. 10-02-2308); and (3) 2012 – finish third floor of South Tower addition to add 30 MSGA beds (Docket No. 12-02-2388). One change in the 2006 CON was also approved.

Reviewer's Analysis and Findings

I find that the applicant has demonstrated compliance with all terms and conditions of previous Certificates of Need.

F. Impact on Existing Providers and the Health Care Delivery System

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers.
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.

Applicant's Response

AAMC addresses the impact on its proposed psychiatric hospital on: the volumes of other providers of acute psychiatric hospital services; access for the service area population; and costs to the health care system, as described below.

AAMC: Impact on volumes of other providers

Addressing the impact on the volumes of other providers of inpatient psychiatric care, AAMC states that it does not expect that its proposed psychiatric hospital will affect any existing inpatient psychiatric unit's volume enough to "compromise the financial viability of the existing program." (DI #6, p.92). Based on AAMC's expectation that the vast majority of its patients will be patients who are currently referred from its ED, it presented the following FY 2015 data reflecting transfers from AAMC for psychiatric admission. See Table III-7, below.

Table III-7: AAMC: Adult Transfers to Other Maryland Hospitals for Psychiatric Admission FY 2015

Receiving Hospital	Patients Transferred From AAMC for Psychiatric Hospital Services	Proportion of Total AAMC Transfers	Total Psychiatric Admissions at Receiving Hospital	Proportion of Total Admissions Accounted for by AAMC Transfers
Sheppard Pratt	669	75.7%	9,151	7.3%
Bon Secours	36	4.1%	1,552	2.3%
UM Shore Dorchester	31	3.5%	682	4.5%
Calvert Memorial	23	2.6%	654	3.5%
Washington Adventist	20	2.3%	1,597	1.3%
Laurel Regional	14	1.6%	696	2.0%
All other hospitals	91	10.2%	34,723	0.3%
Total	**884**	**100%**	**49,055**	**1.8%**

Source: HSCRC FY2015 Experience Reports
Note: Total adult transfer volume limited to "AAMC-eligible" volume and excludes Prince George's County volume as the basis for projections. (DI #6, p. 92).

AAMC notes that its referrals to Sheppard Pratt constituted less than 8% of Sheppard Pratt's admissions, less than 5% of admissions at UM Shore-Dorchester, and no more than 4 percent of total psychiatric admissions at any other Maryland hospital. AAMC points out that Sheppard Pratt, the program most affected, is supportive of the new program at AAMC, as evidenced by its letter and the Memorandum of Understanding under which AAMC will consult with Sheppard Pratt in the design of the new inpatient psychiatric program. (DI #6, p.95).

AAMC: Impact on access for the service area population

Addressing the impact on access for the service area population, AAMC presented mileage and drive time comparisons for residents of Anne Arundel and Queen Anne's Counties to its proposed site, and the inpatient psychiatric beds at BWMC, UM Shore-Dorchester, and Sheppard Pratt. AAMC states that it will reduce driving time for acute psychiatric care for patients and families living in Queen Anne's County and some areas of Anne Arundel County, and will encourage more active engagement of family members in the treatment process by providing a service site closer to home. It also notes that the proposed facility will improve access to partial hospitalization services for residents of the two-county region by increasing the number of treatment slots and by offering direct admission from outpatient care environments and the ED. AAMC notes that, in the last two years, AAMC has been able to refer only one patient from its ED to the BWMC partial hospitalization program, which it states routinely operates at full capacity. (DI #6, p.96).

AAMC: Impact on costs to the health care delivery system

To address the impact on costs to the health care delivery system, AAMC submitted a table comparing the revenue it would realize for its projected 2023 volume arrayed against what would otherwise be paid to the hospitals to which these patients would have gone if the AAMC mental health hospital were not developed, and projected a savings of $3.3 million. (DI #6, p. 99 and App. 4).

Interested Party Comments

BWMC also opened its remarks with the statement that prefaces its comments on the proposed project's impact on the health care delivery system with an acknowledgement of the need for inpatient psychiatric services at AAMC. However, BWMC stresses that such beds should be added as a hospital-based unit rather than as aa freestanding psychiatric hospital because,

> as part of a hospital based unit, the additional beds would have a favorable impact on costs to the health care delivery system...[but] if approved as a new health care facility with the potential risk of not admitting adult Medicaid patients, the project would have an adverse impact on both UM BWMC and the costs to the health care delivery system.
> (DI #34, p. 14).

BWMC explains that the IMD exclusion means that ,if the proposed facility is built and adds even one bed, it would be an IMD and thus at risk for not receiving Medicaid reimbursement for adult Medicaid patients. BWMC posits that, if Medicaid patients were excluded at the proposed facility, such exclusion would lead to an increase in demand by Medicaid patients for admission to BWMC, which would have an adverse impact on BWMC because treating these patients is more costly and would yield substantially lower reimbursement for physicians, requiring higher levels of subsidy to physicians by BWMC.

With respect to the costliness of Medicaid patients, BWMC states that

> [N]ational data show that...Medicaid patients have a greater rate of readmission for mood disorders and schizophrenia than privately insured or uninsured patients. According to an analysis of 2012 data, Medicaid patients suffering from mood disorder had a readmission rate of 14.4%, while the rate of readmission was 9.1% for privately insured patients and 10.4% for uninsured patients. For schizophrenia, the differences were even greater, with Medicaid patients experiencing a 20.4% readmission rate, while privately insured patients were readmitted at a rate of 13.1% and uninsured patients at a rate of 11.8%. Under the Maryland GBR system, readmissions are more costly for hospitals. Thus, if UM BWMC treats more Medicaid patients as a result of AAMC's facility possibly becoming an IMD, the cost of the care at UM BWMC will increase.[25] (DI #34, p. 4).

BWMC also notes that it "receives approximately 14% less payment for physician services provided to Medicaid patients for psychiatric care than for the same services provided to patients with commercial payers." (DI #34, p. 4).

BWMC states that, even if the new facility does not become an IMD, the cost to the health care system of a special psychiatric hospital would be greater than if AAMC established an inpatient unit in its existing acute care general hospital. This is because a hospital-based unit would be reimbursed under AAMC's GBR agreement with a 50% variable cost factor, while a special

[25] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf

hospital would receive 100% of its charges; thus the hospital-based option would be more beneficial to the health care delivery system. BWMC states: "It is simply not good health planning policy to permit AAMC to improve its revenue by building a new facility that will cost $18 million more than the hospital based unit option and will cost the health care delivery system more in charges." (DI#34, pp. 16, 17).

Although it did not raise the point in its comments on the impact that the project would have on BWMC and the health system, in its "Statement of Interested Party Status" BWMC stated that the proposed AAMC facility would "cause UM BWMC to suffer a depletion of essential staffing – especially psychiatrists -- for its existing inpatient psychiatric unit." BWMC states that there is a shortage of psychiatrists, and that, "Like most providers, UM BWMC is experiencing great difficulty recruiting psychiatrists to serve its patients,:" and that proposed program would make staffing even more difficult, especially since AAMC would have a competitive advantage with the benefit of full revenue for its special hospital while UM BWMC will receive substantially reduced revenue for the expansion portion of its inpatient psychiatric unit." (DI#34, pp. 2,3).

BWMC concluded its comments with an exhortation to the Commission to impose conditions if it chooses to approve the application. It suggests that the Commission "take (di#34precautionary steps to ensure that the facility does not become an IMD" by requiring AAMC to seek approval before adding any additional beds; and that if the Commission approves the inclusion of shell space in the facility it should require AAMC to seek approval before using any shell space. (DI#34, p.17).

Applicant's Response to Comments

Responding to BWMC's comments related to a potential "depletion of staffing," AAMC argues that BWMC does not qualify for the interested party status that it seeks under COMAR 10.24.01.01B(20) because it "claim[s] that the approval of the project would adversely affect its hospital-based inpatient psychiatric unit...[by]...deplet[ing] essential clinical staff, specifically, psychiatrists" even as it "does not oppose AAMC establishing – and staffing – the same size unit within AAMC's acute care general hospital building." AAMC points out that there would be no difference between the number of psychiatrist or other clinical care staff FTEs) necessary to staff a 16-bed hospital-based unit and the proposed mental health hospital, and that "because there is no difference between the clinical staffing required for the proposed mental health hospital and for the hospital-based unit that UM BWMC does not oppose, this is not a basis upon which UM BWMC should be granted interested party status." (DI#36, p.7).

AAMC opened its response to BWMC's comments related to impact on existing providers and the health system by outlining the positive impact it sees as deriving from its proposed project. AAMC states that the project will:

(a) Improve access, minimize the need for hospital-to-hospital transfer, and reduce delays in care for patients in crisis;

(b) Improve quality of care by providing continuity of care for patients who require ongoing treatment; maintain clinical relationships across acute and community-based treatment settings;
(c) Reduce length of stay in the acute care setting by providing alternative mental health settings in the same building, and by integrating closely with local community-based support services;
(d) Reduce relapse rates, readmissions, and return visits to the ED, and improve long-term outcomes through the integration of substance use and medical services to patients and through more effective use of local community-based services;
(e) Involve family members in the recovery process by providing a more local service site and removing the hardship of travel that currently discourages family involvement;
(f) Produce operating efficiencies by leveraging the mental health workforce within the inpatient and outpatient programs and sharing well-trained, hard-to-recruit professionals;
(g) Become a community-oriented model for comprehensive mental health services; and
(h) Promote the training of clinicians at all levels, attract clinical research, and provide a setting for effective collaboration with social services.
(DI.#36, p.17).

AAMC characterizes BWMC's comments as being about "how...a project not proposed in the Application – the establishment of an IMD – would have a negative impact on the health care system." and goes on to say that there is no basis to disapprove a project "based on unfounded speculation about expansion in the future." The applicant reiterates its intent for its special hospital to be an additional non-IMD resource "for the care of Medicaid patients in Maryland in need of an inpatient psychiatric admission." (DI #36, p.18).

AAMC also states that BWMC was misleading in its description of the current environment for IMDs in Maryland, noting that

> [w]hile the Federal Medicaid program will not pay for an adult psychiatric admission to an IMD, State reimbursement for these admissions is not prohibited and, to date, the State has made up for the loss of Federal funds for these admissions with State funds. ... [I]n FY16, the loss of Federal funds was addressed through an emergency fund transfer. In the FY17 budget, $30 million in State-only funds was appropriated for adult Medicaid admissions to psychiatric IMDs, the same level appropriated in the FY15 budget (the last fiscal year under the IMD waiver) split between State and Federal funds. In order to manage costs now that these admissions are funded with State funds only, the Medicaid program requires hospital EDs to first attempt to locate an available bed in a hospital-based unit, but if no beds are available, the admission to the IMD is approved. ... While future State budget decisions are always subject to uncertainty, the State's level of funding since the loss of the waiver demonstrates the State's continued commitment to ensuring access to inpatient psychiatric care for adult Medicaid recipients.
> (DI #36, p.18-19)(footnotes deleted).

AAMC states that an IMD is not prohibited from admitting Medicaid patients, and also commented that BWMC's suggestion that its Medicaid share would increase if AAMC could not admit Medicaid patients is ironic since BWMC rarely accepts transfers from AAMC's ED, and in fact had accepted no adult transfers from AAMC's ED in FYs 2015 or 2016. It points out that adding beds in the future – other than through the provisions of COMAR 10.24.01.03E(2)[26] would require a CON, enabling the Commission to review the "status and ramifications of the IMD exclusion" before any such expansion could occur. (DI #36, p.19).

AAMC states that, unless Maryland is granted another IMD waiver, any such incremental expansion allowed without Commission approval would be irrational because, to gain a single bed, the facility would: (1) expose itself to uncertainty surrounding Medicaid reimbursement; and (2) would become an option for adult Medicaid admissions only when a hospital-based bed is not available.

Responding to BWMC's statement that the project will adversely impact the health care system through higher costs as a result of the 100% variable cost factor that applies to special psychiatric hospitals, AAMC states that its special hospital would instead be a lower-cost alternative that would reduce the per capita costs by shifting volume from higher cost facilities. AAMC notes that its average payment per case will be 33% below the statewide average, and 43% lower than Sheppard Pratt, where the large majority (75%) of its referred patients currently receive inpatient care. AAMC translates that shift into a $3.3 million annual savings to the health care system. It also points out that its average charge per case will be 18% lower than BWMC's. (DI #36, p. 20; DI #6, pp. 97-99).

Reviewer's Analysis and Findings

This criterion requires an applicant to provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, 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.

The applicant has presented a comprehensive and thorough response on the likely impact of this proposed project and the comments of the interested party on this criterion. I am convinced that the project will have a positive impact on geographic access to mental health services, especially inpatient services. The significant number of patients presenting at AAMC's emergency department who need hospitalization are subject to lengthy delays and are often referred to facilities that are up to an hour's travel time from Annapolis. This presents difficulty for the patient and family at the time of hospitalization, and also makes continuing care far less seamless than it would be if this project were to be implemented. The proposed special psychiatric hospital will improve the regional health care system.

[26] COMAR 10.24.01.03E(2) provides that "a health care facility that is not an acute general hospital, 2 years after its initial licensure or after its last change in licensed bed capacity... may request that the Commission authorize an increase ... in bed capacity... if the increase ... in the total bed capacity of the facility does not exceed ten beds or 10 percent, whichever is less ...."

The proposed project also promises lower charges and cost savings to the health care delivery system, as its projected aggregate charges are below those of current alternatives. The modeling done by the applicant projects that a $3.3 million dollar savings (approximately 30%) may be realized in 2023 if patients who would have gone to higher cost facilities elsewhere are instead admitted to the AAMC special hospital. I find those projections to be credible.

As for impact on other providers, Sheppard Pratt, the special psychiatric hospital that stands to lose the most patients, supports the project. Interested party BWMCdoes not object to the addition of 16 psychiatric beds in Anne Arundel County, but objects to the location of the beds outside of AAMC's general hospital. BWMC's expressed fear that the shell space in the project provides the possibility for additional bed capacity that would push the hospital into IMD status, raises a concern that may need to be considered in the future, given that demand may exceed the 16-bed capacity being proposed. I note that AAMC has defined other uses (adult and child/adolescent outpatient and adult pain management programs) for the third floor shell space it has proposed. AAMC has stated that expansion of bed capacity is an option that it will only undertake "if the State is granted a waiver or other relief from the IMD exclusion and depending on whether there is demonstrated need at the time." (DI #24, p.78b and DI#36, p.16).

I find that the applicant has demonstrated that the overall impact of this project will be positive and that BWMC's concerns are not well-founded. Other providers of service to the region are very supportive of the proposed project. I recommend that approval of AAMC's establish of a special hospital - psychiatric include a condition that prohibits the applicant from adding inpatient psychiatric beds without obtaining required approval from the Commission.

IV. REVIEWER'S SUMMARY AND RECOMMENDATION

Anne Arundel Medical Center proposes to establish a special hospital–psychiatric adjacent to Pathways, an affiliated facility that offers inpatient and outpatient substance abuse treatment. The proposed 16-bed adult special hospital-psychiatric, to be known as Anne Arundel Medical Center Mental Health Hospital, will also provide outpatient and partial hospitalization programs for adults and for children and adolescents. It will include 56,236 SF of space on four levels. The estimated cost is just under $25 million and will be funded with approximately $15 million in cash and borrowed funds of $10 million.

I found that the applicant made a strong case that its proposed 16-bed facility is needed, and also that its decision to locate the unit in a freestanding facility adjacent to Pathways was supported. I believe that this option will better advance the needs of the patients in its service area for a facility that will serve as the centerpiece of a comprehensive, community-based behavioral health program with the potential to enhance collaboration and synergy among providers and programs.

The applicant is strong financially and has the resources to implement the project, for which it projects a modest but self-sustaining operating margin. The project has garnered a high level of community support.

BWMC, the interested party in this review, has acknowledged the need for the proposed inpatient psychiatric beds but has maintained that the most cost-effective alternative would be

locating the unit in the general hospital. As explained in this Recommended Decision, I found that AAMC's arguments with respect to the infeasibility and disadvantages of this alternative were convincing. However, I recommend a condition that may address BWMC's main concern that AAMC may add beds in the future, thereby creating an IMD, which may result in a barrier and/or disincentive to serving Medicaid patients.

Therefore, based on my findings that result from my review and analysis of the application and the full record in this review, I recommend that the Commission issue a Certificate of Need for the project, with the following condition:

> The Anne Arundel Medical Center Mental Health Hospital shall not increase its bed capacity without obtaining required approval from the Maryland Health Care Commission.

IN THE MATTER OF	*	
	*	**BEFORE THE**
ANNE ARUNDEL MEDICAL	*	
	*	**MARYLAND**
CENTER MENTAL HEALTH	*	
	*	**HEALTH CARE**
HOSPITAL	*	
	*	**COMMISSION**
Docket No. 16-03-2375	*	
	*	

* *

FINAL ORDER

Based on the analysis and findings in the Recommended Decision, it is this 19th day of April 2018:

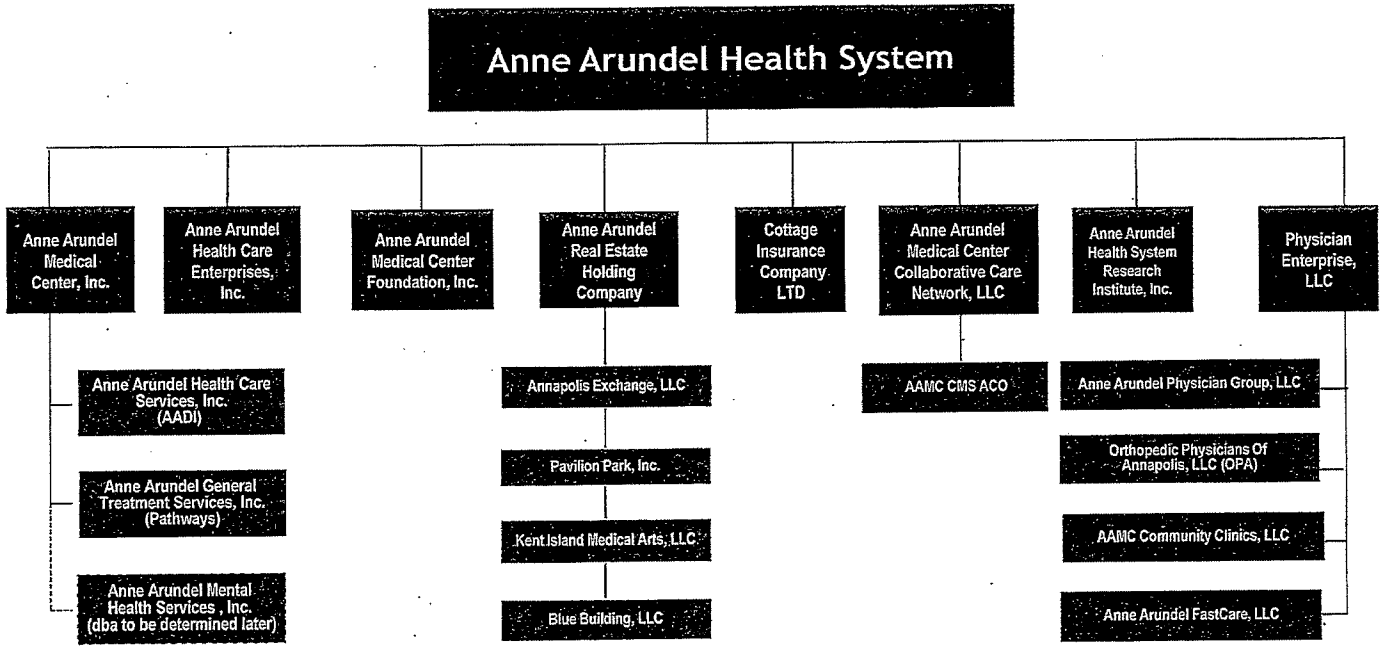
ORDERED, by a majority of the Maryland Health Care Commission, that the application of Anne Arundel Medical Center, Inc. ("AAMC") for a Certificate of Need to establish a 16-bed special hospital-psychiatric to be known as Anne Arundel Medical Center Mental Health Hospital in a new building to be constructed on a site approximately two miles from its general hospital and adjacent to Pathways at Riva Road & Harry S. Truman Parkway in Annapolis, MD, at a total project cost of $24,984,795, be, and hereby is, **APPROVED**, subject to the following condition:

> The Anne Arundel Medical Center Mental Health Hospital shall not increase its bed capacity without obtaining required approval from the Maryland Health Care Commission.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: ANNE ARUNDEL HEALTH SYSTEM CORPORATE STRUCTURE

Corporate Structure



APPENDIX 2: RECORD OF THE REVIEW

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Marta Harting, Esq., on behalf of Anne Arundel Medical Center (AAMC), submitted a notice of intent to apply for a Certificate of Need (CON) for an acute care project at the hospital campus for the addition of inpatient psychiatric beds. Commission staff acknowledges receipt of Letter of Intent on December 11, 2017.	12/04/15
2	Marta Harting, Esq., on behalf of her client AAMC, withdraws the Letter of Intent for the acute care project at the hospital campus for the addition of psychiatric beds.	1/29/16
3	Marta Harting, Esq., on behalf of AAMC, submitted a notice of intent to apply for a CON for the establishment of a new mental health hospital on Riva Road in Anne Arundel County.	1/29/16
4	Commission staff sends notice to Maryland Register Notice to request additional Letters of Intent for inpatient psychiatric beds in Anne Arundel County.	2/5/16
5	Commission receives letters of support from Delegate Ted Sophocleus, Anne Arundel County; Steven Schuh, Anne Arundel County Executive; and community members.	Various Dates
6	Joshua Jacobs, Vice President of Strategic Planning and Marketing/Communications for AAMC submits a CON Application to the Commission.	3/29/16
7	Commission staff acknowledges receipt of the CON application for completeness review in letter to AAMC.	3/30/16
8	Commission staff requests *The Baltimore Sun* publish notice of receipt of application.	3/30/16
9	Commission staff requests *The Capital* publish notice of receipt of application.	3/30/16
10	Commission staff requests *The Maryland Gazette* publish notice of receipt of application.	3/30/16
11	Commission staff requests the Maryland Register publish notice of receipt of application.	3/30/16
12	Marta Harting, Esq., on behalf of AAMC, provides Commission staff with corrected Tables J and K for Application.	4/1/16
13	Marta Harting, Esq., on behalf of AAMC, provides Commission staff with Certificate of Service for Application.	4/4/16
14	Commission staff receives notice of receipt as published in *The Baltimore Sun*.	4/7/16
15	Commission staff receives notice of receipt as published in *The Capital*.	4/11/16
16	Following completeness review, Commission staff requests AAMC submit additional information before the application can be docketed as complete.	5/3/16
17	Van T. Mitchell, Secretary of Department of Health and Mental Hygiene, acknowledges AAMC notification of CON application.	5/9/16
18	Commission staff grants an extension to file completeness information.	5/16/16
19	Marta Harting, Esq., on behalf of AAMC, provides designation of intended licensee of project. Designee identified as Anne Arundel Mental Health Services, Inc.	5/26/16
20	Commission staff receives response to the May 3, 2016 request for additional information.	5/26/16
21	Commission staff sends letter acknowledging receipt of request for notification from Ella Aiken, Esq. of Gallagher, Evelius & Jones, on behalf of Recovery Centers of America, on June 9, 2016.	6/22/16
22	Following a second completeness review, Commission staff requests additional completeness information.	6/23/16

23	Commission staff grants AAMC an extension to file additional information.	8/1/16
24	Commission staff receives Project Cost and Shell Space Revisions from AAMC dated August 1, 2016.	8/2/16
25	Commission staff receives AAMC's response to the June 23, 2016 request for additional information.	8/2/16
26	Commission staff notifies Joshua Jacobs, Vice President of Strategic Planning and Marketing/Communications for AAMC, of formal start of CON application review and upcoming docketing date of October 14, 2016.	9/30/16
27	Commission staff requests publication of the docketing notice in the next edition of *The Baltimore Sun.*	9/30/16
28	Commission staff requests publication of the docketing notice in the next edition of *The Capital.*	9/30/16
29	Commission staff requests publication of notification of formal start of review for the AAMC CON application in the Maryland Register.	9/30/16
30	Commission staff sends a copy of the CON application to the Anne Arundel County Health Department for review and comment.	9/30/16
31	Commission staff requests publication of the notice of formal start of review in the next edition of *The Baltimore Sun.*	10/10/16
32	Commission staff requests publication of the notice of formal start of review in the next edition of *The Capital.*	10/13/16
33	Anne Arundel County Department of Health requests interested party status in support of AAMC's application.	11/4/16
34	Commission staff receives interested party comments from Thomas C. Dame, Esq., on behalf of University of Maryland Baltimore Washington Medical Center's (UM BWMC).	11/14/16
35	Commission staff grants an extension to UM BWMC to file additional interested party comments.	11/21/16
36	Commission staff receives AAMC's response to interested party comments.	12/1/16
37	Commission staff receives UM BWMC's Motion for Leave to Submit Response to AAMC's Opposition to Interested Party Status.	12/15/16
38	Marta Harting, Esq., on behalf of AAMC, submits Opposition to UM BWMC's Motion for Leave to Submit Response to Applicant's Opposition to Interested Party Status.	12/21/16
39	Commission staff requests additional information from AAMC.	3/17/17
40	Commission staff receives response to the March 17, 2017 request for additional information and modifications to funding sources.	4/6/17
41	Commissioner Cassandra B.Y. Tomarchio, Commission appointed Reviewer, notifies AAMC that UM BWMC accepted their modification of funding source and requests that responding comments be submitted by April 21, 2017.	4/7/17
42	Commission staff sends a copy of the application to the Health Services Cost Review Commission (HSCRC) for comment.	9/22/17
43	Reviewer requests AAMC's availability for site visit.	10/13/17-10/17/17
44	AAMC replies with availability and a date of October 27, 2017 is set for site visit.	10/20/17
45	Reviewer requests information for parties attending site visit.	10/24/17
46	Ella Aiken, Esq. of Gallagher, Evelius, & Jones, on behalf of UM BWMC, provides list of participants for site visit.	10/25/17
47	Anne Arundel County Department of Health requests to no longer be considered an interested party in review of AAMC's CON application.	10/26/17
48	AAMC provides Reviewer with a list of participants and confidentiality pledge for the site visit.	10/26/17
49	AAMC provides Commission staff with floor plans for alternative site.	10/26/17
50	AAMC provides Commission staff with a revised confidentiality pledge for site visit.	10/26/17
51	Ella Aiken, Esq. of Gallagher, Evelius & Jones, on behalf of UM BWMC, provides	10/26/17

	updated list of participants for site visit to Commission staff.	
52	Commission staff provides itinerary and attendee list for all site visit attendees.	10/27/17
53	Gerald J. Schmith, Deputy Director of Hospital Rate Setting at HSCRC provides Reviewer with response to September 22, 2017 request for comments. HSCRC notifies the Commission they cannot provide an opinion without additional information.	11/9/17
54	UM BWMC submits a request to file comments regarding information presented by AAMC representatives during site visit to Reviewer.	11/13/17
55	Reviewer receives letter from AAMC opposing UM BWMC's request to submit comments.	11/15/17
56	Reviewer rules that UM BWMC may file comments regarding information presented by AAMC representatives during site visit. Commission enacted deadline of December 11, 2017 for UM BWMC to file comments.	11/16/17
57	Reviewer requests information from AAMC in response to HSCRC's November 9, 2017 response to Commission's request for comments.	11/17/17
58	Marta Harding, Esq., on behalf of AAMC, confirms for Commission staff that additional information to satisfy HSCRC's request will be submitted by deadline December 11, 2017.	11/21/17
59	UM BWMC notifies Reviewer that they do not wish to file comments regarding information presented by AAMC representatives during site visit.	12/1/17
60	Marta Harting, Esq., on behalf of AAMC, provides Commission staff with information to satisfy HSCRC's request for information.	12/11/17
61	Thomas Dame, Esq. of Gallagher, Evelius, and Jones, on behalf of UM BWMC, provides Reviewer with comments on AAMC's response to HSCRC's request for information.	12/26/17
62	Reviewer provides HSCRC with AAMC's response to HSCRC's request for information.	12/28/17
63	Marta Harting, Esq., on behalf of AAMC, requests opportunity to respond to UM BWMC's comments on AAMC's response to HSCRC's request for information.	12/28/17
64	Marta Harting, Esq., on behalf of AAMC, submits responding comments to UM BWMC's comments on AAMC's response to HSCRC's request for information to Reviewer.	12/29/17
65	Gerald J. Schmith, HSCRC, provides final comments on AAMC's CON application to Reviewer.	1/24/18
66	Marta Harding, Esq., on behalf of AAMC, submits a response to HSCRC's final comments to Commission staff.	2/2/18
67	Ella Aiken, Esq. of Gallagher, Evelius, & Jones, on behalf of UM BWMC, notifies Reviewer that UM BWMC has no comments.	2/7/18
68	Commissioner-Reviewer Cassandra Tomarchio informs parties that her Recommended decision will include data on the use of general hospitals and special hospitals for the delivery of acute psychiatric services that are drawn from the HSCRC discharge database for the years 2011 through 2016.	2/28/18

APPENDIX 3: EXCERPTED CON STANDARDS FOR PSYCHIATRIC BEDS FROM STATE HEALTH PLAN CHAPTER 10.24.07

EXCERPTED CON STANDARDS FOR PSYCHIATRIC BEDS FROM STATE HEALTH PLAN CHAPTER 10.24.07

Each of the following six (6) 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 #)
Standard AP 3a Inpatient acute psychiatric programs **must provide an array of services.** At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.	DI #6, p. 106
Standard AP 5 Once a patient has requested admission to an acute psychiatric inpatient facility, **the following services must be made available:** (i) intake screening and admission; (ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or (iii) necessary evaluation to define the patient's psychiatric problem and/or (iv) emergency treatment.	DI #6, p. 107
Standard AP 6 All hospitals providing care in designated psychiatric units **must have separate written quality assurance programs, program evaluations and treatment protocols for special populations**, including children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.	DI #6, pp. 107-108
Standard AP 12a Acute inpatient psychiatric services **must be under the clinical supervision of a qualified psychiatrist.**	DI #6, p. 112
Standard AP 12b **Staffing of acute inpatient psychiatric programs should include** therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.	DI #6, pp. 112-113

Standard AP 13 Facilities providing acute psychiatric care **shall have written policies governing discharge planning and referrals** between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.	DI #6, p. 113

APPENDIX 4: COST COMPARISON

AAMC Mental Health Hospital Reduction in the Costs of Acute Psychiatric Services

FY 2023

	Est. FY 2016 - Charges[1]				
	Cases	CPC@ CMI of 0.5679[4]	Revenue	VCF	Revenue @ VCF
AAMC Projected Psych Cases[2]	892	$7,644	$6,818,753	100%	$6,818,753
Incremental Revenue	892	7,644	$6,818,753	100%	$6,818,753
Impact on Psych Hospitals:					
University of Maryland	(9)	14,472	(131,426)	50%	(65,713)
Johns Hopkins	(3)	18,270	(55,306)	50%	(27,653)
UM Shore Medical Center at Dorchester	(31)	10,804	(337,965)	50%	(168,983)
Lifebridge Sinai Hospital	(6)	9,736	(58,947)	50%	(29,473)
Bon Secours	(36)	6,672	(242,349)	50%	(121,175)
MedStar Franklin Square	(8)	9,424	(76,076)	50%	(38,038)
Washington Adventist	(20)	6,858	(138,399)	50%	(69,200)
MedStar Montgomery General	(3)	6,302	(19,078)	50%	(9,539)
Suburban Hospital	(4)	7,455	(30,091)	50%	(15,045)
MedStar Union Memorial	(10)	7,289	(73,546)	50%	(36,773)
MedStar Saint Mary's Hospital	(1)	6,749	(6,811)	50%	(3,405)
Johns Hopkins Bayview (acute)	(15)	13,394	(202,725)	50%	(101,363)
Union of Cecil	(4)	9,500	(38,343)	50%	(19,171)
UMM Center Midtown Campus (acute)	(1)	6,869	(6,932)	50%	(3,466)
Calvert Memorial	(23)	10,303	(239,103)	50%	(119,551)
Lifebridge Northwest Hospital	(6)	8,284	(50,155)	50%	(25,077)
Howard General Hospital	(3)	6,495	(19,661)	50%	(9,830)
Greater Laurel	(14)	6,386	(90,216)	50%	(45,108)
MedStar Southern Maryland	(7)	5,589	(39,478)	50%	(19,739)
UM Saint Joseph	(5)	8,635	(43,567)	50%	(21,783)
Sheppard Pratt (Private)	(675)	13,493	(9,108,585)	100%	(9,108,585)
Potomac Ridge (Private)[3]	(6)	10,407	(63,007)	100%	(63,007)
Total Estimated Charges	(892)	$12,412	($11,071,766)	91%	($10,121,679)
Net Impact on the System			**($4,253,012)**		**($3,302,925)**

Notes:

[1] MD Hospital CPC calculated as Hospital-specific total CPC @ CMI 1.00 for Adult Psychiatric APR-DRGs 750-760, 779-790, patients age 18 or greater price leveled to FY 2016 dollar (2.4% for acute general hospitals and 1.9% for Psychiatric Specialty hospitals

[2] AAMC projected cases for FY 2023

[3] Due to data availability, Potomac Ridge average charges were based on the averge charge of Brooklane, Potomac Ridge and Adventist Behaviorial Health for APR-DRGs 750-760, 779 - 790, patients age 18 or greater price leveled FY 2016 based on a 1.9% Update Factor

[4] Reflects AAMC Projected CMI of 0.5679

APPENDIX 5: 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

Memorandum

Date: January 24, 2018

To: Commissioner Cassandra Tomarchio – Maryland Health Care Commission

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

Subject: Anne Arundel Medical Center Mental Health Hospital ("AAMHH") CON

On December 28, 2017, you requested that we review and comment on the financial feasibility and underlying assumptions of the proposed new Mental Health Hospital (AAMHH) to be located on property owned by Anne Arundel Medical Center approximately two miles from the main hospital campus adjacent to Pathways, a 40 bed substance abuse facility owned by Anne Arundel Medical Center. The proposed facility will include 4 floors and 56,236 square feet. The facility will be licensed as a private psychiatric hospital and will include space for the initially requested 16 beds with sufficient shelled space for either outpatient services or alternatively, an additional 16 beds.

Staff's review included an assessment of the original CON filed on March 26, 2016, and subsequent filings of response to completeness questions and revisions of the underlying financial projections submitted on April 6, 2017. Staff also reviewed AAMHH's responses to our questions regarding the financial projections and underlying assumptions submitted by AAMHH on December 11, 2017, and Baltimore Washington Medical Center's (BWMC) comments regarding AAMHH's responses to our questions, which BWMC submitted on December 28, 2017.

The remainder of this memo provides our comments regarding the AAMHH CON.

General Comments on Financial Feasibility

Data Reviewed

We reviewed the financial information contained within the CON application as well as other pertinent supplemental information associated with the CON process provided by AAMHH. The information submitted included projected financial data for the fiscal years ending June 30, 2019 through 2023. We also reviewed the underlying assumptions included in the CON and subsequently filed information.

Sources and Uses of Funds

The total projected cost of the project is $24,984,795. AAMHH is budgeting $16,080,433 for construction costs, $900,000 for major moveable equipment, $1,600,000 for contingencies, $4,167,870 in other capital costs including architect fees, site and infrastructure costs, and inspections and permits, $1,575,000 for IT integration, landscaping, and commissioning and testing, $511,492 for an inflation allowance, and $150,000 for financing costs.

AAMHH intends to finance the project by incurring $10,000,000 in debt and receiving a $14,984,795 cash contribution from its parent, Anne Arundel Medical Center.

Projected Volumes and Occupancy Levels

Included in Table 1 below are AAMHH's projected patient days and occupancy levels and partial hospitalization visits in the CON for FY 2019 through FY 2023:

Table 1 - Summary of Projected Patient Days, Occupancy Rates, and Partial Hospitalization Visits
Anne Arundel Medical Center Mental Health Hospital CON Projections

	2019	2020	2021	2022	2023
Patient Days	4,409	5,397	5,440	5,477	5,477
Occupancy Rate	75.5%	92.2%	93.2%	93.8%	93.8%
Partial Hospitalization Patients	4,699	5,679	5,718	5,758	5,799

Source: Financial information and projections submitted by AAMHH in the CON application.

Revenue Projections

We have reviewed the assumptions regarding the projections of patient revenue. Included in Table 2 below are the assumed inflated charges per patient day and per partial hospitalization visit for FY 2019 through FY 2023:

Table 2 – Projected Inflated Average Revenue Per Inpatient Day and per Partial Hospitalization Visit
Anne Arundel Medical Center Mental Health Hospital CON Projections

	2019	2020	2021	2022	2023
Projected Revenue Per:					
Patient Day	$1,412	$1,438	$1,465	$1,492	$1,519
(Excluding Physicians)	$1,320	$1,345	$1,370	$1,396	$1,423
Partial Hospitalization Visit	$416	$471	$480	$489	$498
(Excluding Physicians)	$403	$456	$465	$474	$483

Source: Financial information and projections submitted by AAMHH in the CON application and subsequently filed documentation.

The AAMHH projected inpatient revenue per patient day regulated by the HSCRC appears reasonable. However, AAMHH included physician revenue not regulated by the HSCRC, and, therefore, staff cannot comment on the reasonableness of the projected physician revenue.

The 13.2% projected increase in revenue per partial hospitalization visit between FY 2019 and FY 2020 ($416 to $471 reflected in Table 2) should be explained by AAMHH. The 13.2% increase may be related to an error in the utilization table submitted as part of the CON. In the CON, AAMHH projected 4,699 partial hospitalization visits during FY 2019 increasing by 21% to 5,679 in FY 2020. Patient days in the CON were projected to increase by 22% between FY 2019 and FY 2020. However, in AAMHH's responses to staff's question regarding outpatient rates, AAMHH stated that there would be 4,229 partial hospitalization visits in FY 2019, which would then indicate that AAMHH was projecting a 34% increase in outpatient volume between FY 2019 and FY 2020.

During the year ended June 30, 2017, the other private psychiatric hospitals in Maryland reported the following outpatient revenue and visits:

Table 3 – Average Revenue per Outpatient Visit
Maryland Private Psychiatric Hospitals
For the Year Ended June 30, 2017

Hospital	Outpatient Revenue	Outpatient Visits	Outpatient Revenue Per Visit
Sheppard Pratt	$16,581,207	64,900	$255
Adventist Behavioral Health	$4,783,750	15,232	$314
Brooklane	$1,516,207	3,729	$407
Totals	$22,880,984	83,861	$273
Median			$314

Source: Monthly Revenue and Statistics Reports submitted by hospitals to HSCRC. For Sheppard Pratt and Brooklane, outpatient visits were reported as Psychiatric Day Care Visits while Adventist Behavioral Health reported outpatient visits as Clinic visits.

The AAMHH projected outpatient revenue regulated by the HSCRC appears high. The projected 13.2% increase in projected revenue per visit between FY 2019 and FY 2020 would be more than the approximately 2% annual increase currently allowed under the Update Factor.. If the projected 4,229 visits included in AAMHH's response to staff's questions regarding the outpatient rates were the visits AAMHH meant to include in their projections, then the projected 34% increase in visits between FY 2019 and FY 2020 appears high given the assumed 22% increase in inpatient volumes during the same period.

Finally, the projected revenue per outpatient visit of $403 appears high based on the average private psychiatric hospital statewide rate for the year ended June 30, 2017 of $273, or the statewide median rate of $314 during the same period.

Staff has concerns that AAMHH may have projected outpatient revenue at a level 20% to 25% higher than would be reasonable given the current outpatient rates at other private psychiatric hospitals in Maryland. A 20% to 25% reduction in AAMHH's projected outpatient revenue would result in reduced net revenue of $400,000 to $500,000 annually.

AAMHH projected that charity write-offs would equal 1.5% of gross patient revenue and bad debts at 8.2% of gross patient revenue. This 9.7% uncompensated care provision appears high compared to

other Maryland psychiatric hospitals. AAMHH projected that contractual adjustments would equal 18.9% of gross patient revenue. As a Specialty Hospital, AAMHH does not fall under the Waiver provision whereby Medicare or Medicaid is required to reimburse hospitals at 94% of charges. AAMHH has projected Medicaid collections at 83% of charges and Medicare collections at 67% of charges.

Staff is concerned that AAMHH could be considered as part of the existing 40 bed Pathways facility operated by Anne Arundel Medical Center, which would trigger the Institutions for Mental Diseases (IMD) exclusion, potentially resulting in a large reduction in Medicaid reimbursement to less than the projected 83% of charges. In addition, if CMS were to view AAMHH as a 32 and not 16-bed hospital because the CON refers to shell space for an additional 16 beds as part of the constructions costs, Medicare reimbursement would likely be reduced as well.

Staff has attached a copy of the CMS guidelines that pertain to the reimbursement of services provided by IMDs.

AAMHH did not project any other operating or non-operating revenue.

Expense Projections

In its responses to staff's questions regarding projected expenses, AAMHH provided an analysis comparing its projected costs to the costs at other private psychiatric hospitals in Maryland on a per Equivalent Inpatient Patient Day (EIPD) basis. A summary of this analysis is provided below:

Table 4 – Comparison of Projected Cost per Equivalent Inpatient Patient Day (EIPD)
Anne Arundel Medical Center Mental Health Hospital CON Projections
versus other Maryland Private Psychiatric Hospitals

	AAMHH FY 2022 (16 beds)	Sheppard Pratt FY 2016 (414 beds)	Adventist Behavioral Health FY 2015 (107 beds)	Brooklane FY 2016 (66 beds)
Cost Per EIPD:				
Overhead	$350	$397	$375	$375
Inpatient Care	$349	$493	$335	$335
Clinic and Ancillary	$90	$100	$57	$129
Hospital Based Physicians	$96	$33	$0	$0
Information Services	$15	$45	$34	$19
Depreciation, Interest, Leases	$136	$110	$58	$59
Malpractice and Other	$2	$20	$53	$15
Total	$947	$1,179	$912	$944
Total Excluding Physicians	$851	$1,146	$912	$944
Total Excluding Physicians and Depreciation and Interest	$715	$1,036	$854	$885

Source: Financial information and projections submitted by AAMHH in the CON application and subsequent information. The information provided by AAMHH contained addition errors in the depreciation, interest and other expenses for the other private psychiatric hospitals which were corrected in the table above.

Staff has concerns that AAMHH's projected expenses may be understated for the following reasons:

1. When AAMHH projected revenue under the "inflated projected financial statements," they assumed that revenue would be inflated by approximately 6% (approximately 2% annually) between FY 2016 and FY 2019 and used these amounts as the projected FY 2019 revenue. However, when projecting operating expenses, AAMHH projected expenses expressed in FY 2016 dollars "uninflated." Furthermore, when AAMHH made comparisons of its inflated projected FY 2019 expenses to other private psychiatric hospitals it used expenses from Annual Reports filed by the other private psychiatric hospitals in FY 2015 and FY 2016 "uninflated."

2. Even after adjusting for the fact that there is a three-year timing difference in the expense comparisons to the other private psychiatric hospitals in Maryland, AAMHH's projected operating expenses per EIPD are significantly below what the other psychiatric hospitals are actually incurring.

3. AAMHH is a proposed 16-bed hospital with few economies of scale when compared to the other existing private psychiatric hospitals in Maryland, but AAMHH still projected operating expenses per EIPD well below what the other existing private psychiatric hospitals are actually incurring. Staff reviewed data for Medicare Cost Reports filed by private psychiatric hospitals throughout the country during Calendar Year 2015. For the 39 private psychiatric hospitals that reported having 16 licensed beds, the average Medicare per diem inpatient cost was $1,130, or 19.4% greater than AAMHH is projecting for FY 2019 based on FY 2022 volumes.

4. A major projected cost component at AAMHH is the projected hospital-based physician expense for which AAMHH has included projected revenue that would not be regulated by the HSCRC. By including these hospital-based physician costs in the cost comparison with the other private psychiatric hospitals in Maryland that do not include these costs, AAMHH appears less reasonable in the cost comparison with the other private psychiatric hospitals in Maryland.

In AAMHH's projected inflated financial statements, the projected costs per EIPD in FY 2022 were $992 compared to the $947 uninflated cost per EIPD shown in the table above. Reducing the projected $992 cost per EIPD for capital costs of $136 per EIPD and physician costs of $96 per EIPD would result in an estimated projected inflated adjusted cost per EIPD of $760 per EIPD. If AAMHH's FY 2022 projected inflated costs per EIPD excluding hospital-based physicians and capital costs were equal to Brooklane's actual FY 2016 costs excluding capital inflated by 2% per year for 6 years, AAMHH's projected costs would be approximately $1,700,000 more than what AAMHH has projected for FY 2022.

Summary

Staff is concerned about the construction of a 16-bed freestanding psychiatric facility, which may not have sufficient economies of scale to provide services effectively or efficiently. Given the New Model, global budgets, and the emphasis on reducing avoidable utilization and excess capacity, Staff questions whether it might not be more prudent to have these services provided in an existing acute care hospital, where the additional marginal costs could be significantly lower. Furthermore, if the new beds were located in an acute care facility, Medicare and Medicaid reimbursement would be 94% of charges rather than 67% and 83%, respectively, as estimated by AAMHH. Additionally, the IMD exclusion would not apply, thereby reducing the potential risk of future reductions in Medicaid reimbursement.

Staff is also concerned that outpatient revenue projected in the CON could be too high, and that operating expenses projected in the CON could be too low, based on comparisons to actual revenue and expenses incurred at other private psychiatric hospitals in Maryland. This combination of overstated revenue and understated expenses casts doubt on the projected profits in the CON. The HSCRC staff would closely analyze the projected revenue and expenses when setting the rates for this facility at the time it would open. However, Anne Arundel Medical System has shown a propensity to manage their operations appropriately in the past, and staff expects that they would continue to do so in the future.

4390. INSTITUTIONS FOR MENTAL DISEASES

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines

to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?

2. Is one chief medical officer responsible for the medical staff activities in all components?

3. Does one chief executive officer control all administrative activities in all components?

4. Are any of the components separately licensed?

5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?

6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;

2. The facility is accredited as a psychiatric facility;

3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);

4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and

5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient§s current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients

admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

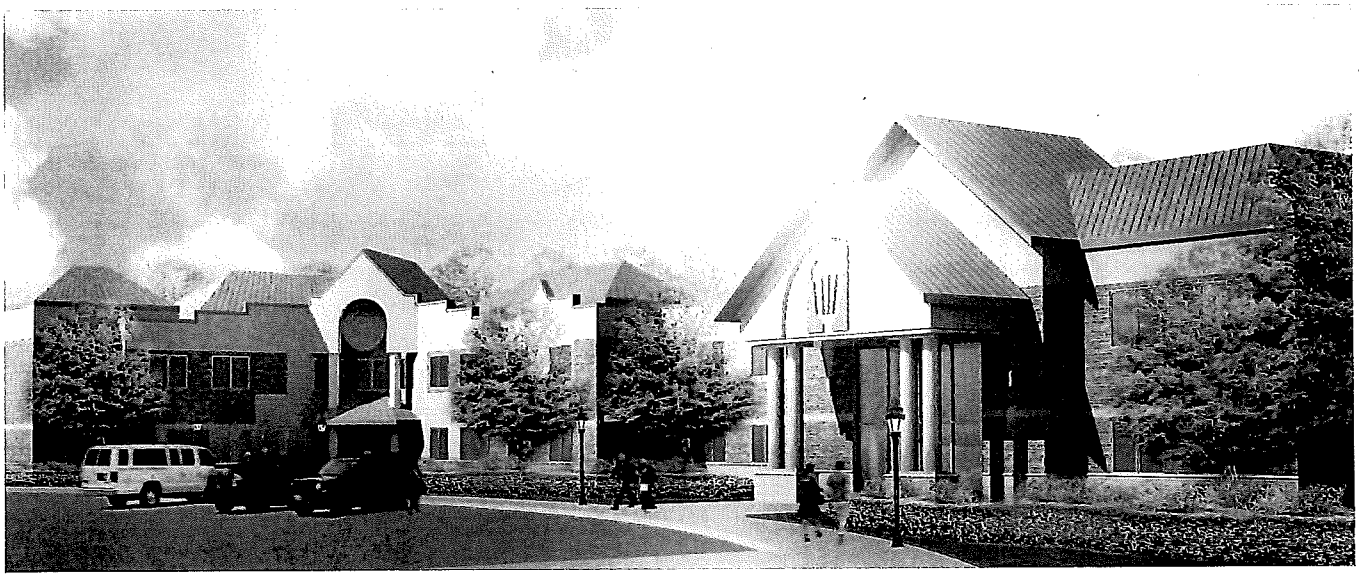
In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

4390.1 Periods of Absence From IMDs.--42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient.

The regulations contain a separate provision for individuals under age 22 who have been receiving the inpatient psychiatric services benefit defined in 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.

APPENDIX 6: PROJECT DRAWINGS



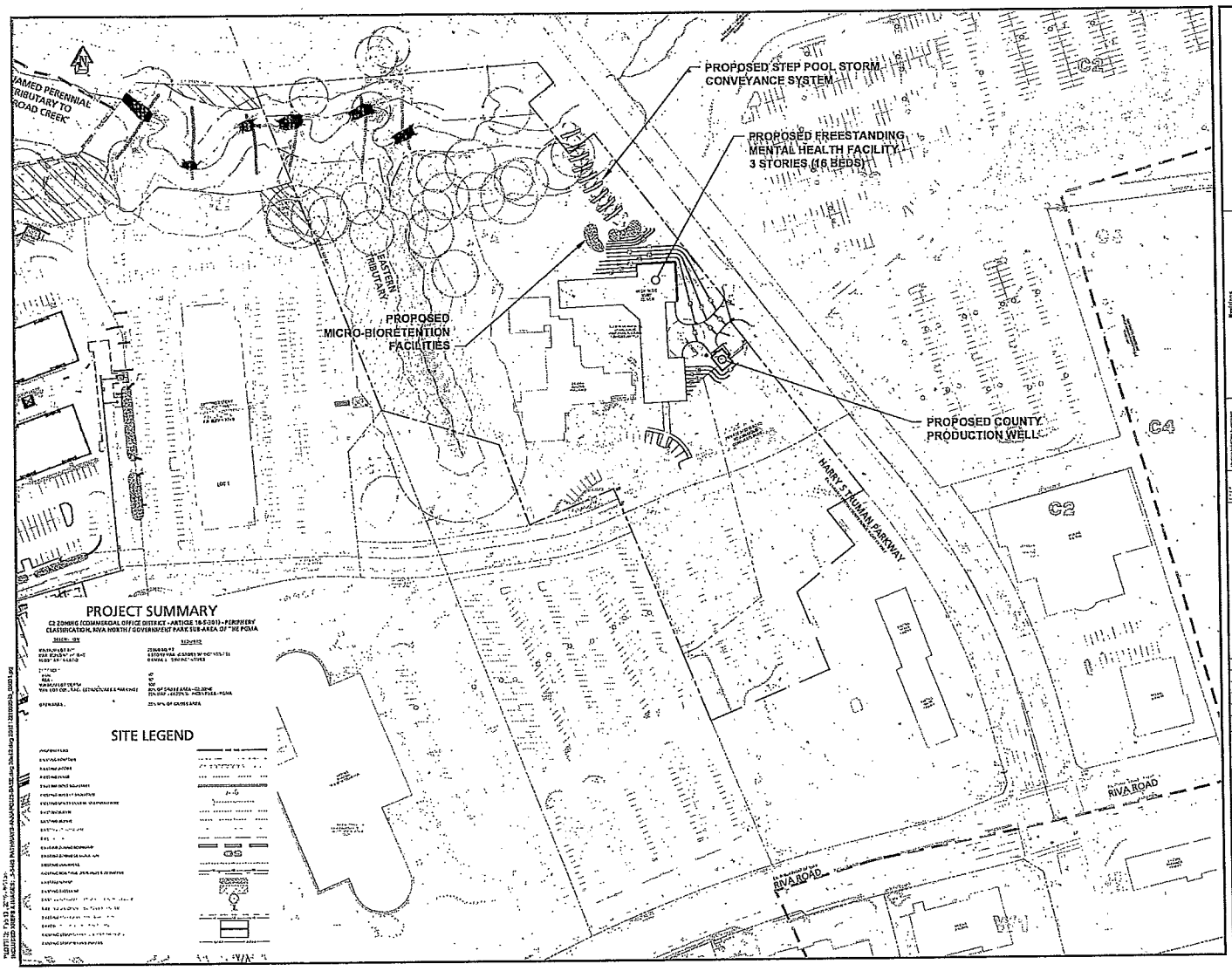
CRGoodmanAssociates
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

Anne Arundel Medical Center

MENTAL HEALTH HOSPITAL

EXTERIOR RENDERING

A101



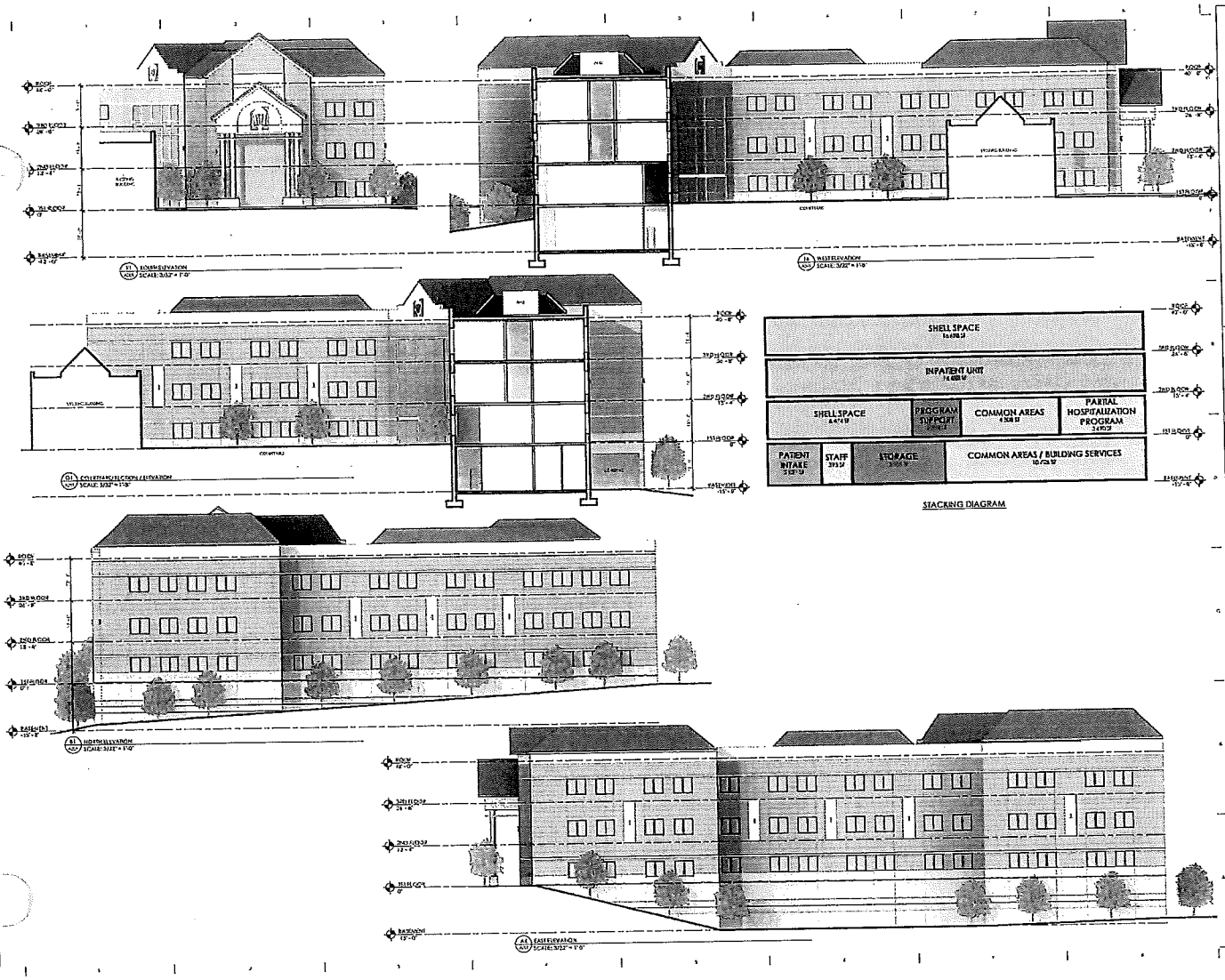
Bay Engineering Inc.

PROPOSED SITE PLAN
FEASIBILITY PLAN

FREESTANDING MENTAL HEALTH HOSPITAL
INDEL MEDICAL CENTER

Date:

1 OF 1



STACKING DIAGRAM

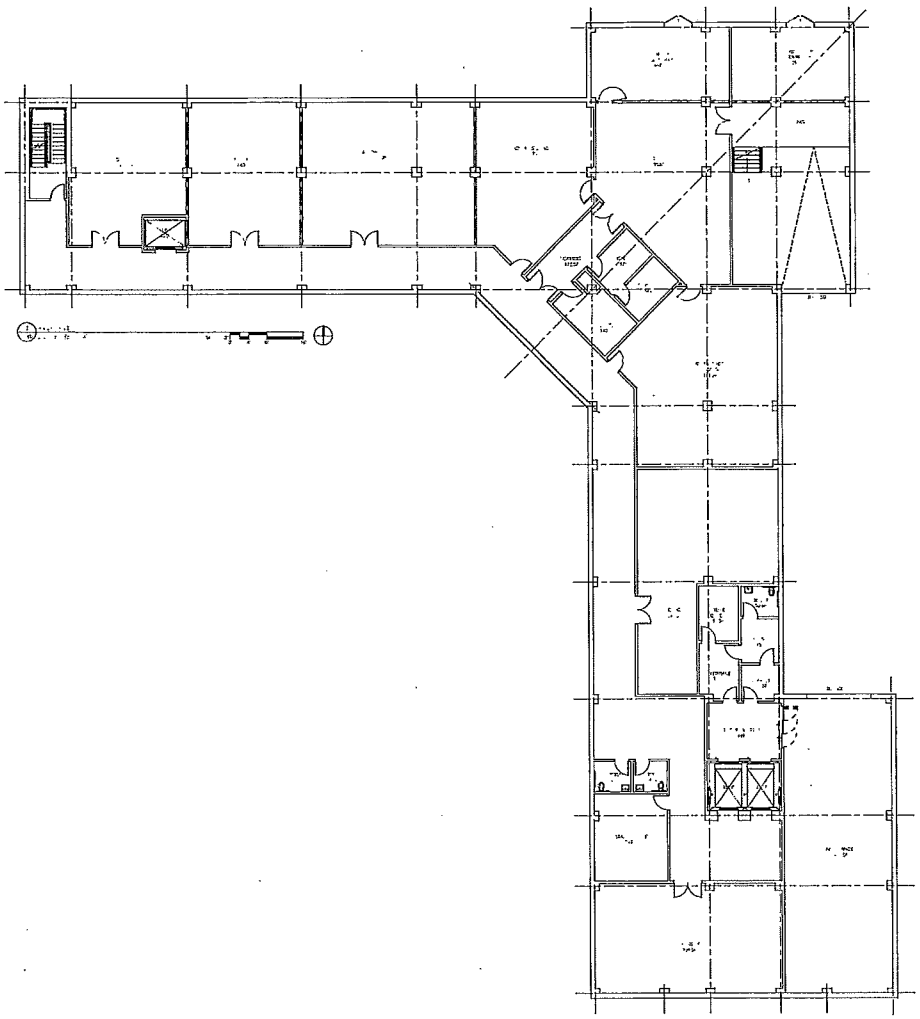
CRGoodmanASSOCIATES
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

Anne Arundel Medical Center

MENTAL HEALTH SPECIALTY HOSPITAL

BUILDING ELEVATIONS

A201



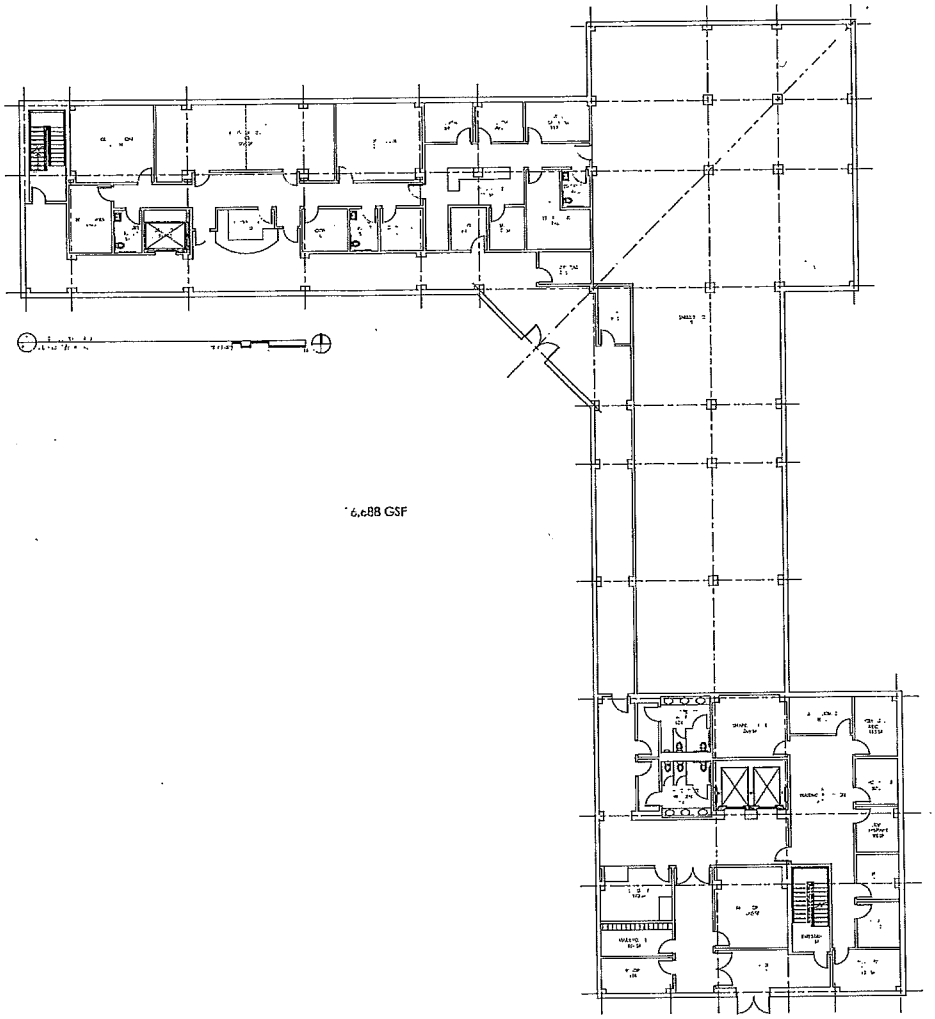
CRGoodmanASSOCIATES
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

Anne Arundel Medical Center

MENTAL HEALTH SPECIALTY HOSPITAL

BASEMENT FLOOR PLAN

A100



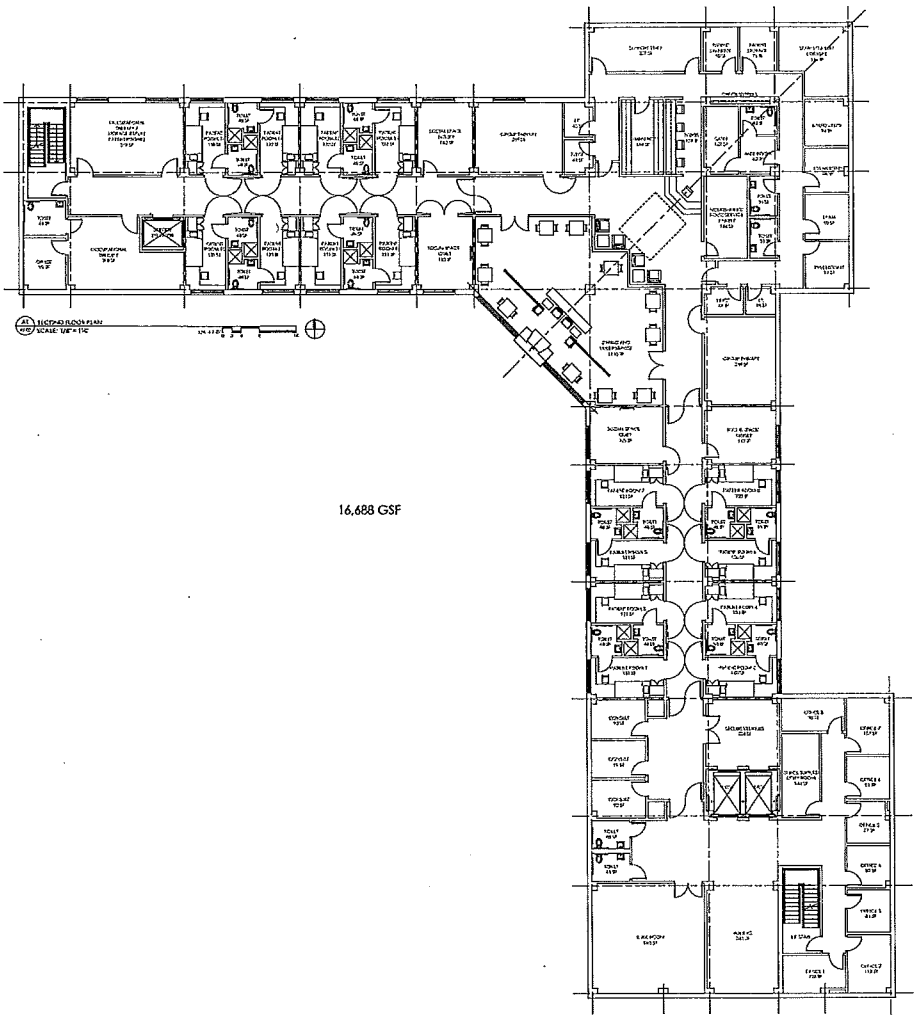
CRGoodmanAssociates
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

Anne Arundel Medical Center

MENTAL HEALTH SPECIALTY HOSPITAL

FIRST FLOOR PLAN

A101



16,688 GSF

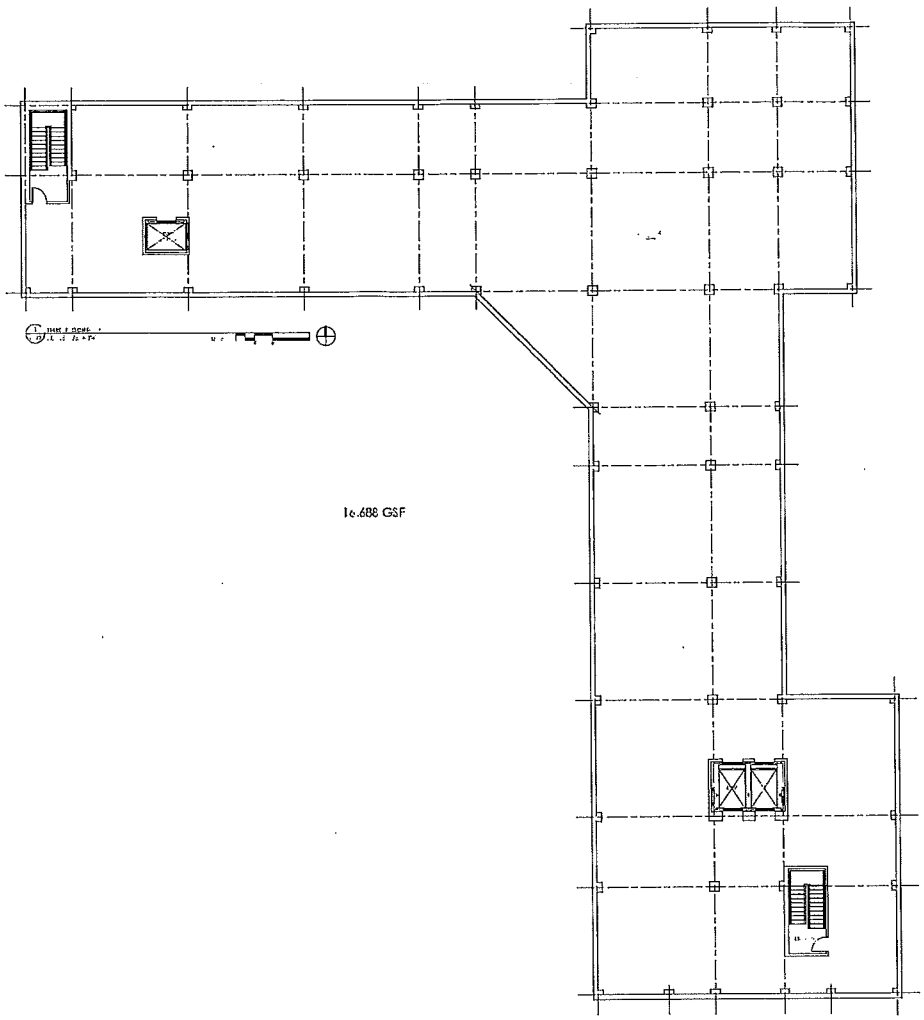
CRGoodmanASSOCIATES
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

Anne Arundel Medical Center

MENTAL HEALTH SPECIALTY HOSPITAL

SECOND FLOOR PLA

A102



16,688 GSF

CRGoodmanASSOCIATES
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING

Anne Arundel Medical Center

MENTAL HEALTH SPECIALTY HOSPITAL

THIRD FLOOR PLAN

A103