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MEMORANDUM

TO: Commissioners

FROM: Paul E. Parker PEP
Director, Health Care Facilities Planning & Development

DATE: September 20, 2018

SUBJECT: Conversion of the University of Maryland Laurel Regional Hospital to a Freestanding Medical Facility
Docket No. 18-16-EX002

The attached staff report and recommendation considers the proposed conversion of the University of Maryland Laurel Regional Hospital to a freestanding medical facility. This is the first project of its kind to be considered by the Commission and is a request for an exemption from Certificate of Need review undertaken using a review process and requirements established in Maryland law in 2016. The general hospital in Laurel is proposing to eliminate inpatient services and establish an outpatient campus providing full-time, hospital emergency department-style care and observation services. Patients seen at the proposed facility requiring hospital admission will be transported to a general hospital. The FMF will also offer outpatient surgical services, wound care, and psychiatric partial hospitalization and intensive outpatient services. UM Prince George's Hospital Center will be the parent hospital for the FMF and the two facilities will share a combined global budget.

Staff recommends that the Commission **APPROVE** the project based on its review of the consistency of the project with the applicable criteria and standards.

IN THE MATTER OF	*	**BEFORE THE**
	*	
CONVERSION OF	*	**MARYLAND**
	*	
UNIVERSITY OF MARYLAND	*	**HEALTH CARE**
	*	
LAUREL REGIONAL HOSPITAL TO A	*	**COMMISSION**
	*	
FREESTANDING MEDICAL FACILITY	*	
	*	
Docket No. 18-16-EX002	*	
	*	

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STAFF REPORT & RECOMMENDATION

EXEMPTION FROM CERTIFICATE OF NEED REVIEW
CONVERSION OF THE UNIVERSITY OF MARYLAND LAUREL REGIONAL HOSPITAL TO A FREESTANDING MEDICAL FACILITY

September 20, 2018

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I. INTRODUCTION

A. Background

In June 2017, the Maryland Health Care Commission ("MHCC") adopted COMAR 10.24.19 ("FMF Chapter"), a chapter of the State Health Plan for Facilities and Services ("SHP") governing Certificate of Need ("CON') regulation of Freestanding Medical Facilities ("FMFs"). This type of health care facility was first established in Maryland in 2005 and three FMFs are currently operating in Maryland. For the first ten years following creation of this category of health care facility, FMFs operated as "pilot" programs, subject to study by MHCC and subsequent legislative action. Since Fiscal Year ("FY") 2016, FMFs have been subject to CON regulation. This staff report addresses the second FMF project submitted for review by MHCC and the first FMF project ripe for review and action by the Commission.

A freestanding medical facility is an outpatient health care facility that: (a) provides medical and health care services; (b) is an administrative part of an acute care general hospital; (c) Is physically separated from the hospital or hospital grounds; (d) operates 24 hours a day, seven days a week; (e) complies with the provisions of the Emergency Medical Treatment and Active Labor Act[1] and Medicare Conditions of Participation; (f) has the ability to rapidly transfer complex cases to an acute care general hospital after the patient has been stabilized; (g) maintains adequate and appropriate delivery of emergency medical care within the statewide emergency medical services system as determined by the Maryland State Emergency Medical Services Board; and (h) may provide observation services. COMAR 10.24.19.05B(8). The FMF model created in Maryland is one that is commonly referenced as a "freestanding emergency center" in other states.

Establishment of a new FMF by a general hospital, the relocation of an FMF, or a capital expenditure made by or on behalf of an FMF that exceeds the applicable capital expenditure threshold requires CON approval. Maryland's three existing FMFs all function as FMFs of this type.[2] They were established by parent hospitals as satellite locations extending level of care similar to the full-time and specialist-directed emergency services found in the parent's emergency department to alternative locations within the parent's service area. MHCC has found that these FMFs have lower patient acuity and produce lower numbers of inpatient admissions than their parent hospitals. (*Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities*, MHCC, February 4, 2015)

In 2016, Maryland law was amended to permit a general hospital that is part of a multi-hospital system to transition from an inpatient facility to an FMF through an exemption from Certificate of Need review, a review process that requires approval by the Commission but, unlike CON review, does not permit intervention and possible judicial appeal by interested parties. This is similar in some respects to a concept embodied in Maryland law decades ago, creating a facility called a "limited service hospital" as the hospital-successor outpatient campus. No limited service hospitals were ever established in Maryland. In contrast, creating an FMF as a rate-regulated

[1] Also known as EMTALA, 42 U.S.C. §1395.

[2] The pre-existing Bowie Health Center was initially licensed as a department of UM PGHC but was licensed as an FMF after this category of health care facility came into existence.

facility within a hospital system to replace a general hospital is an option that has three active transition plans underway, all proposed by the University of Maryland Medical System.

B. The Applicant

Dimensions Health Corporation ("Dimensions") is a not for profit health system owned by the University of Maryland Health System ("UMMS"). UMMS acquired Dimensions on September 1, 2017. Dimensions now does business as the University of Maryland Capital Region Health ("UM CRH") and operates two general hospitals in Prince George's County: the University of Maryland Laurel Regional Hospital ("UM LRH" or "Laurel"); and the University of Maryland Prince George's Hospital Center ("UM PGHC").

Laurel Regional Hospital was established at 7300 Van Dusen Road in Laurel in 1978 as the "Greater Laurel-Beltsville Hospital." It is an acute care hospital with 45 licensed medical/surgical/gynecological/addictions ("MSGA") beds and 10 licensed acute psychiatric beds.[3] In recent years it has seen its acute care admissions decline by approximately 36%, falling from 5,843 in 2013 to 3,766 in 2017. Part of this decline is a result of its elimination of obstetric and perinatal services in FY 2016. It has not been successful in generating income from operations in recent years.

UM PGHC is a 238-bed general hospital, with 174 MSGA beds, 30 obstetric beds, two pediatric beds, and 32 acute psychiatric beds, located at 3001 Hospital Drive in Cheverly. A special pediatric hospital, the 15-bed Mt. Washington Pediatric Hospital, jointly owned by UMMS and Johns Hopkins Medicine, operates in leased space at UM PGHC. The relocation and replacement of the general hospital and the special pediatric hospital to a site in Largo was authorized in October 2016.

UM CRH also operates the UM Bowie Health Center, a freestanding medical facility located at 15001 Health Center Drive in Bowie, the UM Capital Region Surgery Center, an ambulatory surgical facility located on the campus of the UM Bowie Health Center, and four health and wellness centers offering a variety of primary care services to families and seniors, located in Laurel, Cheverly, Capital Heights, and Suitland.

C. The Project

The applicant, Dimensions d/b/a UM CRH, UM-LRH, and UM PGHC, requests an exemption from CON review to convert UM LRH to a freestanding medical facility to be known as the "UM Laurel Medical Center." It would initially be housed in the existing hospital building (Phase 1) while a new building is constructed on the campus (Phase 2). When the new building is

[3] Two special hospitals have operated on the UM LRH campus in recent years, one providing acute rehabilitation services and the other providing chronic care. These special hospital facilities were authorized to relocate to the UM Prince George's Hospital Center campus in March of this year. This transition will reduce the bed capacity used for these special hospital services. In FY 2016, the reported chronic care average daily census ("ADC") at the UM LRH campus was 18.7 patients. In FY 2017, the reported acute rehabilitation ADC at the same campus was 6.5 patients.

complete, the FMF will be relocated there and the existing hospital building demolished. CRH describes the conversion of UM LRH to an FMF as "part of UM CRH's plan to create an optimal patient care delivery system for the future health care needs of residents living in UM LRH's Inpatient Service Area." (Request for Exemption from CON Review, p. 4)

In Phase 1, the applicant will implement the FMF operation within the existing building space that currently operates as a general hospital. CRH states that it will "mothball" 86,000 square feet ("SF") of the building's 304,000 SF and projects spending $125,855 to modify the facility space that will be used as an FMF.

Phase 2 will involve construction of a new FMF building on the southwestern portion of the current UM LRH campus. Its services will be housed on two floors in 75,855 SF. The total project budget estimate is $53.1 million, which will be funded through a combination of $38.1 million in tax exempt bonds issued in FY 2018 through UMMS, $500,000 in interest earnings on the bonds, and $14.5 million in grant funding from the State of Maryland.

The applicant requests that certain outpatient services provided by the FMF be rate-regulated, although Maryland law does not require the services to be rate-regulated. The law mandates rate regulation of the emergency services provided by an FMF and, if provided by the FMF, observation services. The additional services that the applicant proposes for rate regulation are: (1) ambulatory surgery services; (2) diagnostic imaging and other clinical ancillary services required to support the emergency, observation, and ambulatory surgery services of the FMF; (3) partial hospitalization/intensive outpatient behavioral health services; and (4) wound care, including hyperbaric oxygen therapy. Maryland law provides the Health Services Cost Review Commission ("HSCRC") with discretion in determining whether outpatient services beyond emergency and observation services in an FMF setting should be subject to rate regulation.

Table 1 juxtaposes the services proposed for the FMF, in each phase of the proposal – i.e., the converted UM LRH (Phase 1) and its proposed successor, UM Laurel Medical Center (Phase 2). There is very little difference in the proposed iterations.

Table 1
Comparison of Proposed Laurel Medical Center Freestanding Medical Facility by Phase

	FMF operating in LRH space	New FMF (UM Laurel Medical Center)
Emergency Unit	An emergency unit with 27 exam rooms at approximately 120 SF (23) or 130 SF (four behavioral health rooms), three patient toilets, and one staff toilet, as well as related staff and support spaces, including an ambulance entrance and decontamination facilities	An emergency unit with two triage rooms at 110 SF, 24 exam rooms at 140 SF (20) or 130 SF (four behavioral health rooms) and one trauma/ resuscitation room at 280 square feet, four patient toilets, and two staff toilets, as well as related staff and support spaces, including an ambulance entrance and decontamination facilities
Observation Unit	An observation suite with ten (10) patient rooms at 260 SF, each having its own private toilet at 60 SF, and related staff and support spaces	An observation suite with ten (10) patient rooms at 170 SF (including two bariatric rooms at 215 SF), each having its own private toilet at 60 SF and related staff and support spaces
Diagnostic Imaging	A diagnostic imaging suite with x-ray, ultrasound, computed tomography (CT), nuclear medicine, two cardio-vascular ultrasound modalities, and related staff and support spaces A magnetic resonance imaging (MRI) unit in a modular building adjacent to the FMF, which will be accessible by a covered walkway	A diagnostic imaging suite with x-ray, ultrasound, CT, two (2) cardio-vascular ultrasound modalities, and related staff and support spaces An MRI unit in a modular building adjacent to the FMF, which will be accessible by a covered walkway
Behavioral Health Outpatient Services	Space for outpatient behavioral health services, including partial day hospitalization	Space for outpatient behavioral health services, including partial day hospitalization
Outpatient Surgical Suite	Two sterile operating rooms and two non-sterile procedure rooms with related pre-operative preparation spaces, post-anesthesia care unit, and staff and support spaces	Two sterile operating rooms and two non-sterile procedure rooms with related pre-operative preparation spaces, post-anesthesia care unit, and staff and support spaces
Laboratory/Pharmacy Services	A laboratory and in-house pharmacy	A laboratory and in-house pharmacy
Other Services	Ancillary services including respiratory and physical medicine	N/A
Administrative and Staff Support	Administrative staff and support spaces	Administrative staff and support spaces

D. Staff Recommendation

MHCC staff recommends that the Commission approve the request for an exemption from Certificate of Need to convert UM Laurel Regional Hospital to a freestanding medical facility that will provide rate-regulated outpatient services beyond emergency and observation services and will be an administrative unit of UM Prince George's Hospital Center. The basis for this recommendation is the request's compliance with the applicable criteria and standards established for such conversions, as discussed in the body of this report.

II. PROCEDURAL HISTORY

Description	Date
Anonymous letter to Craig A. Moe, Mayor of Laurel providing comments in opposition to the project	Jan. 16. 2018
Anonymous letter to Craig A. Moe, Mayor of Laurel providing comments in opposition to the project	Jan. 18, 2018
Notice of Intent to seek exemption from Certificate of Need (CON) review for the conversion of University of Maryland (UM) Laurel Regional Hospital to a freestanding medical facility from UM Capital Region Health, UM Laurel Regional Hospital, and UM Prince George's Hospital Center	Apr. 13, 2018
MHCC request for publication of notification of receipt of the request for exemption from CON review in the *Washington Times*	Apr. 23, 2018
MHCC request for publication of notification of receipt of the request for exemption from CON review in the *Maryland Register*	Apr. 24, 2018
The *Washington Times* provided an Affidavit of Publication that the notice was published on May 3, 2018	May 3, 2018
Summary of public information hearing held on May 7, 2018	May 21, 2018
Letter to Kevin McDonald from Lisa Brown and Taren Peterson, Service Employees International Union, providing comments concerning the lack of transparency and collaboration for job security by the applicants, and the negative impact of the project hospital employees and their families	June 19, 2018
Letter to Ben Steffen from Patricia S. Gainer, Acting Co-Executive Director of MEIMSS, transmitting determination of the State Emergency Medical Services Board in re the proposed project	July 17, 2018
MHCC staff request for additional information from the applicants	July 24, 2018
Partial response to July 24 request for information	Aug. 3, 2018
Partial response to July 24 request for information	Aug. 7, 2018
Memorandum to Donna Kinzer and Jerry Schmith, HSCRC staff, from Paul Parker requesting review of the financial feasibility of the proposed project and specific findings needed for this type of exemption from CON request	Aug. 23, 2018
Memorandum to Paul Parker from Katie Wunderlich and Jerry Schmith, HSCRC staff, responding to August 23, 2018 request for HSCRC staff review of the proposed project	Sep. 13, 2018
E-mail from Donna Kinzer to Paul Parker transmitting revised financial schedule for the proposed FMF from Mike Wood of UMMS	Sep. 13, 2018
Revisions to the request for exemption from CON review	Sep. 13, 2018
E-mail from Paul Parker to Tom Dame reminding the applicants to assure that all information on the proposed project provided to MHCC be provided to MIEMSS	Sep. 14, 2018
E-mail from Tom Dame to Paul Parker responding to September 14, 2018 e-mail in re provision of information to MIEMMS	Sep. 14, 2018
E-mail from Paul Parker to Tom Dame inquiring about revised Table H	Sep. 14, 2018
E-mail from Tom Dame to Paul Parker responding to September 14, 2018 e-mail in re revised Table H	Sep. 14, 2018

III. REQUIREMENTS FOR AN EXEMPTION

A Request for an Exemption from Certificate of Need Review to Convert a General Hospital to a Freestanding Medical Facility must meet the requirements of COMAR 10.24.19.04C of the State Health Plan

(1) A freestanding medical facility created through conversion from a general hospital shall only retain patients overnight for observation stays.

Implementation of the proposed project will eliminate the provision of inpatient services on the UM LRH campus and convert this general hospital to a freestanding medical facility limited to providing outpatient care. Some patients will be observed overnight. Observation is defined as an outpatient service.

(2) Each notice, documentation, or other information regarding a proposed conversion of a general hospital to a freestanding medical facility that is required by Section C of this regulation or by COMAR 30.08.15.03 shall be provided simultaneously to the Commission and to the Maryland Institute for Emergency Medical Services Systems.

This communication requirement has been met.

(3) A notice of intent to seek an exemption from Certificate of Need review to convert a general hospital to an FMF shall:

(a) Be filed in the form and manner specified by the Commission, which may require a pre-filing meeting with Commission staff to discuss the proposed project, publication requirements, and plans for a public informational hearing.

(b) Be filed with the converting hospital and its parent hospital as joint applicants;

A notice to seek an exemption from CON review to convert UM Laurel Regional Hospital from a general hospital to an FMF was filed in a form and manner specified by the Commission.

The applicant has satisfied the requirements of (3)(a) and (b) above.

(c) Only be accepted by the Commission for filing after:

(i) The converting hospital publishes on its website and otherwise makes available to the general public and community stakeholders, at least 14 days before holding a public informational hearing, the hospital's proposed transition plan that addresses, at a minimum, job retraining and placement for employees displaced by the hospital conversion, plans for transitioning acute care services previously provided on the hospital campus to residents of the hospital service area, and plans for the hospital's physical plant and site.

(ii) The converting hospital, in consultation with the Commission, and after providing at least 14 days' notice on the homepage of its website and in a newspaper of daily circulation in the jurisdiction where the hospital is located, holds a public informational hearing that addresses the reasons for the conversion, plans for transitioning acute care services previously provided by the hospital to residents of the hospital service area, plans for addressing the health care needs of residents of the hospital service area, plans of the hospital or the merged asset system that owns or controls the hospital for retraining and placement of displaced employees, plans for the hospital's physical plant and site, and the proposed timeline for the conversion.

(iii)Within ten working days after the public informational hearing, the converting hospital provides a written summary of the hearing and all written feedback provided by the general public and from community stakeholders to the Governor, Secretary of DHMH, the governing body of the jurisdiction in which the hospital is located, the local health department and local board of health for the jurisdiction in which the hospital is located, the Commission, and the Senate Finance Committee, House Health and Government Operations Committee, and members of the General Assembly who represent the district in which the hospital is located;

The applicant satisfied the provisions of COMAR 10.24.19.04C(3)(i), (ii), and (iii). Prior to holding its public informational meeting on May 7, 2018, it published a transition plan,[4] which addressed plans for conversion of UM LRH to an FMF and transitioning inpatient care to alternative hospitals, work force retraining and job placement, and plans for disposition of the hospital site and buildings on its website. UM CRH published notice of the hearing date and location on its websites beginning on Friday, April 13, and in the Maryland Daily Record in print and electronic versions beginning on Monday, April 23. CRH stated that it also purchased half-page advertisements in the Laurel Leader announcing the date and location of the public hearing. Notice about the hearing was also posted on the City of Laurel's website, electronic signage, social media platforms, and its public television channel. CRH also publicized the meeting on its social media platforms, and distributed flyers about the hearing throughout the community.

UM CRH provided the required written summary of the public meeting and distributed it to the required bodies and individuals on May 21, 2018.

(iv) The State Emergency Medical Services Board has determined that the proposed conversion of the general hospital to an FMF will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system;

[4] https://umcapitalregion.org/wp-content/uploads/2018/04/Transition20Plan20for20UM20Laurel20Regional20Hospital.pdf

The applicant satisfied this provision by providing a letter from the Maryland Institute for Emergency Medical Services Systems ("MIEMSS") dated May 21, 2018 documenting that the State EMS Board "unanimously determined that the proposed conversion of the University of Maryland Laurel Regional Hospital to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system." That letter is attached as Appendix 1.

> **(v) The applicants receive a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the proposed FMF for which the applicants seek rate regulation.**
>
> **(vi) The applicants receive approved rates from HSCRC for each rate-regulated outpatient service at the proposed FMF; and**
>
> **(vii) The applicants provide any additional information determined by Commission staff as necessary for the notice of intent to seek an exemption to convert to an FMF to be complete.**

On August 2, 2018, UMMS filed a partial rate application on behalf of UM Prince George's Hospital Center and UM Laurel Regional Hospital requesting that HSCRC move certain rate centers from UM LRH to UM PGHC and combine the hospitals' global budgets into one single global budget.[5] It stated that the requested changes were necessary to implement the plan to convert UM LRH to a freestanding medical facility, discontinue inpatient services on the Laurel campus, and move services from UM LRH to UM Prince Georges Hospital.

The hospitals requested that the HSCRC approve a final recommendation to establish a rehabilitation and chronic rate for UM Prince George's Hospital Center.[6] The request also asked HSCRC to approve combining the global budgets for UM PGHC and UM LRH to effectuate an orderly conversion of the Laurel hospital to an FMF.

As part of the Certificate of Need proceedings for relocation and replacement of UM PGHC, HSCRC reviewed the projections utilized for this modernization and, in conjunction with that review, appraised a Comfort Order request to HSCRC concerning the issuance of bonds to fund a portion of the capital costs of the plan, which included the reconfiguration of UM LRH to a freestanding medical facility and the transitioning of the remaining inpatient services of the Laurel hospital to the UM PGHC campus. The analyses assumed that UM Capital Region Health would retain all revenues for services moved to the UM PGHC campus and retain approximately fifty percent of the global budget revenue ("GBR") when services shift to non-system hospitals or unregulated settings. Through this retention, in addition to substantial capital funding from the State of Maryland and Prince George's County, the hospitals projected that they would be able to

[5] *IN RE: THE PARTIAL RATE APPLICATION FOR LAUREL REGIONAL HOSPITAL AND PRINCE GEORGE'S HOSPITAL BEFORE THE HEALTH SERVICES COST REVIEW COMMISSION*, HSCRC Docket: 2018, Folio: 2260, Proceeding: 2450R, September 12, 2018. The information provided here regarding the requirements of COMAR 10.24.19.04C(3)(c)(v)-(vii) have been drawn from this proceeding.
[6] See footnote 3, *supra*,, p. 3.

undertake these major construction and reconfiguration plans without requesting an increase in the GBR revenues for the UM CRH system.

In July 2018, HSCRC staff met with UMMS representatives to discuss the approach to implement the reconfiguration and conversion of UM LRH to an FMF. HSCRC was informed that UM CRH anticipated that, on or about October 1, 2018, the special hospital services of acute rehabilitation and chronic care will be relocated to the UM PGHC campus. UM CRH requested that the current HSCRC-approved rates for these services be moved from the rate order of UM LRH to UM PGHC. HSCRC staff was told that, on or about January 1, 2019, the remaining inpatient general medical/surgical, intensive care, and acute psychiatric services will also be relocated. Since both facilities have rates for these services, it was noted that UM PGHC will not need a new rate center, but that its rates will need to be adjusted to blend these and supporting ancillary services into its facility rates, while maintaining compliance with the overall global revenue limits.

Upon completion of the service relocation, UM LRH will become an FMF. At that time, its services will be billed as a part of UM PGHC, under UM PGHC's provider number. To facilitate this reconfiguration, HSCRC staff and UM CRH discussed the combination of the two facilities under one GBR, but continuing to maintain two rate orders under the GBR. This will facilitate the service combination and compliance without multiple rate order adjustments.

HSCRC staff's review of the partial rate application for consistency with the plans previously submitted to HSCRC and its approach to revenue and rate management under the GBR, previously discussed with HSCRC staff, found that the approach outlined above will provide the smoothest rate and revenue transition. Based on this review, HSCRC staff recommended that: (1) HSCRC approve the combination of the GBRs of UM PGHC and UM LRH into a single GBR for calculation of compliance with the global revenue budget; (2) that rates for the special hospital services of chronic care and acute rehabilitation be established in the UM PGHC rate order at the same level as the rates of UM LRH until rate realignment occurs in conjunction with the rate year 2020 update; and (3) that rate orders be maintained for each of the two locations, with compliance calculated in the aggregate for the two health care facilities using the combined GBR. These recommendations were approved by HSCRC on September 12, 2018.

On September 13, 2018, HSCRC staff provided MHCC staff with a memorandum responding to MHCC staff's request for a determination regarding each outpatient service to be provided at the proposed Laurel FMF for which rate regulation had been sought and information on the approved rates from HSCRC for each rate-regulated outpatient service at the proposed FMF. That memorandum is attached as Appendix 2. HSCRC staff found that the rationale for rate regulating the additional outpatient services provided by the proposed FMF (ambulatory surgery, diagnostic imaging, and other clinical ancillary services supporting the emergency, observation, and ambulatory surgery services, partial hospitalization/intensive outpatient behavioral health services, and wound care) to be "reasonable . . . "so long as the surgery services are operated at rates comparable to freestanding ambulatory surgical facilities after adjustment for severity levels, uncompensated care and payer differential and any assessments."

HSCRC staff noted that "HSCRC already regulates diagnostic services that are performed as part of the emergency services provided" by an FMF and "including wound care can support effective follow-up of emergency care to avoid infections, improve recovery and avoid emergency department visits or inpatient hospitalizations. The wound care program can also support other preventive efforts in the service area." HSCRC staff indicated support for inclusion of the outpatient behavioral health services based on their understanding "that partial hospitalization for outpatient psychiatric patients was requested by community representatives. With the All-Payer and Total Cost of Care Model focus on improving community behavioral health, this service request appears consistent with Model goals."

While the September 12, 2018 action by HSCRC on the partial rate request by UMMS provides the rate approvals needed to initiate the hospital to FMF conversion plan, HSCRC staff noted that UMMS "will need to file a rate application to establish the rates" in the new FMF that will be constructed in Phase 2 of the conversion plan. The staff noted that it

> expects to establish rates for emergency, observation, wound care, and related ancillary services that are consistent with other hospital and FMF center rates. Staff will evaluate the outpatient psychiatric services relative to other outpatient hospital programs. Lastly, staff will require that the rates for the outpatient surgery service be lower than acute hospital rates.

Specifically, with respect to outpatient surgery, HSCRC staff noted that UMMS "has submitted financial projections incorporating outpatient surgery rates lower than hospital rates, but higher than freestanding counterparts." These rates were developed using the Medicare Ambulatory Surgery Center fee schedule as a base, with an

> add-on to estimate FMF rate levels. On top of the estimated FMF rate staff added a severity increase. HSCRC staff used MedPAC estimates of severity level differences between hospitals and FMFs to evaluate the potential add-on for severity. Finally, there will be an add-on to rates for the markup for payer differential and uncompensated care, as well as any assessments (e.g., Medicaid deficit assessment or Medicaid averted bad debt assessment) that are applicable to the rates of the FMF. At least six months before occupancy of the new medical center facility (Phase 2), UMMS should file a rate determination with the HSCRC, including documentation regarding market rates. UMMS can derive these market rates from sources such as Truven Market Scan, the MHCC All-Payer claims data base, or other market data. These figures can be increased for the severity adjustment, mark up and assessments to set the surgery rates. The remaining rates will be established consistent with HSCRC processes.

On September 14, 2018, the applicant filed revisions to the exemption request pending before the MHCC to reflect the actions taken by HSCRC, including revised financial projections for the FMF that cover fiscal years 2019 through 2024 and account for the agreement by HSCRC staff on the rate structure for the additional outpatient services of the proposed FMF. This updated pro forma schedule of projected revenues and expenses is provided in Appendix 3. As will be noted, these projections show that the FMF is projected to sustain operating losses throughout the

projection period, slightly exceeding $3 million in the full fiscal years of 2020 and 2021 when the FMF is projected to be operating in the reconfigured physical plant of UM LRH, and smaller losses in FY 2022 to FY 2024 (averaging $2.6 million during those three years) when the FMF is projected to be operating in its newly constructed building. However, the applicant projects modest positive cash flow throughout the projection period, i.e., the non-cash expenses of depreciation and amortization are projected to exceed the operating loss projections in each year. Importantly, these losses appear to be sustainable for the overall UM Capital Region Health operations, as reflected in the financial schedule for UM CRH (Table H) also included in Appendix 3.[7]

The requirements of COMAR 10.24.19.04C(3)(c)(iv) and (v) have been met, as have the information requirements of Subparagraph (vi).

(4) The Commission shall require that a freestanding medical facility created through the conversion of a general hospital remain on the site of, or on a site adjacent to, the converting general hospital unless:

(a) The converting general hospital is the only general hospital in the jurisdiction or is one of only two general hospitals in the jurisdiction and both belong to the same merged asset system; and

(b) The site is within a five-mile radius and in the primary service area of the converting general hospital.

UM Laurel Regional Hospital is in Prince George's County. There are currently five general hospitals in the county and there will be four if the proposed conversion is implemented. Therefore, the State Health Plan requires that an FMF established through the conversion of UM LRH remain on the site of UM LRH or be developed adjacent to the hospital site. The proposal is to locate the FMF on the current campus of UM LRH, first in the existing hospital building followed by the construction of a new building on the campus. Thus, the proposed FMF meets this standard.

(5) The parent hospital shall demonstrate compliance with applicable general standards in COMAR 10.24.10.04A.

There are three applicable general standards in COMAR 10.24.1.0.04A, Information Regarding Charges, Charity Care Policy, and Quality of Care. These will be addressed immediately below.

Information Regarding Charges

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

[7] This schedule was not updated. The applicant states that the financial projections for UM CRH have not changed because the HSCRC has permitted UM CRH to retain the revenue within the GBR for UM PGHC, and the differences in contractual discounts were deemed to be immaterial by the UM CRH finance team and outside financial consultants. Therefore, Table H was not revised from the original filing earlier this year.

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

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

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

This standard is intended to ensure that information regarding the average cost for common inpatient and outpatient procedures is readily available to the public and that policies are in place and employees are trained to address charge-related inquiries. The policy must include requirements to post a current list of charges for common inpatient and outpatient services, procedures for responding to requests and inquiries, and requirements for staff training.

The applicant provided a link to the information regarding charges for University of Maryland Capital Health on its website: **https://umcapitalregion.org/for-patients/estimated-charges/**, which provides readily available information on the most frequently accessed inpatient and outpatient procedures by service line. The estimated average charges are to be updated quarterly as set forth in application Exhibit 5 based on actual patient charges over the previous 12 months. The website directs individuals with questions about estimated charges to contact a financial counselor and provides a telephone number. Application Exhibit 4 sets forth UM Capital Region Health's policy regarding the provision of information on charges for hospital services to the public and on hospital internet sites. This policy establishes departmental responsibilities for the provision of the information and for the education and training of staff.

Commission staff has verified that University of Maryland Capital Region Health complies with this standard.

Charity Care Policy

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. COMAR 10.24.10 10

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**
2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and**

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

To demonstrate compliance with this standard, Capital Region Health provided a copy of its financial assistance policy, implemented at both UM PGHC and UM LRH. (Exemption Request, Exh. 6). UM CRH stated that this policy will be implemented at UM Laurel Medical Center when the proposed FMF opens. The policy expresses UM CRH's commitment to provide financial assistance to persons who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay. The policy provides for determinations of probable eligibility within two business days following a patient's request for charity care or for medical assistance, or both. (Exh. 6, pp. 4-5). The policy also provides that a patient billing and financial assistance information sheet will be available to all patients upon request and will be provided to all patients before discharge. (Exh. 6, p. 1). The policy states that notices of the availability of financial assistance will be published in local newspapers on an annual basis. Copies were submitted as Exhibit 8. The policy also directs CRH entities including UM PGHC to post such notices at intake locations including the admissions and registration offices, business offices, and emergency department.

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

According to HSCRC's FY 2017 Community Benefit Report, UM Prince George's Hospital Center reported the provision of charity care with a value of $9.17 million, which was equivalent to 3.2% of its operating expenses. As such, UM PGHC ranked seventh among Maryland's 47 general hospitals in the level of charity care reported for FY 2017, placing it in the top quartile of Maryland hospitals. UM LRH also had a level of charity care reported for FY 2017 that placed it in the top quartile for Maryland hospitals. It reported charity care with a value of $2.52 million, equivalent to 2.7% of total operating expenses. The median level of charity care provided by Maryland's general hospitals in FY 2018 was 1.5%.

Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

Both UM LRH, the proposed converting hospital and UM PGHC, the proposed parent hospital of the proposed FMF meet these requirements.

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

Staff notes that Paragraph (b) of this standard has become outdated, as currently written. There is still a Maryland Hospital Performance Evaluation Guide ("HPEG"), which is the hospital consumer guide component of the MHCC website. Quality measures are included as a component of that guide. However, in the eight years since this standard was adopted, the HPEG has been substantially expanded to include many more measures of hospital quality and performance. Moreover, the specific format of the quality measure component of the HPEG no longer consists of a set of measure values that conform with the format of this standard in which each measure is scored as compliance percentage that can be ranked by quartile. The performance for most of the expanded number of quality measures is now in a comparative context, expressed as "Below Average," "Average," or "Better than Average".

UM Prince George's Hospital Center reported its scores as follows: "better than average" or "average" on 41 of 70 quality measures; "below average" on 21 measures; and noted that there are 13 quality measures for which there was insufficient data to report a score. The 21 quality measures for which UM PGHC reported a "below average" score are addressed in application Exhibit 9 along with a corrective action plan for each. There are also a few quality measures for which hospitals are compared to predicted results for that measure. UM PGHC identified one measure for which it scored worse than predicted and included its corrective action plan for that measure in application Exhibit 9.

Commission staff examined the latest results for UM PGHC as reported on the Commission's website and found that there are currently 72 quality measures that are now measured compared to the other Maryland hospitals. Staff found that UM PGHC rated above average on three measures, average on 33 measures, and below average on 24 measures. There were also 12 measures for which there was not enough data. Twenty-one of the 24 measures for which UM PGHC was worse than average are addressed with a corrective action plan in Exhibit 9.

Commission staff finds that UM PGHC has demonstrated substantive compliance with Paragraph (b) of the quality standard by identifying quality measures for which it scored worse than average compared to the other Maryland hospitals and documenting actions being taken to correct the low scores.

(6) The applicants shall document that the proposed FMF will meet licensure standards established by DHMH.

The applicant states that UM Laurel Medical Center will meet or exceed licensure standards established by the Department of Health. Staff finds that this statement is sufficient documentation to satisfy this requirement for a proposed facility.

(7) The applicants shall establish and maintain financial assistance and charity care policies at the proposed freestanding medical facility that match the parent hospital's policies and that are in compliance with COMAR 10.24.10.

The applicant states that UM Laurel Medical Center will use the financial assistance and charity care policies detailed in Exhibit 6 that are currently used at UM Prince George's Hospital Center. The details include the eligibility criteria used to determine whether patients qualify for charitable or reduced charge services. As indicated on pages 1-3 of the policy, financial assistance is and will be provided at UM Capital Region Health facilities, including at the proposed Laurel facility, to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation. Coverage amounts are and will be determined, in part, based upon an eligibility standard of 200-500% of family income as defined by federal poverty guidelines.

As indicated on page 7 of the policy, medical financial hardship assistance is also available, with limited exceptions, to patients who do not otherwise qualify for financial assistance, but for whom: (1) medical debt incurred at UM Capital Region Health facilities exceeds 25% of the family annual household income, creating a presumption of medical financial hardship; and (2) the income standards for this level of assistance are met.

Section 2(c) of the procedure section on pages 4-5 of the policy states that UM Capital Region Health will provide a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both.

The applicant has committed to using the same financial assistance and charity care policy at the proposed freestanding medical facility that is used at the parent hospital. Thus, this requirement is satisfied.

(8) Applicants seeking to convert a general hospital to a freestanding medical facility, in addition to meeting the applicable requirements in 10.24.01.04, shall:

(a) Provide the number of emergency department visits and FMF visits by residents in the converting hospital's service area for at least the most recent five years;

The applicant identified a service area of 35 zip code areas that contributed 85% of the converting hospital's emergency department ("ED") visits in FY 2017. These zip code areas are located in Prince George's (20), Anne Arundel (5), Montgomery (3), and Howard (5) Counties, and the District of Columbia (2).

The applicant reports that in FY 2017, there were 305,073 visits to Maryland hospital EDs by residents of this service area. This visit volume has declined approximately 9% since FY 2013. The applicant also reports that UM LRH's emergency department visit volume originating from this service area declined by 26.0% from 30,503 visits in FY 2013 to 22,565 visits in FY 2017.

In FY 2017, UM LRH had a 7.4% market share of the total service area ED visits. As shown in the following Table 2, five other hospitals had a greater market share of ED visits in the service area in that year. Three of the hospitals profiled in Table 2 saw their ED visit volume originating in this service area increase over the last four years. UM LRH and MedStar Southern Maryland saw the largest declines.

Table 2
Hospital Emergency Department Visits Originating from the
UM LRH Emergency Department Service Area
FY2013 – FY2017

Hospital Name	2013	2014	2015	2016	2017	Change 2013-17	FY 2017 Market Share
Doctors Community	41,654	42,447	46,775	46,886	46,537	11.7%	15.3%
UM Baltimore Washington	42,120	40,736	40,885	38,977	37,592	-10.8%	12.8%
UM Prince George's	38,791	37,110	37,255	38,268	35,997	-7.2%	11.8%
Howard County General	28,997	26,712	25,030	26,188	30,636	5.7%	10.0%
Holy Cross of Silver Spring	30,035	28,647	29,139	29,449	28,074	-6.5%	9.2%
UM Laurel Regional	30,503	28,207	28,328	24,205	22,565	-26.0%	7.4%
AHC Washington Adventist	23,748	21,990	22,162	21,785	21,343	-10.1%	7.0%
MedStar Southern Maryland	26,745	24,195	23,147	21,728	19,880	-25.7%	6.5%
Anne Arundel	16,144	16,595	17,543	18,422	18,847	16.7%	6.2%
Other Hospitals (Market Share < 3%)	56,450	43,767	41,006	41,974	43,602	-22.8%	14.3%
Total Service Area ED Visits	335,187	310,406	311,270	307,882	305,073	-9.0%	

Source: UM Laurel Regional Hospital Exemption Request, p. 21.

A review of HSCRC data indicates that Maryland's three existing FMFs accounted for 27,804 visits from residents of the UM Laurel Regional Hospital ED service area in FY 2017, with CRH's Bowie Health Center accounting for almost all of this demand (98.5%). If we equate hospital ED and FMF visit demand, the UM LRH emergency department service area generated 332, 877 total visits (hospital ED and FMF combined) in FY 2017 and the Bowie Health Center has a market share of 8.2% for that combined market.

The applicant has satisfied the requirements of this standard.

(b) Assess the availability and accessibility of emergent, urgent, and primary care services otherwise available to the population to be served, including information on the number and location of other hospital emergency departments, FMFs, and urgent care centers in the service area of the converting hospital or within five miles of any zip code area in the service area of the converting hospital.

Within UM Laurel Regional Hospital's FY 2017 service area, there are three other general hospitals and one FMF, UM Bowie Health Center (located 15.2 miles from UM LRH). The three hospitals are: Doctors Community Hospital (10.9 miles away); UM PGHC (14.1 miles away); and UM Baltimore Washington Medical Center (20.2 miles away). A replacement for AHC

Washington Adventist Hospital is being constructed at a site in the White Oak area of Silver Spring, which is approximately seven miles from the UM LRH campus. It is also in UM LRH's 85% relevance ED service area. This future AHC hospital will be the closest general hospital to the proposed Laurel FMF when put into operation, expected in 2019. Based on current calculations from Google Maps, the following general hospitals, although not in the UM LRH ED service area, are also within a relatively short distance from the UM LRH campus: Anne Arundel Medical Center – 14.2 miles; Holy Cross Hospital of Silver Spring – 11.5 miles; Howard County General Hospital – 14.3 miles; and AHC Washington Adventist Hospital's current Takoma Park campus – 11.5 miles. In 2015, AHC committed to developing an urgent care center that is always open for patient visits on this Takoma Park site after the relocated general hospital, AHC White Oak Medical Center goes into operation in 2019.[8]

To evaluate the ability of the EDs at area hospitals to absorb Laurel's visit volume, the applicant considered the number of ED visits at the five hospitals with the highest market share of ED visits originating in the UM LRH ED service area and each hospital's capacity based on the number of treatment spaces and a benchmark number of visits per treatment space from the most recent edition of ACEP's *Emergency Department Design: A Practical Guide to Planning for the Future.* The applicant used the benchmark of 1,250 visits per treatment space from the guide, which is the estimated capacity for Emergency Departments with 50,000 to 100,000 visits that operate at the high range on the majority of 18 parameters. The applicant stated that this analysis indicated that the volume of ED visits per treatment space in FY 2018 ranged from 1,043 visits per treatment space at Doctors Community Hospital to 1,332 visits per treatment space at UM Baltimore Washington Medical Center, and that the average visits per treatment space at the five hospitals was more than 83% of the ACEP guideline. The applicant further stated that ,at this level of utilization, these hospitals would have difficulty absorbing all of the approximately 26,000 total ED visits seen at UM LRH in fiscal years 2017 and 2018.

Commission staff reviewed the applicant's analysis and calculated that the five Emergency Departments operated in total at almost 92% of the ACEP benchmark as detailed in the following table. While these EDs appear to be operating at a sufficiently high level compared to the benchmark, the analysis indicates that the EDs could accommodate an additional 31,000 visits, which is more than UM-LRH's recent total visit volume of 26,000 per year.

[8] "Urgent care" is defined in the State Health Plan, as "the provision of medical services on a walk-in basis for primary care, acute or chronic illness, and injury." Self-styled "urgent care centers" are not licensed health care facilities. They do not typically provide the scope, medical direction, or scheduled availability of urgent or emergent care that would be required for a licensed FMF in Maryland.

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Table 3
FY 2018 Treatment Capacity of Hospital Emergency Departments in UM Laurel Regional Hospital Service Area

Hospital Name	ED Treatment Spaces	FY 2018 Total Visits	Visit Capacity Based on ACEP Benchmark*	Level of Capacity Use
Doctors Community	55	57,352	68,750	84%
UM Baltimore Washington	65	86,594	81,250	107%
UM PGHC	46	49,428	57,500	86%
Howard County General	74	78,088	92,500	84%
Holy Cross-Silver Spring	64	77,223	80,000	97%
Totals	304	348,685	380,000	92%

*1,250 visits per space per year
Source: August 3, 2018 Completeness Response, p. 4; *Emergency Department Design: A Practical Guide to Planning for the Future.*

While the above analysis suggests that LRH's Emergency Department volume could be accommodated by these hospitals, this analysis does not account for the variations in ED visit volume throughout the day, week, month, and year. The applicant took these variations into account by considering information from the Maryland Institute of Medicine Medical Services System on the hours each ED was on alerts that limit their ability to treat additional patients. When viewed from the perspective of a full year's availability of 8,760 hours, the information shown in the following table shows that, during FY 2018, as a daily average, these five hospitals were on some form of alert from 1.5 to 6.0 hours per day. This daily average disguises the actual pattern of alerts and how they are distributed (i.e., higher or lower frequency of alerts at certain times of the day and certain days of the week), as previously noted.

Table 4
Maryland Institute of Emergency Medical Services Systems
FY2018 Emergency Department Alerts

Hospitals	Yellow Alerts		Red Alerts		Other Alerts		Total Alerts		
	#	Total Hours	#	Total Hours	#	Total Hours	#	Total Hours	Hours Per Day
Doctors Community	100	640.3	39	626.0	8	25.0	147	1,291.3	3.5
UM-Baltimore Washington	140	882.4	21	207.3	212	286.6	373	1,376.3	3.8
UM-Prince George's	7	16.9	34	459.8	51	81.9	92	558.6	1.5
Howard Co. General	103	521.2	4	31.4	37	80.2	144	632.8	1.7
Holy Cross of Silver Spring	202	1305.4	44	804.2	31	64.2	277	2,173.8	6.0
UM-Laurel Regional	27	93.1	19	219.2	6	11.7	52	324.0	0.9

Source: August 3, 2018 Completeness Response, p. 5 and MEIMSS Region V – County/Hospital Alert Tracking System
NOTES:
Yellow Alerts – ED temporarily requests that it receive absolutely no patients in need of urgent care because ED is experiencing a temporary overload such that priority II and II patients may not be managed safely.
Red Alerts – Hospital has no monitored (electrocardiogram) beds available.
Other Alerts – ED is on reroute due to the lack of an available bed or the ED reports that it has suspended operation due to a situation such as a power-outage, fire, gas leak, bomb scare, etc.

UM Capital Regional Health does not currently operate an urgent care center in the area. However, the applicant identified 22 urgent care centers within approximately ten miles of the Laurel campus. UM CRH is in discussions with ChoiceOne, UMMS's urgent care partner, concerning the opening of an additional urgent care center in the area.

The applicant states that "despite the presence of these urgent care centers, emergency department visits at area hospitals have not declined sufficiently to warrant the closure of emergency services on the UM LRH campus."[9] The applicant also pointed to the limited hours of operation of these urgent care centers and observed that such operations do not provide an alternative for patients experiencing emergency medical conditions during after-hours. The applicant conclude that the development of UM Laurel Medical Center with the proposed level of beds and ancillary equipment is critical to ensure continued access to emergency and observation services for the service area population. (Laurel Exemption Request, pp. 23-25).

UM Capital Region Health established a Community Engagement Team to educate the community on the proposed FMF. This education included the development and dissemination of materials on when care should be sought from urgent care centers versus when care should be sought from an emergency room. This material was also shared with local primary care offices. UM-CRH states that it intends to continue such educational activities to ensure that the community is aware of the appropriate lower cost alternatives to emergency care such as urgent care, primary care, and specialist services

The applicant assessed the availability and accessibility of emergent and urgent care available to the population to be served as required by this subsection. In summary, the applicant concluded that the other area emergency departments would have difficulty accommodating the UM LRH's ED volume due to the amount of time such departments were on various alerts that restrict visits. The applicant also pointed to the inability of urgent care centers to meet the needs of patients seeking care during the hours in which these centers are closed.

(c) Demonstrate that the proposed conversion is consistent with the converting hospital's most recent community health needs assessment;

A UM LRH's community health assessment report was prepared as a collaboration with other area hospitals and the Prince George's County Health Department. It can be viewed at Exhibit 10 of the request. The applicant states that "conversion of UM LRH to an FMF will support and advance UM CRH's objectives to improve community health. UM CRH is developing more health initiatives directed toward promoting prevention and raising awareness of risks associated with health conditions such as asthma, diabetes, and mental health." UM CRH states that it "has also worked with local and state health officials to develop and implement programs that address the County's health plan goals."

"Priority community health needs" identified in this needs assessment were behavioral health services, services addressing metabolic syndrome, and cancer. Hospital-specific

[9] Request for Exemption, pp. 24-25.

"Community Health Implementation Plans ('CHIP')" were developed to elaborate on the community health assessment. The UM LRH priorities, in its specific plan, were:

- "Priority Area 1: Social Determinants of Health Risk Factors The objectives under this priority are: (1) raise awareness about health risk factors, health promotion, and wellness; (2) promote engagement in primary care and behavioral health services; and (3) raise awareness about mental, emotional, and behavioral risk factors. The CHIP activities for this priority include health education and prevention programing, nutrition education, linkage to care (primary and specialty), health screenings, and peer support programs;

- Priority Area 2: Physical Health and Chronic Disease Management The objectives for priority area 2 are: (1) increase evidence-based screening, education, referral and/or treatment services for adults with chronic disease; (2) identify condition-specific priorities and barriers to care coordination; (3) develop and implement enhanced care coordination plans for chronic disease patients discharged from the hospital; (4) promote enhanced primary care follow-up and home care services; (5) partner with elder services programs to enhance linkages to care; and (6) reduce 30 day emergency department and inpatient admissions. To achieve the objectives, activities and programs focus on chronic disease self-management, care transitions and care coordination through partnership and collaboration with community providers; and

- Priority Area 3: Behavioral Health The CHIP includes the following objectives related to behavioral health: (1) improve behavioral health screening and identification protocols; (2) develop an internal strategy to address behavioral health needs of the community; (3) create a resource inventory of mental health and substance abuse providers to streamline the referral process; (4) reduction of hospital length of stay; and (5) educate the public about behavioral health risk factors and other behavioral health and wellness issues. The activities to achieve the objectives are designed to refine behavioral health infrastructure to better serve the community, improve education and awareness to reduce stigma, integrate primary care and behavioral health screening and treatment services, and more effectively coordinate to improve referrals and access to behavioral health services in clinical and community settings."

The applicant describes an FMF in Laurel as "partnered with an array of other outpatient health services." Beyond the FMF's provision of outpatient medical and surgical services, the applicants state that the FMF will be a venue for "health education and preventive health programs to address the identified needs of the Laurel community. Services provided on the campus of the FMF and at a variety of community locations will ensure appropriate access to care and community-based resources to improve the overall health of residents within Laurel and surrounding communities."

Staff's review suggests that the proposed project does not appear to be inconsistent with the community health needs assessment developed for Prince George's County or the more local plan that elaborated on the County plan at the UM LRH service area level. There does not appear to be a direct connection between addressing the identified priorities and the conversion of a

general hospital to an FMF. CRH can use any of its health care facilities, including FMF campuses, to support many of the priorities it has identified. A direct connection between a facility transition project such as the one under review and the issues that tend to be top priorities in a community health needs assessment would not be expected. Staff recommends a finding that the proposed FMF complies with this standard.

(d) Demonstrate that the number of treatment spaces and the size of the FMF proposed by the applicant are consistent with the applicable guidance included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future*, published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume.

(i) Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces.

(ii) Demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage.

Emergency Department Design: A Practical Guide to Planning for the Future, published by ACEP, is commonly referred to as the "ACEP Guidelines." Its two iterations have been incorporated by reference in the State Health Plan since 2009. MHCC referenced these ED planning guidelines in the FMF Chapter in order to provide applicants and the Commission with a basis for evaluating the appropriate space and service capacity needs for an FMF, even though the guidelines were specifically developed as guidelines for hospital ED planning and not freestanding emergency centers.

The guidelines set forth estimates of the number of treatment spaces and the departmental space appropriate for a range of projected annual ED visit volumes for EDs with low to high range operating characteristics. The position of an ED on the low to high range operational spectrum is determined on the basis of 16 factors such as percentage of admitted patients, length of stay in the ED, location of observation space, percentage of behavioral health patients, percentage of non-urgent patients, and age of patients, as well as the presence of specialty units within the ED. If an ED ranks high on more of the factors, space and treatment capacity should be planned for the number of treatment spaces and square footage called for in the high range estimate for a given volume. If an ED ranks on the low range for more factors, the low range guidance should apply. The guidelines also identify medium measures for each factor but not space and the number of treatment spaces. If the facility ranks in the mid-range for more factors the number of treatment space and the amount of space should fall in between the low and high range.

The applicant proposes to operate 27 treatment spaces initially, including four rooms dedicated to behavioral health, in the existing hospital building. The new building to be constructed in Phase 2 will include 17,960 BGSF for emergency services including behavioral

health and will have 24-27 treatment spaces, depending on what is recognized as a "treatment space." The applicant states that the new ED will have 20 treatment spaces but this count excludes behavioral health treatment spaces and does not include a trauma/resuscitation room or the two-triage rooms. The ACEP Guidelines treatment space count clearly includes resuscitation rooms and care initiation rooms. The applicant also compared the number of treatment spaces and the size of the behavioral health area separately from the rest of the ED, which is not an approach outlined in the guidelines. The comparisons made to the ACEP guideline values were made to a calculated mid-range as opposed to the low range specified in the standard.

Staff has evaluated the methods and results of the applicants' approach to demonstrating consistency with the ACEP guidelines in terms of the number of treatment spaces and building space. Staff's assessment is that the applicants have deviated from the guidelines with respect to the treatment spaces planned for the FMF but that the building space proposed does not exceed the ACEP planning guidance. Using a more conservative projection of visit volume which staff believes is more realistic and the low range guidance recommended by the FMF Chapter as appropriate for FMFs, yields a treatment space target of 18 spaces. CRH is proposing an FMF with 24 treatment spaces, exclusive of the trauma/resuscitation rooms and two triage rooms, the latter of which have not historically been viewed as equivalent to ED treatment spaces in Maryland CON regulation. The standard allows justification of treatment capacity that exceeds the low range guidance "based on the particular characteristics of the population to be served." In this case, the applicant's demonstration is more focused on an assumption that replacing a general hospital with an FMF will not significantly change the visit volume or the types of visits recently experienced by the general hospital.

Despite the apparent excess capacity that staff believes has been planned for the project, based on the standard, staff does not recommend denial of this project based on this planned capacity and the standard. Staff is mindful that a project of this type, in which a freestanding emergency center is replacing a general hospital, has not been implemented in Maryland before. The capital cost savings achievable by marginally reducing the number of treatment spaces in a project such as that proposed would not be great. And a deviation from the ACEP guidance that the applicant used to account for peak levels of demand, which was a significant factor in raising the number of treatment spaces programmed for the FMF above the ACEP guidelines target, may have some merit. While ACEP's guidance assumes that ED capacity will not be immediately available at all times (up to 20% of the time), CMS has reported that Maryland has some of the longest hospital ED wait times in the nation[10] and staff believes it is rational for CRH to seek to assure a successful launch of an alternative emergency venue in Laurel that will not regularly frustrate patients with long waits for evaluation and treatment. Thus, staff recommends finding that the proposed capacity of the FMF is acceptable, in view of the analysis presented by the applicants in the request for exemption from CON review.

Staff's perspective on the proposed capacity and space is summarized in the following pages. Staff's chief concerns with respect to the applicants' analysis are as follows:

[10] https://projects.propublica.org/emergency/

(1) Use of the mid-range as opposed to the low range, as called for in the exemption requirement, was not definitively demonstrated as appropriate. Specifically, in making the projections of visit volume, the applicant does not appear to have made any adjustment for higher acuity patients that would no longer be brought to or self-seek care at the Laurel FMF, because it will not be a hospital ED;

(2) For purposes of determining the number of treatment spaces, the applicant adjusted the visit forecast to account for peak use, even though the ACEP guidance takes such variation into account; and

(3) Regarding the use of a mid-range comparison instead of a low range comparison, the applicant compared the operation of the current ED at UM LRH to the 16 ACEP guidelines factors instead of comparing the likely characteristics of how the FMF's emergency unit should operate.

To demonstrate consistency with the ACEP guidelines, the applicant first projected future visit volume at the proposed FMF. Then the applicant evaluated the operations of the UM LRH ED against the 16 factors used in the ACEP guidelines to classify the ED operations as low, medium, or high.

In projecting future ED visit volume, the applicant separated behavioral health visits from other visits starting in FY 2019 and further adjusted the volume in FY 2020 for the expected opening of the relocated Washington Adventist Hospital, which, as noted, will be the closest general hospital to the proposed Laurel FMF site when completed. In FY 2020, the applicant projects 21,704 general ED visits and 1,904 behavioral health visits. These projections are based on the 26,533 actual FY 2017 visits experienced by UM LRH and a projected visit volume of 25,683 visits in FY 2018 (based on annualization of year-to-date visits at the time the request was prepared). This represents a 2.5% reduction in visits from the previous year. The applicant assumed no change in visit volume for FY 2019 followed by an 8.7% reduction in FY 2020 related to the relocation of WAH. This estimated reduction was calculated by using a drive time analysis during rush hour and non-rush hour from each zip code area in the UM LRH ED service area. The applicant did not make any adjustment for high acuity patients that would no longer be transported to the FMF. The applicant's projections are detailed in the following table.

Table 5
Historic and Projected Emergency Department and FMF Visits
UM Laurel Regional Hospital and UM Laurel Medical Center
FY2017 – FY2024

	Hospital ED Actual	Hospital ED Projected	FMF Projected Operating in Existing Building			FMF Projected in New Facility	
Visits	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Inpatient	2,897	2,824	2,824	2,824	2,824	2,824	2,824
Outpatient	23,636	23,039	23,039	23,039	23,039	23,039	23,039
Total without changes	26,533	25,863	25,863	25,863	25,863	25,863	25,863
Year-to-Year Change	-7.3%	-2.5%	0.0%	0.0%	0.0%	0.0%	0.0%
WAH Impact Adjustment				-2,254	-2,254	-2,254	-2,254
Adjusted Visits	26,533	25,863	25,863	23,608	23,608	23,608	23,608
Behavioral Health Visits			1,904	1,904	1,904	1,904	1,904
Total Less BH Visits			23,959	21,704	21,704	21,704	21,704

Source: UM Laurel Regional Hospital Exemption Request, p. 34

The applicant states that using the ACEP Guide is problematic in that it addresses only the average number of patients in the emergency department in a year to guide planning for the number of emergency department treatment spaces.[11] The applicant further states that the guide does not address the peak number of patients in the emergency department, each of which will require a treatment space. UM LRH reports that from January through June 2017 the peak number of non-behavioral health patients in the emergency department during the 9:00 pm hour was 21.3, 26.8% higher than the average of 16.8 patients per day. To account for this fluctuation in demand, the applicants adjusted the projected non-behavioral health visits detailed above by 27% and, therefore, applied the ACEP guidance for the number of treatment spaces based on a projection of 25,000 to 30,000 visits instead of the approximate 22,000 they actually project.

This approach does not appear to be consistent with ACEP Guide, which addresses the issue of variations in hourly utilization (page 108 of the ACEP guidelines) and recognizes that such spikes could be as much as 25% to 30% above average, but states that this does not mean that an ED should be designed to accommodate all spikes. ACEP indicates that formulas include some flexibility and, if calculated correctly should have adequate treatment capacity 80% to 90% of the time. While some adjustment may be appropriate, to be consistent with the guidance, the applicant would need to show that the number of treatment spaces derived from using the guidelines would not result in adequate treatment spaces to meet patient needs 80 to 90 percent of the time.

To characterize the future operations of the proposed FMF, the applicant evaluated the operations of the UM LRH against the 16 factors used in the ACEP guidelines to classify the ED operations as low, medium, or high range. As presented in the following table, seven or 43.8% of the 16 factors fell in the "mid-range", five in the low range, and four in the high range. Staff questioned why a new setting for emergency care detached from the general hospital setting could not be planned so as to improve performance on some of these operational characteristics. The response was not persuasive.

[11] Request for exemption, p. 36.

Table 6
UM LRH ED Comparison to ACEP Guidelines

Indicators for Adult ED	Low Range	Mid-Range	High Range	Proposed FMF
% Admitted Patients	<8%	12% to 20%	>25%	Mid-Range
Average length of stay	<2.25 hours	2.5 to 3.75 hrs	>4 hours	High
Private rooms	Fewer	Majority	All	High
Inner waiting & result waiting areas	Available	Limited	None	Low
Location of observation beds	Outside ED	Limited # within	Inside ED	Low
Boarding of admitted patients	Stay < 60 Min.	Stay 90 to 120 Minutes	> 150 Minutes	High
Turnaround time Dx tests	<45 Minutes	60 Minutes	>90 minutes	Mid-Range
Percentage of behavioral health patients	< 3%	4% to 6%	> 7%	High
% non-urgent patients	>45%	25% to 45%	<25%	Mid-Range
Age of patients	<10% Age 65+	10 to 20% 65+	>20% Age 65+	Mid-Range
Imaging within ED	No	General & CT	Extensive	Mid-Range
Family amenities	None	Limited	Multiple	Mid-Range
Specialty components: geriatrics	None	Designated Area	Module with Support	Low
Specialty components: pediatrics	None	Designated Area	Module with Support	Low
Specialty Components: detention	None	Designated Area	Module with Support	Low
Admin or Teaching Space	Minimal	Moderate	Extensive	Mid Range

Source: *Emergency Department Design: A Practical Guide to Planning for the Future* Published by the American College of Emergency Physicians and Applicants Request for Exemption, p. 36

The applicant found that for the adjusted 25,000 to 30,000 ED visits, exclusive of behavioral health visits, operating at the low range the current ACEP Guide calls for 18 to 21 treatment spaces and at the high range the guide calls for 20 to 25 treatment spaces. The applicant characterized the UM LRH ED has being in the mid-range based on the 16 factors. Taking the average of the low range and high range treatment spaces results in a range of from 19 to 23 treatment spaces. The applicant states that, exclusive of behavioral health spaces, the proposed FMF would operate with 23 treatment spaces in the existing hospital building and, ultimately, 20 spaces after it relocates to the new building. The 23 treatment spaces are at the high end of the range. At 20 treatment spaces the proposed ED in the new building would be within the range suggested by ACEP.

From the ACEP guidelines, the applicant determined that the departmental gross square feet ("DGSF") per treatment space should be 800 SF at the low range of operations and 875 SF at the high range of operation for an average of 838 SF per treatment space and a total of 16,750 DGSF. For new construction, the ACEP Guide suggests using building gross square feet at 1.25 times DGSF. Thus, the applicant calculated that the guide calls for 20,938 BGSF for the proposed 20 treatment spaces in the new building, which is greater than the proposed 17,960 BGSF that also includes the four additional treatment spaces for behavioral health.

As previously noted, the applicant made no adjustment for a reduction in higher acuity patients that are not likely to be brought to or seek care in the proposed FMF. Therefore, staff believes that a projection of approximately 20,000 visits is more appropriate for purposes of using the ACEP benchmarks. Also as noted, staff believes that the ACEP benchmarks incorporate consideration of variation in hourly visit volume[12] and that extraordinary adjustments such as that used by the applicants is not consistent with the guidelines. Staff would expect a lower proportion of ED patients to be admitted from the proposed FMF than is seen for the current hospital ED and a lower average stay in the FMF (currently reported as greater than 4 hours in the UM LRH ED). Staff would also expect the time experience by the hospital for patients boarded in the ED (currently greater than 150 minutes) to drop in the FMF setting and believes it is highly likely that the FMF operation will see a higher proportion of non-urgent patient visits than the hospital ED.

For 20,000 visits at a low range of operation, the ACEP guidelines call for 14 treatment spaces including five care initiation rooms and one resuscitation room. Regarding the size of the ED, the ACEP Guide specifies an average of 825 DGSF for 20,000 visits at the low range for a total of 11,550 DGSF and 14,438 BGSF. While the proposed number of treatment spaces is higher than called for in the guide for this visit volume at a low range of operation, to evaluate the consistency of the proposed 17,960 BGSF requires consideration of the space required for behavioral health ED patients.

In order to demonstrate consistency with the current ACEP guidelines, the applicant made a separate comparison to the guide for the proposed four-room behavioral health unit. However, the applicant found this comparison difficult because of the relatively small number of visits and the average length of stay experienced by the behavioral health emergency patients. While the projected visit volume is 1,904, the number of treatment spaces and the square footage set forth in the ACEP Guide starts with 10,000 annual visits. Regarding length of stay, according to ACEP, a high range ED would have an ALOS of greater than four hours. However, the applicant reports that the peak average length of stay for behavioral health ED patients at UM LRH from January to June 2017 was 15.4 hours.

With a peak average length of stay of 15.4 hours per visit, the applicant calculated that the average daily census in the behavioral health treatment area will be 3.5 patients. The applicant then assumed an occupancy rate of 95% and calculated a need for four behavioral health emergency department treatment spaces. To calculate the amount of needed space, the applicant took the average DGSF per space for low and high range called for in the ACEP guidelines for 10,000 annual visits (825 DGSF at the low range and 875 DGSF at the high range) to arrive at an average of 850 DGSF per treatment space and a total of 3,400 DGSF. The applicant then applied the 1.25 multiplier specified in the guide to arrive at a total of 4,250 BGSF for the behavioral health space.

While staff concludes that the four treatment spaces proposed for behavioral health are reasonable, the projection of 1,904 behavioral health visits appears a bit high given that it assumes that over eight percent of the total FMF visits will be behavioral health patients, even though UM

[12] The applicants projected a visit volume of 21,704 but used a visit volume of 27,499 visits for comparison purposes (21,704 times 1.27 to account for peak hour variations).

LRH reported that in FY 2016 and 2017, 6.7% of its ED visits were for behavioral health. Staff is skeptical of the application of the 95% occupancy rate to an average daily census based on the peak average length of stay. However, excluding the 95% factor would not change the projection of a need for four beds. The use of the average of the low and high range to determine consistency with ACEP is reasonable given the long length of stay.

Combining the applicant's calculation of the number of treatment spaces and BGSF for the behavioral health unit with staff's assessment of what the guidelines indicate for treatment capacity based on a more conservative visit expectation yields a projected need for 18 treatment spaces and 18,688 BGSF. Therefore, the proposed FMF, with at least 24 treatment spaces and just under 18,000 BGSF is high on capacity but within the guidelines with respect to emergency unit space. As previously noted, staff recommends a finding that the applicant has demonstrated why the additional treatment capacity is appropriate.

(e) Demonstrate that the proposed number and size of observation spaces for the FMF are consistent with applicable guidance included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future,* published by the American College of Emergency Physicians, based on reasonably projected levels of visit volume and average patient time in observation spaces.

(i) Demonstrate that the FMF will achieve at least 1,100 visits per year per observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of observation spaces;

(ii) Demonstrate that the size of each observation space does not exceed 140 square feet, exclusive of any toilet or bathing area incorporated into an individual observation space, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for larger observation spaces.

The applicant projects 1,984 observation visits in FY 2019 and 1,822 such visits in the five fiscal years following the relocation of WAH to the White Oak site. The proposed FMF is designed for ten observation rooms of 260 SF in the existing hospital building. The new FMF building is designed to have ten observation rooms, eight of 170 SF in size and two rooms of 215 SF, to accommodate bariatric patients.

The applicant pointed to the following guidance in the ACEP guideline:

> [G]enerally program[s] [clinical decision unit or observation] spaces in the range of 900 to 1,100 patients per space annually. Use the lower number if your patients use the [clinical decision unit] for 12+ hours, and use the higher number if your patients use the space for 8 to 12 hours. [13]

[13] *Emergency Department Design A Practical Guide to Planning for the Future,* second edition, 2016, p. 273

The applicant reports that UM LRH had 1,369 observation cases in FY 2016 and 1,443 such cases in FY 2017. Almost all (96%) of these cases came through the ED. The applicant also reports that the average length of stay for these cases was about 24 hours. UM LRH projected the need for FMF observation treatment spaces based on expected changes in the emergency department visits, including a reduction in fiscal year 2020 with the opening of the new WAH facility nearby in White Oak, and increases in ED visit volume as follows:

- A 2% increase is projected in placement of ED patients in observation beds to preserve ED throughput due to the elimination of inpatient beds;
- An increase in the number of projected observation patients due to a reduction in potentially avoidable utilization (PAU) of inpatient care; and
- A higher number of higher acuity outpatient surgical cases that will require an overnight stay in the observation unit.

With these adjustments, UM CRH projects 1,984 observation cases in FY 2019 and 1,822 observation cases for the years 2020 through 2024, as shown in the following table.

Table 7
Historic and Projected Observation Cases, UM LRH and UM Laurel Medical Center
FY 2017 to FY 2023

	Actual Hospital	Projected Hospital	Projected FMF in Existing Hospital Building			Projected FMF in New Facility	
Observation Cases	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Inpatient	296	289	289	263	263	263	263
Outpatient	1,447	1,118	1,118	1,021	1,021	1,021	1,021
Total without Adjustments	1,443	1,407	1,407	1,284	1,284	1,284	1,284
Impact of No Inpatient Beds			427	387	387	387	387
Reduction in PAU			101	101	101	101	101
Extended Outpatient Surgery Recovery			50	50	50	50	50
Total	1,443	1,407	1,984	1,882	1,882	1,882	1,882
Year-to-Year Change	-7.56%	-2.5%	41.1%	-8.2%	0.0%	0.0%	0.0%

Source: UM Laurel Regional Hospital Exemption Request, p. 43.

While staff can understand why the transition to a freestanding emergency center with no associated inpatient facilities might be viewed as likely to lead to more observation cases and longer stays, staff also believes that this transition will cause some ED visits that might otherwise have occurred in Laurel to migrate to remaining area hospitals and result in more observation stays at these hospitals rather than at the Laurel site. Staff also does not understand why there would be an increase in the number of projected observation patients due to a reduction in potentially avoidable utilization of inpatient care when there will no longer be any potential inpatient care that is not transported away from Laurel. Finally, with regard to the higher acuity surgery cases that the applicant maintains will require an overnight stay, staff does not understand why the number would increase simply because the site of the surgical facility is transitioning from a hospital setting to a freestanding surgical venue.

In addition to adjustments to the projected number of observation cases, UM CRH also expects that the average length of stay ("ALOS") of the observation cases will increase by 25% to

31.1 hours (1.3 days) beginning in 2019. The reason given for this projected increase is that, currently, borderline acuity inpatients are placed in observation and, in some cases, are ultimately denied for that level of care and that inefficiencies or social determinants have caused some observation patients to be prematurely changed to inpatient status due to delay in the discharge process. The implication here is that an observation service operating within the FMF setting will see a reduction in short-stay observation patients and an increase in the length of stay of certain observation patients when compared with how such patient would be managed in the general hospital setting, thus increasing the ALOS.

UM CRH states that, due to the current and projected observation lengths of stay, the proposed FMF will not be able to achieve 1,100 visits per year per observation space. This level of utilization would require an average daily census of three and an average length of stay of eight hours. Such a length of stay is inconsistent with UM LRH's recent experience and, as noted, CRH is projecting a significant increase in observation ALOS. The applicant states that applying the standard of

> 1,100 visits per year per observation space would result in only two (2) observation spaces at UM Laurel Medical Center, which would be grossly inadequate to serve the needs of the service area population and overwhelm other area hospitals with transfers from UM Laurel Medical Center for patients who could otherwise be safely and effectively observed at UM Laurel Medical Center. This would result in significant increased costs to the health care delivery system in the form of inter-facility ambulance transfers. Such transfers could also jeopardize patient care outcomes and patient satisfaction. Moreover, the increased number of transports resulting from a lack of observation treatment spaces at UM Laurel Medical Center would be certain to burden EMS providers.[14]

Staff agrees that achieving the standard of 1,100 visits per year per observation space is not realistic given the average lengths of stay that UM LRH has experienced.

For the reasons set forth above, the applicant used a forecast methodology that accounted for longer length of stay and a lower occupancy rate. Because there will be no MSGA beds to accommodate any overflow of observation cases and because any overflow of observation cases would necessitate potentially unnecessary inter-facility transports, a 70% occupancy rate target was used in the forecast model.[15]

Given the assumptions described above and the needs and characteristics of the population to be served, UM CRH projects the need for ten observation spaces in fiscal years 2019 through 2024. While demand for observation beds in Maryland hospitals has grown rapidly in recent years, as hospitals aggressively pursued reductions in short-stay admissions that were once common in hospitals, MHCC staff does not have confidence that the assumptions employed by the applicant to project a significant increase in demand for observation stays at a site that transitions from a

[14] Applicant's request for exemption, p. 44.
[15] This occupancy assumption is based on the State Health Plan for Acute Care Hospital Services, COMAR 10.24.10, which provides the minimum occupancy standard for MSGA services with average daily census of 0-49 patients.

hospital to a freestanding emergency center are reasonable. However, even if there is no increase in observation demand as a result of the transition, experiencing a level of demand similar to that experienced by UM LRH in recent years, would still require seven to eight beds if an average bed occupancy rate of 80% is a reasonable occupancy rate target. Staff concludes that this target and a ten-bed observation unit is reasonable in light of the novelty of this project and the attendant uncertainty that produces.

Table 8
Historic and Projected Demand for Observation and Bed Capacity
UM LRH and UM Laurel Medical Center
FY 2017 to FY 2024

	Actual Hospital		Projected Hospital	Projected FMF in Hospital Building			Projected FMF in New Facility		
	2016	2017	2018	2019	2020[1]	2021	2022	2023	2024
Observation Days	1,369	1,451	1,415	2,568	2,358	2,358	2,358	2,358	2,358
Year-to-Year Change		6.0%	-2.5%	81.5%	-8.2%	0.0%	0.0%	0.0%	0.0%
Average Daily Census	3.8	4.0	3.9	7.0	6.5	6.5	6.5	6.5	6.5
Bed Occupancy Target	70%	70%	70%	70%	70%	70%	70%	70%	70%
Need for Observation Beds	5.4	5.7	5.5	10.1	9.2	9.2	9.2	9.2	9.2
Proposed Observation Beds				10	10	10	10	10	10

[1] Reflects loss of ED visits to AHC White Oak Medical Center (replacement WAH)
Source: Table 18, Request for Exemption from CON Review

The applicants have also planned observation rooms that, for most of the rooms, exceed the 140 SF guidance of the standard by 30 SF. The two bariatric rooms are substantially larger (54%) than the 140 SF guidance but, by definition, this space premium is directly related to the characteristics of the patients for whom the rooms are designed. As with the treatment capacity analysis noted earlier in this report, the scale of this project means that requiring strict compliance with the standard's space guideline would only reduce overall room space by less than 400 SF.

Staff recommends a finding that the ten observation beds proposed for the FMF are compliant with this standard.

(f) Provide utilization, revenue, and expense projections for the FMF, along with a comprehensive statement of the assumptions used to develop the projections, and demonstrate that:

(i) The utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area;

(ii) The utilization projections for rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are consistent with the observed historic trends by the population in the FMF's projected service area.

(iii) The revenue estimates for emergency services and other outpatient services specified by the HSCRC under Health-General Article §19-201(d)(iv)

and COMAR 10.37.10.07-2 are consistent with utilization projections and the most recent HSCRC payment policies for FMFs;

(iv) The staffing assumptions and expense projections for emergency services and any other rate-regulated outpatient services under Health-General Article §19-201(d)(ii) and (iv) and COMAR 10.37.10.07-2 are based on current expenditure levels, utilization projections, and staffing levels experienced by the applicant hospital's ED and with the recent experience of similar FMFs; and

(v) Within three years of opening, the combined FMF and parent hospital will generate net positive operating income.

With respect to Paragraph (f), the applicant very recently filed revisions to the exemption request to reflect the actions taken by HSCRC, including revised financial projections for the FMF covering the fiscal years 2019 through 2024 that reflect the agreement by HSCRC staff and the hospitals on the rate structure for the additional outpatient services of the proposed FMF. This updated pro forma schedule of projected revenues and expenses is provided in Appendix 3. As previously noted, as well, these projections show that the FMF is projected to sustain operating losses throughout the projection period, slightly exceeding $3 million in the full fiscal years of 2020 and 2021 when the FMF is projected to be operating in the reconfigured physical plant of UM LRH, and smaller losses in FY 2022 to FY 2024 (averaging $2.6 million during those three years) when the FMF is projected to be operating in its newly constructed building. However, the applicant projects modest positive cash flow throughout the projection period, i.e., the non-cash expenses of depreciation and amortization are projected to exceed the operating loss projections in each year. Importantly, these losses appear to be sustainable for the overall UM Capital Region Health operations, as reflected in the financial schedule for overall UM CRH operations also included in Appendix 3.

With respect to Subparagraph (f)(i), the basis for the applicant's projection of emergency services was reviewed earlier in this report. As noted, the applicant projects that visit volume will stabilize quickly at the proposed FMF after completion of the new general hospital in the White Oak area of Silver Spring at a level approximately nine percent below recent visit levels at the UM LRH emergency department, which saw substantial declines in ED visits in recent years.

With respect to Subparagraph (f)(ii), the applicant's assumptions with respect to outpatient surgery are reviewed in the following section of this report. It assumes that the FMF will be successful in attracting more outpatient surgery cases (about ten percent more) than were performed at UM LRH in recent years. Even if no increase is realized and even if demand continues to fall in Laurel, the two-OR capacity would still be identified as needed, based on the optimal capacity assumptions of the SHP. The request states that laboratory and imaging services are projected "to grow and decline in relation to the projection of emergency and observation patients" developed for the project. The applicant's project that behavioral health visits will more than double, from an average of 241 in FYs 2016 and 2017, to a projected 599 visits by 2024.

With respect to Subparagraphs (f)(iii) and (iv), a review of the project by HSCRC and the work of this agency with UMMS in reviewing the rate assumptions underlying the financial projections developed by the applicants resulted in positive review of the project's feasibility.[16] The applicant identify their hospitals' financial projections as based "on the Capital Region Health (CRH) FY2017 actual financial performance …."[17]

With respect to Subparagraph(f)(v), as previously noted, the combination of the proposed FMF and its parent hospital within the larger CRH system is projected to generate net positive operating income.

(g) Demonstrate that each operating room at the FMF will be utilized at an optimal level within three years consistent with the standards in COMAR 10.24.11 for operating room capacity and needs assessment for dedicated outpatient operating rooms and that the design is consistent with requirements in COMAR 10.24.11 for health care facilities with surgical capacity.

The proposed FMF is designed to have two operating rooms for outpatient surgery. UM LRH reports an inventory of six ORs. Total outpatient surgery cases at UM LRH declined 42.4% from 3,271 cases in fiscal year 2014 to 1,883 cases in fiscal year 2017. However, the applicant states that "with the recent affiliation with UMMS, the decline in UM LRH's outpatient surgery cases are expected to level off and, beginning in fiscal year 2018, UM LRH's outpatient surgery cases are projected to grow with population and capture additional market share."[18] The applicants reports that this affiliation has improved UM LRH's ability to retain its outpatient surgical caseload. The applicant further reports that HSCRC volume reports show that same day surgery volumes from July 2017 to January 2018 are approximately 8% higher than for the same period in the previous year. The applicant projects further growth including an increase in service are market share from 2.9% in fiscal year 2017 to 3.0% by fiscal year 2019. This expected increase is based on discussion with orthopedic surgeons and pediatric dentists that are seeking to expand their surgical practices at UM LRH as documented in Exhibit 11 of the request for this exemption. As a result of growth in population and market share, UM LRH projects that the UM Laurel Medical Center will see 2,074 surgical cases by fiscal year 2024 as detailed in the following table.

[16] See pp. 9-12, *supra*.

[17] Statement of assumptions included with financial schedules in the request for exemption from CON review.

[18] Request for exemption, p. 54.

Table 9
Historic and Projected Outpatient Surgery Cases
UM LRH and UM Laurel Medical Center
FY2017 – FY2024

	Hospital	FMF in Hospital Building				FMF in New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
Population	1,925,341	1,943,616	1,962,064	1,980,688	1,999,488	2,018,467	2,037,626	2,056,967
Year-to-Year Change	1.1%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%
LRH/FMF Market Share	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Year-to-Year Change	-4.1%	0.0%	1.5%	1.5%	0.0%	0.0%	0.0%	0.0%
LRH/FMF Cases								
Service Area	1,606	1,621	1,662	1,703	1,720	1,736	1,752	1,769
Out of Service Area	270	280	287	294	297	299	302	305
Total	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
Year-to-Year Change	-5.2%	0.9%	2.5%	2.5%	0.9%	0.9%	0.9%	0.9%

Sources: Table 26, Request for Exemption from CON Review
Population: Claritas
FY 2017 Cases: St. Paul Group.

The applicant reports that, in fiscal year 2017, the 1,883 surgical cases required 130,737 minutes or an average of 69.4 minutes of OR time per case. This average time per case is projected to continue through fiscal year 2024. Added to the surgical time is an assumed 25 minutes per case for turnaround time as set forth in the General Surgical Services Chapter of the State Health Plan, COMAR 10.24.11.06.A.(2)(a). Applying the surgical and turnaround times to the projected surgical cases demonstrates the need for two operating rooms throughout the projection period as detailed in the following table.

Table 10
Historic and Projected Operating Room Need
UM LRH and UM Laurel Medical Center
FY2017 – FY2024

	Hospital	Projected FMF in Hospital Building				Projected FMF in New Facility		
	2017	2018	2019	2020	2021	2022	2023	2024
LRH/FMF Cases	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
Average Minutes per Case								
Surgical	69.4	69.4	69.4	69.4	69.4	69.4	69.4	69.4
Turnover	25.0	25.0	25.0	25.0	25.0	25.0	25.0	25.0
Total Minutes/Case	94.4	94.4	94.4	94.4	94.4	94.4	94.4	94.4
Total Minutes	177,812	179,500	183,990	188,593	190,383	192,190	194,014	195,856
Optimal Capacity Minutes [1]	97,920	97,920	97,920	97,920	97,920	97,920	97,920	97,920
Operating Room Need	1.8	1.8	1.9	1.9	1.9	2.0	2.0	2.0
Year-to-Year Change	-2.8%	0.9%	2.5%	2.5%	0.9%	0.9%	0.9%	0.9%
Proposed FMF ORs			2	2	2	2	2	2

Note: from the SHP, based on 80% of eight hours per day, five days per week, 51 weeks per year
Source: Table 27, Request for Exemption from CON Review

With respect to design of the surgical facilities, the applicant submitted a letter from the architectural firm Wilmot Sanz attesting that the design of the UM Laurel Medical Center, including the outpatient operating rooms, is consistent with the FGI Guidelines.

(h) Demonstrate that the proposed construction cost of the FMF is reasonable and consistent with current industry cost experience in Maryland, as provided in Regulation .04B(5) of this chapter.

The applicant responded to this standard by providing an analysis of the project construction cost estimate with a benchmark cost based on the Marshall Valuation Service guidance on hospital costs, given that the facility will be built to hospital standards. Its analysis yielded an adjusted project cost estimate of $395 per SF, within a few dollars of the calculated MVS benchmark cost ($398). Staff found the construction cost analysis undertaken by the applicant to be reasonable and recommends that the Commission find the project to consistent with this standard.

(i) Demonstrate that the conversion to an FMF will result in the delivery of more efficient and effective health care services including an explanation of why the services proposed for the FMF cannot be provided at other area hospital EDs, FMFs, or other health care facilities, and demonstrate why other less expensive models of care delivery cannot meet the needs of the population to be served.

The applicant observes that "the current UM LRH facility is not an efficient or cost effective solution for continuing to provide needed services to residents of its services area." The applicant states that the hospital is inappropriately sized for its use levels and, thus, too costly to operate and maintain; however, it believes that simple closure is not a reasonable approach to fixing this problem, because this alternative would degrade accessibility for certain important service in the hospital's local service area and create problems for hospital EDs in the region.

Staff concludes that the applicant has demonstrated the relationship between the proposed project and its likely impact on improving the efficiency and effectiveness of local health care delivery. There is a strong basis for finding that the proposed project will help to bring the demand and supply for inpatient services within CRH into a better balance. This will create a more rational CRH system with two satellite emergency centers, both with outpatient campuses providing services other than just emergency and observation, and other additional outpatient service locations. CRH's single hospital will, within a few years, be a new facility with a more streamlined and efficient physical plant than the current UM PGHC and a better geographic location within the market. This will provide potential for more efficient and effective delivery of hospital services than the current CRH configuration of two hospitals, one of which has seen a deteriorating market position and poor performance in recent years.

With respect to cost, HSCRC is seeking to avoid large revenue reductions within a short time frame in order to make the investment required for hospital to FMF transitions feasible. Substantive delivery systems saving will be realized over time, as the staffing, capital, and overhead expenses of FMFs will require substantially less revenue than the hospitals these outpatient facilities replace.

(j) Demonstrate that the conversion is in the public interest, based on an assessment of the converting hospital's long-term viability as a general hospital through addressing such matters as:

(i) Trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends;

(ii) The financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals;

(iii) The age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant;

(iv) The availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility; and

(v) The adequacy and appropriateness of the hospital's transition plan.

(k) Demonstrate that the conversion is in the public interest, based on an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

The applicant believes that UM LRH is not viable as a general hospital, in the long-term, and specifically speaks to the evidence supporting this conclusion, addressing:

- The downward trends in the hospital's inpatient utilization for the previous five years, noting the context of statewide trends;
- The poor financial performance of the hospital over the past five years, again in the context of the statewide financial performance of Maryland hospitals;
- The age of the UM LRH physical plant relative to other Maryland hospitals and the large investment required to maintain and modernize the physical plant;
- The availability of alternative sources for acute care inpatient and outpatient services that will no longer be provided on the campus after conversion to a freestanding medical facility;
- The adequacy and appropriateness of the hospital's transition plan; and
- The parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

It is in the public interest for the health care delivery system to be reconfigured in ways that better match health care facilities' capabilities and capacity to the changes that have been occurring. This project is a major component of the reconfiguration of Dimensions Health System, being led by UMMS, that should advance this objective. Staff has reviewed the bases for this finding and recommends that the Commission find that the proposed project is in the public interest.

(9) The Commission shall grant a requested exemption from Certificate of Need within 60 days of receipt of a complete notice of intent from a general hospital to convert to a freestanding medical facility if the Commission, in its sole discretion, finds that the action proposed:

(a) Is consistent with the State Health Plan;

Staff recommends that the Commission find that the proposed conversion is consistent with the State Health Plan.

(b) Will result in more efficient and effective delivery of health care services;

As noted in its analysis under Subsection (8)(i),[19] MHCC staff concludes that there is a strong basis for finding that the proposed project will help to bring the demand and supply for inpatient services within the CRH System into a better balance. Health care delivery of hospital services and outpatient services will be offered in less costly campus venues through a contraction of the number of general hospitals operating in an area that has good accessibility to other hospitals should result in more efficient and effective delivery of the affected services.

(c) Will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board; and

A positive determination on this criterion was made by the State EMS Board.[20]

(d) Is in the public interest.

As noted in MHCC staff's analysis under Subsection 8(j) and (k), staff concludes that reconfiguration of the hospital system currently operating in northern Prince George's County is in the public interest.

(10) If a general hospital decides that it will close because the Commission denied its request for exemption from Certificate of Need to convert to a freestanding medical facility or because its conversion request was not considered by the Commission as the result of a determination by the State Emergency Medical Services Board that conversion to an FMF would not maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system, the hospital must provide the notice of closure and hold the public informational hearing required by Health-General §19-120 and Commission regulations adopted pursuant to the statute.

This requirement is not applicable in this review unless the request for an exemption from CON is denied.

[19] Beginning at p. 33, *supra.*
[20] See discussion at p. 9, *supra.*

IV. RECOMMENDATION

MHCC staff recommends that the Commission approve the request for an exemption from Certificate of Need to convert UM Laurel Regional Hospital to a freestanding medical facility that will provide rate regulated outpatient services beyond emergency services and observation and will be an administrative unit of UM Prince George's Hospital Center. Staff concludes that the request complies with the applicable criteria and standards established for such conversions.

Maryland law and the FMF Chapter have substantial inter-agency review requirements, public input, and also require applicants to demonstrate the proposed FMF's capacity and space, and, thus, indirectly, its costs. Guidance on the development of emergency department space and observation beds produced by the American College of Emergency Physicians has been incorporated by reference, and the FMF Chapter permits applicants to propose and explain the basis for higher levels of planned capacity or space. The Commission determines if the public interest is served by the project and whether it will result in more efficient and effective delivery of health care services.

Both the Maryland Institute for Emergency Medical Services Systems and the Health Services Cost Review Commission have provided input to MHCC that is supportive of the proposed hospital transition. Thus, the transition of UM LRH to an FMF is not anticipated to cause a disruption in the availability and accessibility of emergency medical services that poses a threat to public safety or health care delivery. Additionally, the project was determined by HSCRC to be financially feasible, as a component of the UM Capital Region Health system, with an appropriate array of outpatient services charging regulated rates, pursuant to a projected rate structure that will be revisited when Phase 2 of the project, in a newly constructed FMF building, will be ready to open.

MHCC staff concludes that the treatment capacity for patients presenting at the FMF (24 beds) and the observation bed capacity (10 beds) proposed for development at the FMF may be excessive when the ACEP guidelines are narrowly applied to a projection that the FMF will receive approximately 20,000 visits per year, which is about 75% of the total ED visits that UM LRH experienced in FY 2017. That FY 2017 visit volume was down 26% from the hospital's ED visit volume in FY 2013. The applicant projects that the FMF will experience a stabilization of visit volume at a level approximately nine percent below the visit total experienced in FY 2017. It has designed the FMF to have 24 treatment spaces, exclusive of a trauma/resuscitation room which the applicants do not count as a treatment room but that would, in staff's view, essentially constitute a 25th treatment room. Using MHCC staff's more conservative view of likely visit volume and discounting other adjustments put forward by the applicant, the needed treatment capacity based on the ACEP guidelines, would be 18 treatment beds or spaces.

The applicant projects a significant increase in observation bed use for the FMF when compared with the recent hospital experience. In both FY 2017 and, as projected for FY 2018, UM LRH saw a little over 1,400 observations cases and, as with ED visits, this service has also seen declining case volume in recent years. It projects stabilized case demand for observation at the FMF at a level 30% higher than the most recent experience of UM LRH by 2020 and longer

observation periods for these cases than is being experienced at UM LRH, also increasing the need for bed capacity. It has designed the FMF for 10 observation beds.

The ACEP guidelines provide less definitive guidance on observation bed capacity. The applicant has made a set of assumptions that, in general, appear to view observation as a service that will naturally increase in volume and intensity at the Laurel site because it will no longer be a site with inpatient hospital beds. Staff is skeptical that this perspective is correct but admit that a range of possible changes can be envisioned when a hospital site transitions to an outpatient site and Maryland has not had experience that would inform staff about the direction in which demand for observation of patients might go under these circumstances.

In an FMF project of this type, requiring changes in capacity for what is already a limited scale of operation provide relatively small benefit and erring on the side of slightly more capacity is probably less harmful than building more conservatively and opening a facility that is overbooked within a short period of time and in need for expansion. While a case can be made that an FMF with 18-20 treatment spaces instead of 24-25 and seven to eight observation beds[21] instead of ten may be adequate, MHCC staff does not believe that imposing changes of this scale in a project of this type and novelty would be advisable.

Finally, MHCC staff concludes that there is a strong basis for finding that the proposed project will bring the demand and supply for inpatient services into a better balance, creating a single hospital system with two satellite emergency centers, both with outpatient campuses providing outpatient health care services other than just emergency and observation. If this project is implemented, CRH's single remaining hospital will, within a few years, be a new facility with a more streamlined and efficient capacity for providing hospital services.

For these reasons, MHCC staff recommends that the Maryland Health Care Commission APPROVE the proposed conversion of University of Maryland Laurel Regional Hospital to a freestanding medical facility.

[21] Operating an observation unit that would not exceed an average occupancy rate of 80% for the observation average daily census reported for UM LRH in FY 2017 would require eight beds.

IN THE MATTER OF	*	**BEFORE THE**
	*	
CONVERSION OF	*	**MARYLAND**
	*	
UNIVERSITY OF MARYLAND	*	**HEALTH CARE**
	*	
LAUREL REGIONAL HOSPITAL TO A	*	**COMMISSION**
	*	
FREESTANDING MEDICAL FACILITY	*	
	*	
Docket No. 18-16-EX002	*	
	*	

*** ***

FINAL ORDER

Based on the Commission staff's analysis and recommendation, it is this 20th day of September, 2018, **ORDERED**:

That the request for an exemption from Certificate of Need to convert the University of Maryland Laurel Regional Hospital to a freestanding medical facility, with Phase 1 of the conversion plan involving the operation of a freestanding medical facility in the existing hospital building and the initiation of construction of a new freestanding medical facility building adjacent to the existing hospital building and Phase 2 of the conversion plan, at an approved expenditure of $53,225,855, involving initiation of freestanding medical facility operations in the new building, which will include 24 treatment spaces, one trauma/resuscitation room, two triage rooms, ten observation beds in single occupancy rooms, and two operating rooms, and will include rate regulation of emergency services, observation services, and other services as ordered by the Health Services Cost Review Commission, is **APPROVED.**

MARYLAND HEALTH CARE COMMISSION

Appendix 1

State of Maryland

Maryland Institute for Emergency Medical Services Systems

653 West Pratt Street
Baltimore, Maryland
21201-1536

Larry Hogan
Governor

Donald L. DeVries, Jr., Esq.
Chairman
Emergency Medical Services Board

410-706-5074
FAX: 410-706-4768

CHS-8210

July 17, 2018

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen,

As you are aware, the University of Maryland Capital Region Health, University of Maryland Prince George's Hospital Center, and University of Maryland Laurel Regional Hospital are seeking approval from the Maryland Health Care Commission to convert the University of Maryland Laurel Regional Hospital to a freestanding medical facility, as well as for an exemption from Certificate of Need (CON) review for the proposed conversion.

The Maryland Health Care Commission will determine whether to approve the request for exemption from the CON requirement based on a number of factors, including whether the conversion "will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services (EMS) Board." Health General 19-120 (o)(3)(i)5C. In making this determination, the State EMS Board is required to consider eleven (11) factors specified in regulation. COMAR 30.08.15.03.

Please be advised that at its meeting on July 10, 2018, the State EMS Board reviewed and discussed an analysis of the COMAR-enumerated factors. After consideration of these factors, the State EMS Board unanimously determined that the proposed conversion of University of Maryland Laurel Regional Hospital to a freestanding medical facility will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system. Attached is a copy of the analysis that provided the basis for the Board's determination.

Please let me know if you have any questions or if I may provide any further information.

Sincerely,

Patricia S. Gainer

Patricia S. Gainer, JD, MPA
Acting Co-Executive Director

Enclosure

Cc: Trudy Hall, MD
Interim President & Vice President
Medical Affairs
University of Maryland Laurel Regional Hospital

Appendix 2

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: September 13, 2018

To: Paul Parker, Director, Health Care Facilities Planning and Development, Maryland Health Care Commission

From: Katie Wunderlich, Executive Director
Gerard J. Schmith, Principal Deputy Director, Hospital Rate Setting, HSCRC

Subject: Request for Exemption from Certificate of Need Review Conversion of University of Maryland Laurel Regional Hospital to a Freestanding Medical Facility

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Overview

University of Maryland Laurel Regional Hospital ("the Hospital," or "Laurel Regional") has requested an exemption from Certificate of Need review for the conversion of its general acute hospital to a freestanding medical facility ("FMF") that has its rates regulated by the Health Services Cost Review Commission ("HSCRC"). The Maryland Health Care Commission ("MHCC") has requested that the HSCRC evaluate the services, in addition to the emergency services, that it will regulate at the FMF. MHCC has also requested that HSCRC review and comment on the feasibility analyses provided by the Hospital.

Background

Project Description

UM Capital Regional Health hospitals, formerly the Dimensions Health System, which affiliated with the University of Maryland Medical System ("UMMS") on September 1, 2017, are undertaking a comprehensive modernization plan that includes construction of a replacement facility for Prince George's Hospital Center ("PGHC") and replacement of Laurel Regional with a new FMF. The new FMF will consist of emergency and observation services in addition to outpatient surgery, outpatient psychiatric services, wound care, and supporting ancillary services.

In July 2018, the HSCRC staff met to discuss the plan for converting Laurel Regional to a FMF. A two-phased conversion is proposed. In the initial phase, on or about October 1, 2018, inpatient rehabilitation services and inpatient chronic services will be relocated from Laurel Regional to PGHC. UMMS filed a partial rate application on August 2, 2018 requesting that the current approved rates for these services be

moved from Laurel Regional's rate order to PGHC's rate order. On or about January 1, 2019, the remaining inpatient medical-surgical, intensive care, and psychiatric services will also be relocated from Laurel Regional to PGHC. Since both facilities have rates for these services, PGHC will not need a new rate center, but it will need to adjust its rates to blend these and supporting ancillary services into its facility rates, while maintaining compliance with the overall global revenue limits. The application also requested combining the two facilities' global revenue limits to facilitate the transition. The HSCRC approved the rate application on September 12, 2018, subject to ensuring that volume reductions at Laurel Regional, not shifting to PGHC, would have a revenue reduction applied of no less than fifty percent (consistent with previous discussions with UMMS). The HSCRC also furth er noted that the Laurel Regional and PGHC project is unique and should not be considered a precedent for future conversions or consolidations, where additional savings would be expected.

Upon completion of the service relocation, Laurel Regional will become an FMF. At that time, its services will be billed as a part of PGHC, under the PGHC provider number. The existing physical plant will be converted to function as a freestanding medical facility, using the existing emergency department facilities, patient rooms for observation, surgical facilities for outpatient surgery, diagnostic imaging facilities, and space for the provision of outpatient behavioral health services and wound care.

At a site adjacent to the existing Hospital, Phase 2 will involve construction of a new physical plant with 24 emergency department rooms, ten observation rooms, a two-operating room ambulatory surgical facility operating under the FMF license, and the other outpatient services provided in Phase 1. Phase 2 is estimated to cost $53.1 million, with $38.1 million funded through debt and $14.5 million funded through a State grant.

Determination Requirements

COMAR 10.24.19, contains two requirements for acceptance of the filed request by MHCC that require action by HSCRC. The first requirement [COMAR 10.24.19.04C(3)(c)(v)] is that, "The applicants receive a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the proposed FMF for which the applicants seek rate regulation." The second requirement [COMAR 10.24.19.04C(3)(c)(vi)] is that, "The applicants receive approved rates from HSCRC for each rate-regulated outpatient service at the proposed freestanding medical facility." The proposed FMF is seeking rate-regulated status for outpatient services beyond the standard emergency and observation services specifically authorized by statute for freestanding medical facilities. In addition to these two services, the proposed FMF is asking for rate regulation of charges for:

1. Ambulatory surgery services;
2. Associated diagnostic and other clinical ancillary services required to support the emergency, observation, and ambulatory surgery services;
3. Partial hospitalization/intensive outpatient behavioral health program services; and,
4. Wound care program services, including hyperbaric oxygen therapy.

Legislation provided flexibility to the HSCRC to make such a determination in order to optimize the services that would be provided at a FMF. For example, facilities in rural areas may have additional services to provide healthcare access, including access to uninsured individuals that might not otherwise be readily available. Other specific circumstances could be considered in determining efficiency, effectiveness and access when evaluating any additional regulated services to provide at a FMF.

Analysis

HSCRC staff met with UMMS representatives and reviewed MHCC documents regarding the rationale for providing each service, in addition to emergency services, in the regulated setting. The HSCRC already regulates diagnostic services that are performed as part of the emergency services provided. Including wound care can support effective follow-up of emergency care to avoid infections, improve recovery and avoid emergency department visits or inpatient hospitalizations. The wound care program can also support other preventive efforts in the service area. Staff understands that partial hospitalization for outpatient psychiatric patients was requested by community representatives. With the All-Payer and Total Cost of Care Model focus on improving community behavioral health, this service request appears consistent with Model goals. Ambulatory surgery, in general, is available in both regulated and unregulated sites. However, UMMS representatives argued that access, particularly for Medicaid patients and higher risk outpatients, would be improved through this service offering. With the emergency back-up and 24-hour observation provided through the FMF, patients with chronic conditions and higher risk factors can be treated. MedPAC, Medicare's Payment Advisory Commission, recognizes that lower severity of patients, as well as a lower proportion of Medicaid patients, are treated in freestanding ambulatory surgery centers (See March 2018 MedPAC Report to Congress, Chapter 5).

Because the severity level of patients coming to Laurel Regional's new surgery center will be higher, HSCRC staff expects to establish rates at the new Laurel Regional facility that are higher than unregulated freestanding ambulatory surgical facilities, but lower than hospitals. The capital and overhead costs of Laurel Regional's new surgery suites in the FMF should be competitive with freestanding competitors. While the HSCRC plans to apply existing hospital rates to the Laurel facility during the transition to an FMF once the new facility is constructed, UMMS will need to file a rate application to establish the rates in the new facility. Staff expects to establish rates for emergency, observation, wound care, and related ancillary services that are consistent with other hospital and FMF center rates. Staff will evaluate the outpatient psychiatric services relative to other outpatient hospital programs. Lastly, staff will require that the rates for the outpatient surgery service be lower than acute hospital rates.

UMMS has submitted financial projections incorporating outpatient surgery rates lower than hospital rate, but higher than freestanding counterparts. The rates provided by UMMS are estimated using Medicare Ambulatory Surgery Center fee schedules, plus an add-on to estimate FMF rate levels. On top of the estimated FMF rate staff added a severity increase. HSCRC staff used MedPAC estimates of severity level differences between hospital and FMFs to evaluate the potential add-on for severity. Finally, there will be an add-on to rates for the markup for payer differential and uncompensated care, as well as any assessments (e.g., Medicaid deficit assessment or Medicaid averted bad debt assessment) that are applicable to the rates of the FMF. At least six months before occupancy of the new medical center facility, UMMS should file a rate determination with the HSCRC, including documentation regarding market rates. UMMS can derive these market rates from sources such as Truven Market Scan, the MHCC All-Payer claims data base, or other market data. These figures can be increased for the severity adjustment, mark-up and assessments to set the surgery rates. The remaining rates will be established consistent with existing HSCRC processes.

The projections submitted by UMMS show that in the first three years of operation of the new facility can reach positive cash flows, while experiencing an operating loss when including depreciation. Over time, as capital costs are absorbed, operating results should strengthen.

Summary of Staff Findings

HSCRC staff reviewed the scope of additional services and financial projections provided by UMMS for the Laurel Regional FMF. UMMS provided its rationale for additional services, which appears reasonable to HSCRC staff, so long as the surgery services are operated at rates comparable to freestanding ambulatory surgical facilities after adjustment for severity levels, uncompensated care and payer differential and any assessments. It will be the responsibility of UMMS to operate an efficient and effective FMF with lower outpatient surgery rates. UMMS has presented financial projections that show positive cash flow by the end of the third year of operation at the new facility. Until the new physical plant for the FMF is built (estimated to be in 28 months), HSCRC will continue to set rates consistent with current hospital rate levels. When the new facility opens, HSCRC will set new rates for the FMF.

CC: Ben Steffen

Appendix 3

TABLE K. REVENUES & EXPENSES, INFLATED - UM Laurel Medical Center--REVISED (9-14-18)

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2016**	**FY 2017**	**FY 2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services				$ -	$ -	$ -	$ -	$ -	$ -
b. Outpatient Services				$ 46,268	$ 46,900	$ 48,311	$ 45,787	$ 47,044	$ 48,336
Gross Patient Service Revenues				***$ 46,268***	***$ 46,900***	***$ 48,311***	***$ 45,787***	***$ 47,044***	***$ 48,336***
c. Deductions				$ 10,285	$ 10,425	$ 10,739	$ 10,178	$ 10,457	$ 10,744
Net Patient Services Revenue				***$ 35,984***	***$ 36,475***	***$ 37,572***	***$ 35,609***	***$ 36,587***	***$ 37,592***
d. Grants				$ 4,048	$ 2,200	$ 2,200	$ 1,100	$ 1,100	$ 1,100
e. Other Operating Revenues				$ 475	$ 487	$ 500	$ 512	$ 525	$ 538
NET OPERATING REVENUE				***$ 40,507***	***$ 39,162***	***$ 40,272***	***$ 37,221***	***$ 38,212***	***$ 39,230***
2. EXPENSES									
a. Salaries & Wages (including benefits)				$ 16,530	$ 16,977	$ 17,435	$ 14,890	$ 15,292	$ 15,706
b. Contractual Services				$ 10,692	$ 10,689	$ 10,977	$ 9,605	$ 9,825	$ 10,051
c. Interest on Current Debt				$ 41	$ 41	$ 41			
d. Interest on Project Debt				$ -	$ -	$ -	$ 1,525	$ 1,491	$ 1,455
e. Current Depreciation and Amortization				$ 3,247	$ 3,247	$ 3,247			
f. Project Depreciation and Amortization				$ -	$ -	$ -	$ 2,673	$ 2,788	$ 2,902
g. Supplies				$ 5,616	$ 5,552	$ 5,730	$ 5,897	$ 6,058	$ 6,222
h. Professional Fees				$ 4,429	$ 4,549	$ 4,672	$ 4,798	$ 4,927	$ 5,060
i. Utilities				$ 1,147	$ 1,178	$ 1,210	$ 426	$ 437	$ 449
TOTAL OPERATING EXPENSES				***$ 41,702***	***$ 42,232***	***$ 43,311***	***$ 39,814***	***$ 40,818***	***$ 41,845***
3. INCOME									
a. Income From Operation				***$ (1,195)***	***$ (3,070)***	***$ (3,040)***	***$ (2,593)***	***$ (2,606)***	***$ (2,615)***
b. Investment Income				$ 16	$ 16	$ 17	$ 17	$ 17	$ 18
SUBTOTAL				***$ (1,179)***	***$ (3,054)***	***$ (3,023)***	***$ (2,576)***	***$ (2,588)***	***$ (2,598)***
c. Income Taxes				$ -	$ -	$ -	$ -	$ -	$ -
NET INCOME (LOSS)				***$ (1,179)***	***$ (3,054)***	***$ (3,023)***	***$ (2,576)***	***$ (2,588)***	***$ (2,598)***
d. Add Back Depreciation & Amortization				$ 3,247	$ 3,247	$ 3,247	$ 2,673	$ 2,788	$ 2,902
4. CASH FLOW FROM OPERATIONS				***$ 2,067***	***$ 193***	***$ 224***	***$ 97***	***$ 199***	***$ 304***

TABLE H. REVENUES & EXPENSES, INFLATED - UM Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services	$278,629	$279,142	$289,529	$275,933	$285,327	$300,938	$296,156	$310,712	$325,984
b. Outpatient Services	$ 165,386	$ 164,955	$ 161,767	$ 186,147	$ 191,201	$ 199,113	$ 206,612	$ 214,365	$ 222,435
Gross Patient Service Revenues	***$ 444,015***	***$ 444,097***	***$ 451,296***	***$ 462,080***	***$ 476,528***	***$ 500,052***	***$ 502,768***	***$ 525,077***	***$ 548,419***
c. Deductions	$ 72,297	$ 87,133	$ 76,209	$ 88,283	$ 90,898	$ 94,854	$ 94,837	$ 98,626	$ 102,579
Net Patient Services Revenue	***$ 371,718***	***$ 356,964***	***$ 375,087***	***$ 373,797***	***$ 385,630***	***$ 405,198***	***$ 407,931***	***$ 426,451***	***$ 445,840***
d. Grants	$ 9,828	$ 25,922	$ 39,058	$ 37,127	$ 20,327	$ 20,327	$ 10,327	$ 10,327	$ 10,327
e. Other Operating Revenue	$ 16,118	$ 11,937	$ 13,666	$ 13,678	$ 13,690	$ 13,703	$ 13,715	$ 13,728	$ 13,741
NET OPERATING REVENUE	***$ 397,664***	***$ 394,823***	***$ 427,812***	***$ 424,603***	***$ 419,648***	***$ 439,228***	***$ 431,973***	***$ 450,506***	***$ 469,908***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 209,858	$ 218,978	$ 232,195	$ 200,241	$ 187,842	$ 196,193	$ 190,664	$ 200,291	$ 210,422
b. Contractual Services	$ 80,977	$ 77,448	$ 89,642	$ 75,970	$ 72,711	$ 75,327	$ 70,256	$ 73,289	$ 76,462
c. Interest on Current Debt	$ 295	$ 232	$ 249	$ 194	$ 186	$ 5,603	$ 9,289	$ 8,966	$ 9,208
d. Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,525	$ 1,491	$ 1,455
e. Current Depreciation and Ammortization	$ 13,924	$ 14,243	$ 13,714	$ 17,287	$ 18,458	$ 24,478	$ 39,295	$ 40,465	$ 41,636
f. Project Depreciation and Ammortization	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,673	$ 2,788	$ 2,902
g. Supplies	$ 54,991	$ 55,839	$ 55,456	$ 52,943	$ 51,527	$ 54,529	$ 53,861	$ 57,102	$ 60,545
h. Professional Fees	$ 32,734	$ 37,727	$ 41,367	$ 33,078	$ 31,642	$ 32,774	$ 32,103	$ 33,487	$ 34,930
i. Utilities	$ 5,797	$ 5,575	$ 1,617	$ 5,336	$ 5,346	$ 5,446	$ 4,579	$ 4,670	$ 4,762
j. Fixed Cost Additions	$ -	$ -	$ -	$ 33,155	$ 42,232	$ 35,417	$ 26,625	$ 26,004	$ 26,082
TOTAL OPERATING EXPENSES	**$398,576**	**$410,042**	**$434,239**	**$418,202**	**$409,945**	**$429,767**	**$430,872**	**$448,554**	**$468,404**
3. INCOME									
a. Income From Operation	**$ (912)**	**$ (15,218)**	**$ (6,428)**	**$ 6,400**	**$ 9,702**	**$ 9,461**	**$ 1,102**	**$ 1,952**	**$ 1,504**
b. Non-Operating Income	$ 2,146	$ (1,572)	$ 434	$ 2,687	$ 3,047	$ 3,394	$ 4,138	$ 4,237	$ 4,339
SUBTOTAL	***$ 1,234***	***$ (16,790)***	***$ (5,994)***	***$ 9,088***	***$ 12,750***	***$ 12,854***	***$ 5,240***	***$ 6,189***	***$ 5,843***
c. Income Taxes									
NET INCOME (LOSS)	***$ 1,234***	***$ (16,790)***	***$ (5,994)***	***$ 9,088***	***$ 12,750***	***$ 12,854***	***$ 5,240***	***$ 6,189***	***$ 5,843***

TABLE H. REVENUES & EXPENSES, INFLATED - UM Capital Region Health

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

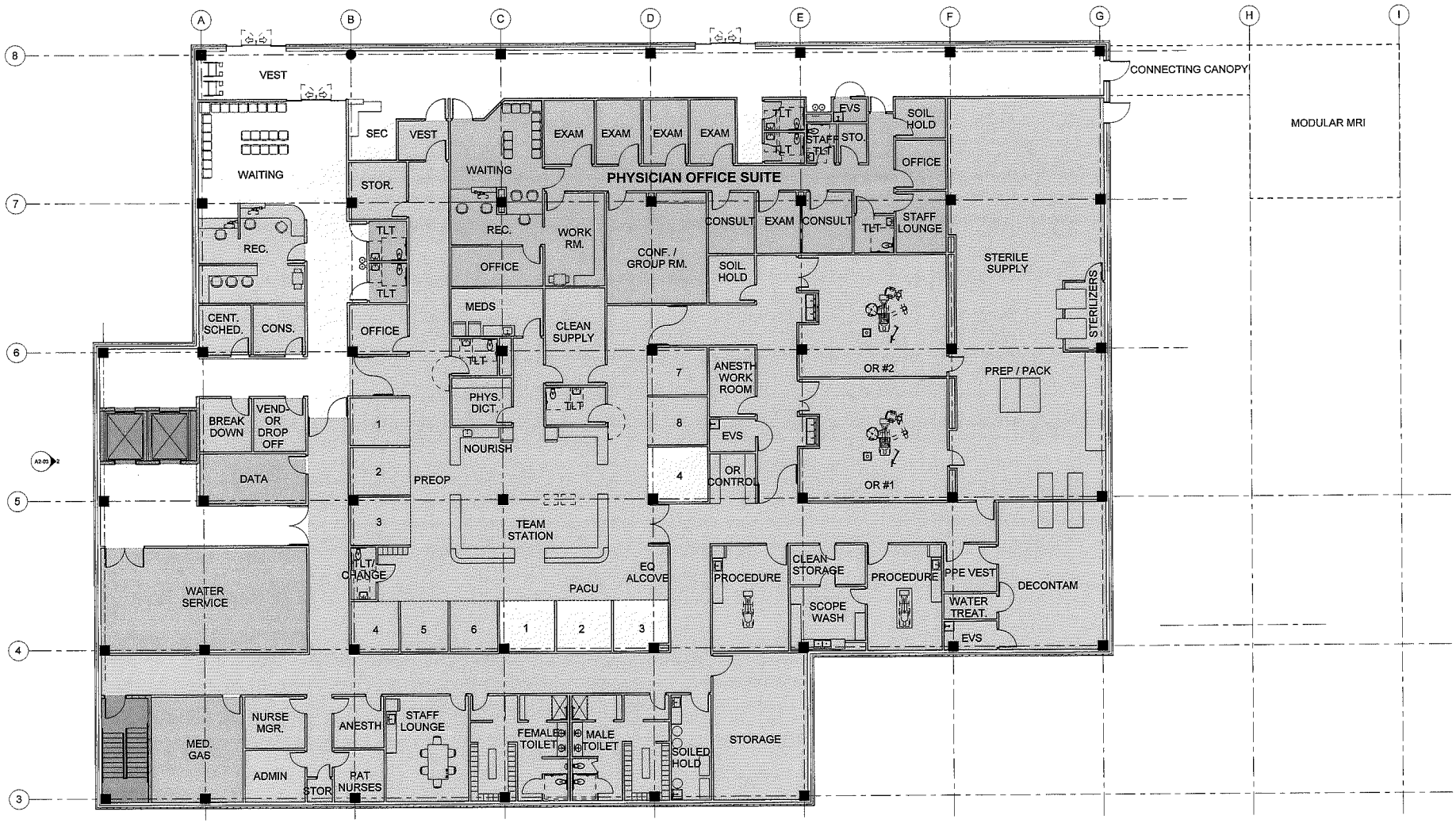
	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	31.5%	34.4%	34.4%	31.1%	31.1%	31.1%	32.0%	32.0%	32.0%
2) Medicaid	32.3%	32.8%	32.8%	34.7%	34.7%	34.7%	35.3%	35.3%	35.3%
3) Blue Cross	11.6%	10.3%	10.3%	10.4%	10.4%	10.4%	9.6%	9.6%	9.6%
4) Commercial Insurance	14.5%	13.7%	13.7%	14.3%	14.3%	14.3%	13.9%	13.9%	13.9%
5) Self-pay	8.5%	7.0%	7.0%	7.5%	7.5%	7.5%	7.3%	7.3%	7.3%
6) Other	1.6%	1.8%	1.8%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Equivalent Inpatient Days									
Total MSGA									
1) Medicare	39.6%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%	44.0%
2) Medicaid	35.4%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%	34.1%
3) Blue Cross	8.3%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%	7.4%
4) Commercial Insurance	10.2%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
5) Self-pay	5.5%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
6) Other	1.0%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H – Key Financial Projection Assumptions for UM Capital Region Health (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Capital Region Health (CRH) FY2017 actual financial performance with assumptions identified below	
Projection period reflects FY2018 – FY2024	
Volumes	- See Table F of the application for volume projections
Patient Revenue • Gross Charges o Update Factor o Demographic Adjustment o Variable Cost Factor o Redistribution of LRH revenue • Revenue Deductions	 - 2.4% annual increase in FY2019 – FY2024 - Remains constant at 0.35% per year - 50% variable cost factor with loss of volumes - 30% variable cost factor with increases in volumes - 50% of $30M of LRH's inpatient GBR will shift to PGHC in FY2019 when LRH IP service are discontinued - $18M of Rehab and Chronic Care revenues will also shift to PGHC in FY2019 – FY2020 as those services are moved to PGHC - Approximately 19.0% of gross revenue per year
Other Revenue • Grants o State o County • Other Operating Revenue	 - $28M support in FY2018, $27M in FY2019, $15M in FY2020-FY2021 and $10M in FY2022-FY2028 - $11.1M in FY2018, 10.1M in FY2019, $5.3M in FY2020-FY2021, and $0.3M in FY2023-FY2024 - Remains relatively constant from FY2018 to FY2024
Investment Income	- Earnings equal 2.5% of projected cash balance
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Drugs o Purchased Services o Other Operating Expenses • Expense Variability with Volume Changes	 - 2.7% weighted average annual increase that reflects the following: - 2.75% - 3.0% - 2.75% - 3.0% - 2.6% - 2.0%

○ Salaries and Benefits ○ Professional Fees ○ Supplies & Drugs ○ Purchased Services ○ Other Operating Expenses	- 30%. - 50% - 70% - 40%. - 0%
• Interest Expense ○ Existing Debt	- CRH has little existing debt and related interest expense
○ Project Debt	- In FY2021 and FY2022, the new Prince George's Regional Medical Center and Laurel Medical Center will open and the interest expense associated with these facilities will be recorded at an average interest rate of 5.0%
• Depreciation and Amortization	- Reflects the opening of the Prince George's Regional Medical Center in FY2021 and Laurel Medical Center in FY2022, both of which are depreciated over 30 years - Routine Capital expenditures are depreciated over 10 years
• Performance Improvements	- $11.4M in FY2019 growing to $38.5M in FY2020, $43.5M in FY2021, $64.0M in FY2022, $66.6M in FY2023 and $69.2M in FY2024 with improvements in the following areas: - Reduction in patient billing denials - Improved hospital and physician collections - Achievement of HSCRC quality payment awards - Reduction in average length of stay - Reduction in labor - Reduction in premium and overtime pay - Reduction in supply and drug costs - Reduction in contract services

Appendix 4



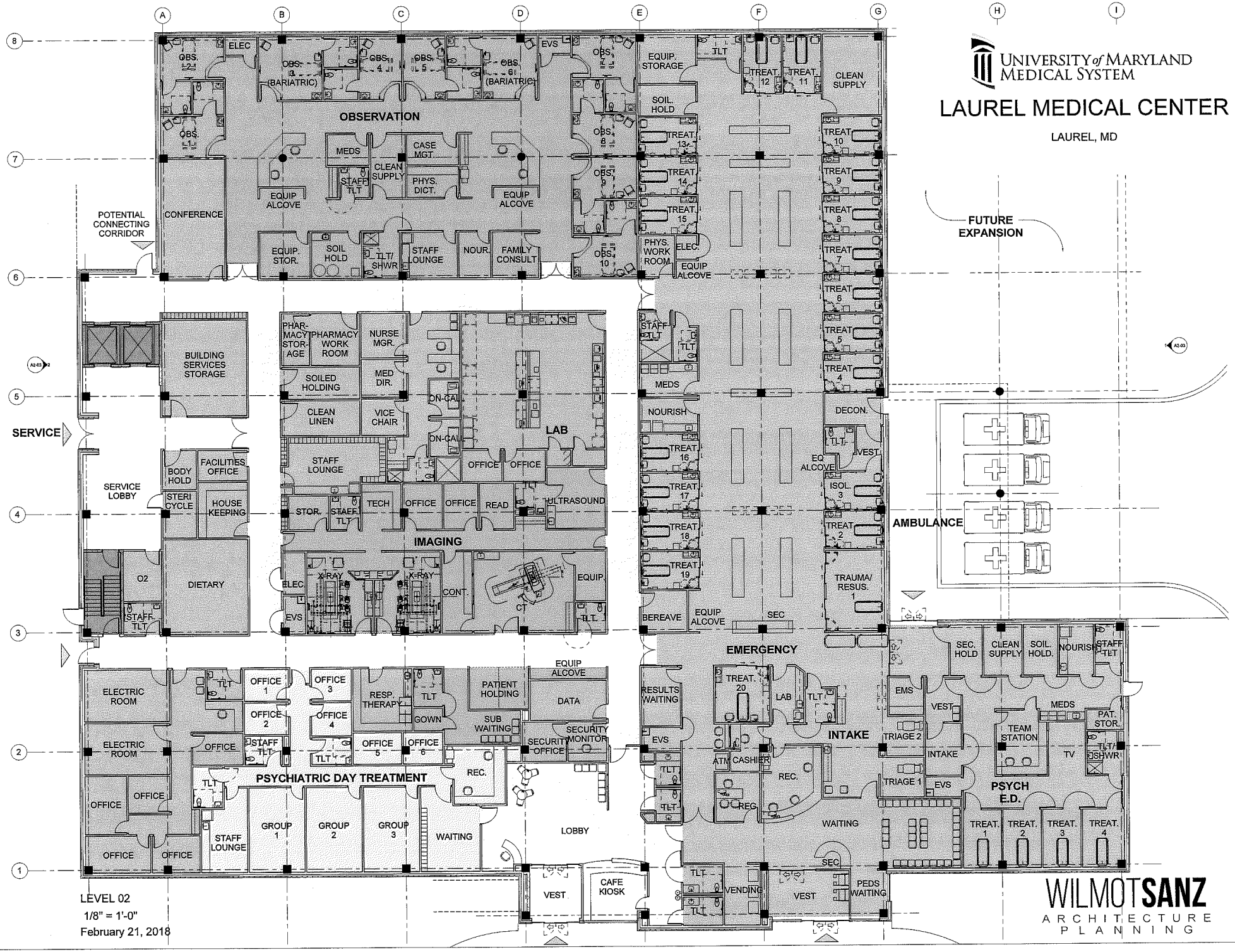
LAUREL MEDICAL CENTER

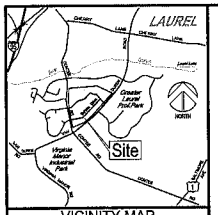
LEVEL 01 LAUREL, MD 1/8" = 1'-0"

March 7, 2018

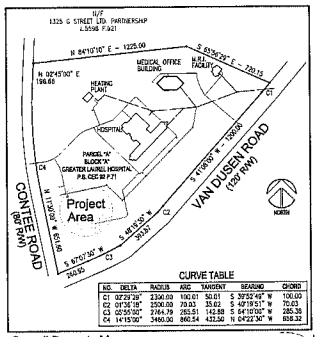
UNIVERSITY of MARYLAND MEDICAL SYSTEM

WILMOTSANZ ARCHITECTURE PLANNING

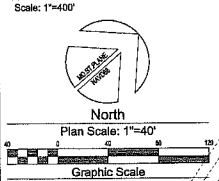

UNIVERSITY of MARYLAND MEDICAL SYSTEM
LAUREL MEDICAL CENTER
LAUREL, MD
OBSERVATION
EMERGENCY
INTAKE
PSYCHIATRIC DAY TREATMENT
PSYCH E.D.
IMAGING
LAB
SERVICE
AMBULANCE
FUTURE EXPANSION
POTENTIAL CONNECTING CORRIDOR
LEVEL 02
1/8" = 1'-0"
February 21, 2018
WILMOTSANZ
ARCHITECTURE
PLANNING



VICINITY MAP
SCALE: 1:=2000'
P.G. CO. ADC MAP #5168 GRID: J/K-6/7
W.S.S.C. 200' SHEET 218 NE 5 & 7



Overall Property Map
Scale: 1"=400'



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Certificate of Need Plan
Parcel "A" Block "A"
Laurel Regional Hospital
Plat Book: CEC 92 Plat No. 71
Laurel Regional Hospital
Laurel Election District Number 10
Prince George's County, Maryland

REVISIONS:

JOYCE ENGINEERING CORPORATION
DESIGN: WJJ DATE: June 2017 JOB No.: 8000FMP
DRAFT: HAL CHKR: JEC SCALE: 1"=40'
CHECK: JEC SURVEY: CIR-RAM SHEET: 1 OF 1

CN-1

Drawing name: R:\Land Projects\8000\22 - Greater Laurel Hospital\dwg\Ambulatory Care Center\8000-CON-1.Phase1.dwg
Printed: Mar 01, 2018 - 9:31am