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TO: Commissioners

FROM: Kevin McDonald
Chief, Certificate of Need

DATE: August 20, 2020

SUBJECT: Greater Baltimore Medical Center
Docket No. 19-03-2439

Enclosed is the staff report and recommendation for a Certificate of Need (CON) application filed by Greater Baltimore Medical Center, Inc. (GBMC). GBMC is licensed for 257 acute care and 27 comprehensive care beds. The applicant states that the primary driver of the project is a need to modernize the hospital, replacing patient rooms that are sub-standard in size and do not meet the current FGI guidelines.

The project proposes to build a three-story, 106,083 square foot expansion in front of the main lobby. The addition will include two thirty-bed nursing units. The project will also renovate about 11,600 square feet. The total estimated cost of the project is approximately $108.2 million, which will be funded with $70 million in authorized bonds, $30 million in philanthropy, $6.5 million in cash reserves and $1.64 million in interest income from bond proceeds.

Staff concludes that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated, and therefore recommends **APPROVAL** of the project, subject to conditions related to the facility's construction costs, charity care performance, and bed usage. The recommended conditions are:

1. **Any future changes relating to this project that result in adjustments in rates set by the HSCRC shall exclude $8,451,328, which is the estimated new construction cost that exceeds the MVS guideline and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.**

2. Prior to its request for first use approval, GBMC shall provide information that details the activities it has undertaken following approval of its CON application to increase the amount of charity provided to patients and demonstrates its progress toward achieving a level of charity care that places it in at least the third quartile among all Maryland hospitals as documented in the HSCRC Community Benefit Report. If staff concludes that GBMC's demonstration of progress is not satisfactory, further action regarding this CON may be considered by the Commission at a public meeting before staff issues first use approval.

3. Prior to its request for first use approval, GBMC will outline a plan for phased modernization of its nursing units that will identify the bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan should specifically address GBMC's assessment of the need for surge bed capacity and GBMC's plan to maintain and deploy adequate surge bed capacity when needed.

IN THE MATTER OF THE	*	
	*	**BEFORE THE**
GREATER BALTIMORE MEDICAL	*	
	*	**MARYLAND HEALTH**
CENTER, INC.	*	
	*	**CARE COMMISSION**
DOCKET NO. 19-03-2439	*	

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STAFF REPORT AND RECOMMENDATION

August 20, 2020

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I. INTRODUCTION

A. The Applicant

The applicant is Greater Baltimore Medical Center, Inc. (GBMC). GBMC, established in 1965, is a general acute care hospital located in Towson, in Baltimore County. GBMC has a reported physical capacity of 344 acute care hospital beds and 39 comprehensive care facility (CCF), or nursing home beds. The hospital is currently licensed for 257 acute care hospital beds and 27 CCF beds. (DI #2, Exh.1, Table A). Of the licensed acute care beds, 189 are medical/surgical/gynecological/addictions (MGSA) beds; 60 are obstetric beds; and eight are pediatric beds. Over the last several years, the hospital has experienced an annual average of about 23,000 acute inpatient and observation admissions and 53,000 outpatient emergency room visits. (DI #2, Exh.1, Table F).

GBMC is one of six subsidiaries of GBMC Healthcare, Inc., which also includes Gilchrist Hospice Care, Inc.

B. The Project

GBMC seeks Certificate of Need (CON) approval to expand its hospital facilities. The primary objective of the project is to upgrade its complement of patient rooms, expanding room size and meeting current design guidance outlined in the Facilities Guidelines Institute (FGI) Guidelines, which are incorporated by reference in Maryland's hospital licensure regulations at COMAR 10.24.07.02. The hospital's patient room complement is already predominantly comprised of private rooms, a design standard for hospitals that has been in place for over ten years.[1] However, some rrooms are of substandard size and are not in compliance with current design guidance (e.g., clearance around the bed and proximity of handwashing sinks). The applicant states that room size is a cause for patient dissatisfaction. Specifically:

a. Approximately 100 of the smallest general medical/surgical patient rooms (42%), originally constructed in the 1960's, range from 100 net square feet (NSF) to 115 NSF, which is less than the minimum of 120 square feet (SF) of clear floor area specified in the current FGI Guidelines. These rooms also lack the FGI *Guidelines'* recommended three foot clearance on each side of the bed. Additionally, the rooms lack certain basic services, such as hand washing sinks in the patient toilet rooms.

b. Seventy-two of the medical/surgical patient rooms (30%) that were built in the 1993 expansion are slightly larger at 130 NSF, but they still lack the recommended clearance around the bed and do not have staff handwashing sinks in the patient room; and

c. To accommodate modern clinical requirements, GBMC plans to replace 60 of the smallest rooms with new MSGA patient rooms that comply with FGI Guidelines. Space vacated

[1] The hospital identifies only 13 existing semi-private rooms, all used as general MSGA rooms, or 5.5% of total general MSGA rooms.

by this expansion will eventually be renovated.

The proposed project is described as the first phase of GBMC's comprehensive Master Facility Plan, the main thrust of which is to modernize the hospital's substandard nursing units over a 10-year period. As the implementation of that modernization proceeds in future phases, the physical bed capacity in some older nursing units will be reduced through renovation of the space, producing larger patient rooms designed in accordance with current FGI Guidelines or renovation that repurposes the space for delivery of outpatient services. This project is the first phase in this modernization plan, creating new patient rooms that will replace older existing rooms and permit renovation to proceed by enabling the necessary temporary or permanent withdrawal of beds from service while maintaining necessary bed supply. In the short term, it appears that this project will increase general MSGA bed capacity by 72 beds, as shown in Table I-1. However, the hospital states that it does not intend to change operational bed capacity significantly, noting that the number of patient rooms routinely available for patients will not change. Hospitals are subject to limitations on the number of beds set up, staffed, and accommodating patients through their licensed bed capacity. GBMC, like most hospitals in Maryland, has and, with this project, will continue to have more physical bed capacity than licensed bed capacity. A hospital's licensed bed capacity is intended to establish the maximum number of beds that a hospital can put into use, unless the hospital obtains approval from the Maryland Department of Health to temporarily exceed its licensed bed capacity (which might occur, e.g., if a spike in patient demand temporarily increases the need for bed spaces). Sustained increases in average patient census increase licensed bed capacity, which is annually adjusted based on average daily patient census experienced over a 12-month period.

A three-story building addition will be constructed in front of the existing main lobby and between two existing wings that will align with the existing third (on grade), fourth, and fifth floors of the hospital. It will create a new space for 60 private patient rooms, and thus, 60 beds, which will replace older rooms in existing nursing units. The ground floor of the new building will house new patient, family, and staff support space.[2] Each of the upper two floors will contain 30 patient rooms meeting current design guidance for room space and clear area around beds. GBMC plans to renovate the existing units which will reduce operational bed capacity after the project is completed and units that will be vacated upon project completion. (DI #2, pp. 4-7).

Existing space with patient rooms that will be retired from use may be renovated in other future projects as GBMC executes its Master Facility Plan over time; the availability of the vacated units will enable future projects that will modernize the existing patient units in succession. The project will increase the hospital's physical bed capacity,

[2] GBMC states that it currently utilizes all of its existing space and has already moved many non-essential administrative functions outside of the hospital and, in many cases, off campus. GBMC states that, to create much needed support space, and to provide future flexibility for other renovations, it will provide new/replacement spaces inside the entry level of the new expansion, including: reception/security desk; public restrooms; spiritual support services, including a chapel, kosher pantry, and inter-faith space; food service amenity; patient/family gift shop amenity; medical staff library; retail pharmacy amenity; vertical circulation to support the building expansion; and outdoor patient, family, and staff respite space.

Table I-1: Physical Acute Care Bed Capacity, Before/After Project

	Current	After Project
MSGA	275	347
Obstetric	60	60
Pediatric	9	9
Total	344	416

Source: DI #25.

The project will include 106,083 square feet (SF) of new construction and renovation of 11,587 SF of existing building space. (DI #2, Exh.1). The estimated total cost of the project is $108,228,049. GBMC anticipates funding the project with $70,000,000 in borrowing (through issuance of authority bonds[3]), $30,000,000 in philanthropic support, $6,582,643 in cash reserves, and $1,645,406 in interest income from bond proceeds during the construction period. The project budget estimate and anticipated source of funds is shown in the table below. (DI #2, Exh.1).

Table1-2: Project Budget

Capital Costs	
New Construction	
Building/site preparation	$63,608,563
Architect/engineering fees/permits	$5,687,848
Renovations	
Building	$3,432,929
Architect/engineering fees/permits	$320,000
Other Capital Costs	
Movable equipment	$11,259,362
Contingency allowance	$8,330,798
Gross interest during construction	$5,825,354
Testing/relocation/risk insurance/commissioning	$895,000
Inflation allowance	$5,190,194
Total Capital Costs	**$104,550,049**
Financing/other cash requirements	$3,678,000
Total Uses of Funds	**$108,228,049**
Sources of Funds	
Cash	$6,582,643
Philanthropy	$30,000,000
Authority bonds	$70,000,000
Interest income	$1,645,406
Total Sources of Funds	**$108,228,049**

Source DI #2, Table A.

C. Summary of Staff Recommendation

Staff recommends conditional approval of the project based on its conclusion that the proposed project complies with the applicable State Health Plan standards, and that the need for the project, its cost effectiveness, and its viability have been demonstrated. Staff also concludes that the project will not have an adverse impact on other providers or the health care system while

[3] Bonds issued by an authority, in this case, the Maryland Health and Higher Education Facilities Authority, for a specific project.

having the positive impact for patients and hospital staff of modernizing some of GBMC's nursing units and facilitating further modernization. A summary of the basis for this recommendation with respect to key standards and criteria follows:

Need for the Project and Bed Capacity

This proposed project by Greater Baltimore Medical Center is part of a long term master facilities plan to modernize the hospital's bed capacity, which the applicant states is characterized by patient rooms that are not in compliance with FGI Guidelines and do not support current technology and contemporary clinical practices. While the project is adding bed capacity that the Commission has not identified as needed in its most recent bed need projections, the project is a means to start a multi-year process through which it wants to replace patient rooms that are approximately 30 to 40 years old in phases that will allow units to be taken out of service for renovation while maintaining an adequate supply of operational beds at the hospital as modernization occurs.

Efficiency and Cost Effectiveness

The project is intended as a response to several strategic objectives of the applicant's master facility plan: the creation of larger patient rooms; improvement in the patient experience; improvement in operational efficiency; and optimization of materials flow and distribution. Modernizing without creating new patient room space was not a feasible option, as it would require the closure of existing nursing units in order to renovate the space through multiple phases of construction, extending the duration of construction and reducing bed availability during construction, reducing GBMC's ability to meet and manage demand for beds. The project's design will foster efficiencies at the unit and patient room level, will enhance individual and team workspace, and improve internal transport through the addition of elevators.

Patient Safety

Each new patient room will be compliant with current FGI Guidelines and, as noted, the project will make it easier to bring more patient rooms into compliance over the next ten years. GBMC states that evidence-based best practices informed the design of the new units, incorporating techniques such as identical design from room to room to standardize patient care, two negative pressure airborne isolation rooms on each unit for safely caring for infectious patients, two bariatric rooms featuring special safety accommodations for patients who weigh more than 300 pounds, and medication rooms on each unit sized to accommodate automated medication dispensing units that will reduce medication errors while also boosting efficiency.

Financial Feasibility and Viability

The audited financial statements for GBMC Healthcare, Inc., and its Subsidiaries showed a healthy excess of assets over liabilities as well as healthy net income in 2017 and 2018. While the hospital as a stand-alone entity loses money from operations, the system as a whole operates with a positive bottom line, which is also supplemented by healthy investment income. Philanthropy is expected to play a not insignificant part in financing the project, and the applicant has a successful track record in attracting philanthropic dollars.

Impact
The project is not expected to impact the volume of service provided by other existing health care providers, as the project is designed to modernize acute care beds without increasing the number of beds put into operation at GBMC.

Staff recommends that any CON issued for the project include the following conditions:

1. Any future changes relating to this project that involve adjustments in rates set by the Health Services Cost Review Commission must exclude $8,451,328, which is the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

2. Prior to its request for first use approval, Greater Baltimore Medical Center shall provide information, acceptable to Commission staff, that details the activities it has undertaken following approval of the Certificate of Need application to increase the amount of charity provided to patients and demonstrates its progress toward achieving a level of charity care that places it in at least the third quartile of charity care provision among all Maryland general hospitals as documented in the HSCRC Community Benefit Report. If staff concludes that Greater Baltimore Medical Center's demonstration of progress is not satisfactory, further action regarding this Certificate of Need may be considered by the Commission at a public meeting before staff issues first use approval.

3. Prior to its request for first use approval, GBMC will outline a plan for phased modernization of its nursing units that will identify the bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan should specifically address GBMC's assessment of the need for surge bed capacity and GBMC's plan to maintain and deploy adequate surge bed capacity when needed.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 1, Record of the Review.

B. Interested Party

There are no interested parties in this review.

C. Local Government Review and Comment

The Baltimore County Health Department chose not to comment on the application. (DI #20).

D. Community Support

The applicant provided letters voicing support for the project. Most are from persons affiliated with GHBMC such as members of the medical staff or volunteers. Others are from local officeholders. The letters generally spoke to the positive impact this project will have on the health care community, and came from:

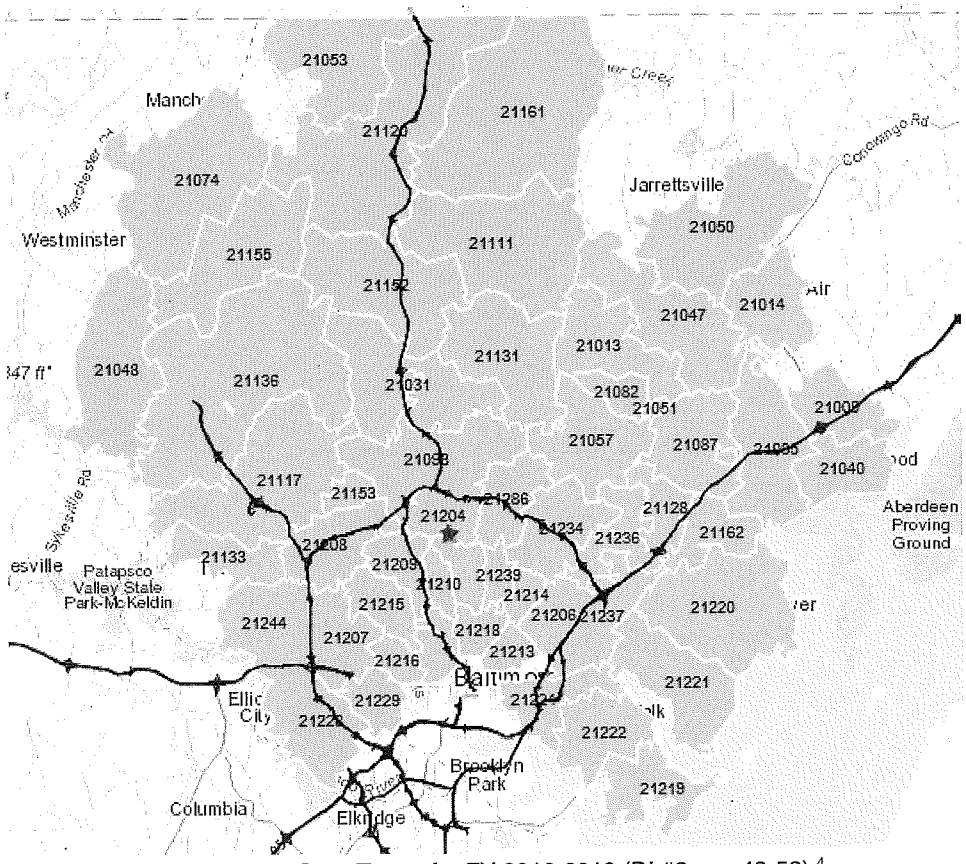
- Heidi Kenny-Berman, Chair, GBMC Philanthropy Committee
- Cate O'Connor-Devlin, GBMC's Senior Director of Patient Experience
- Stephan Plano, President, The Presbyterian ENT Charity Hospital Board
- John J. Kuchar, Chairman, GBMC Department of Anesthesiology
- Dr. Neal M. Friedlander, Chairman, GBMC Department of Medicine
- Dr. Melissa Sparrow, GBMC's Chief of Staff
- Catherine J. Boyne, President, Women's Hospital Foundation
- Nancy Hafford, Executive Director, Towson Chamber of Commerce
- Dr. Robert K. Brookland, Chairman, GBMC Department of Radiation Oncology
- Kenneth E. Ames, Senior Vice President, Advanced Radiology
- John A. Olszewski, Baltimore County Executive
- Peter Franchot, Comptroller of Maryland
- David Marks, Baltimore County Councilman
- Chris West, Senator, Maryland's 42nd Legislative District

III. BACKGROUND

A. Characteristics of the Service Area

GBMC defined its service area as 65 zip code areas accounting for 85 percent of its discharges ranked by the number of discharges contributed from the area. That area includes zip code areas in Baltimore City, Baltimore County, Carroll County, and Harford County. Just over three quarters of its service area discharges originated from zip code areas in Baltimore County. (DI #2, p. 44, Table 5, citing St. Paul's Abstract Data Tapes or FY 2016-2018).

Figure 1: GBMC Service Area (MSGA) FY 2016-2018



Source: St. Paul's Abstract Data Tapes for FY 2016-2018 (DI #2, pp. 43-52).[4]

According to historical and projected population data provided by the applicant, the total population in the service area grew at an annual rate of 1.2 percent from 2010 to 2019, compared to statewide population growth of 4.7 percent during that same period. The service area population is projected to grow 1.4 percent from 2019 to 2024.

Based on population projections for 2024, the age profile of the GBMC service area is remarkably similar to that of the State. The age 65-74 age group is projected to have seen the fastest rate of growth in the current decade (43.5 % from 2010 to 2019), and is projected to grow another 20 percent from 2019 to 2024. The 65 and older population is projected to account for 19.2 percent of the service area population in 2024, a slightly higher proportion than that for the entire state (18 percent).

[4] The proposed service area for all MSGA discharges is defined by 65zip codes that span Baltimore City, Baltimore County, Carroll County and Harford County. Zip codes are ranked from highest to lowest to identify the top 85% of total MSGA discarges.

Table III-1 GBMC 2010, Estimated 2019, and Projected 2024 MSGA Service Area Population and Projected 2024 Maryland Population, by Age

Age	2010		2019		2024		Maryland 2024	
	Population	%	Population	%	Population	%	Population	%
75+	96,097	6.9%	99,258	7.0%	108,500	7.6%	436,424	6.9%
65-74	96,326	6.9%	138,246	9.8%	165,919	11.6%	698,590	11.1%
15-64	950,071	68.0%	924,923	65.4%	907,218	63.2%	4,029,492	64.1%
0-14	255,515	18.3%	252,590	17.7%	252,742	17.6%	1,119,321	17.8%
Total	1,398,009	100%	1,415,017	100%	1,434,379	100%	6,283,827	100%

Sources: DI #2, p.45, Table 6 and DI #23.

Baltimore County's population is 55.6 percent white, compared to the State's 50.5 percent[5] and had a median household income estimated to be $72,764 in 2018 compared to the statewide estimated median of $78,945.[6] Among the Baltimore region's jurisdictions, Baltimore County had the second lowest estimated median household income, lagging the median income estimated for Anne Arundel, Carroll County, Harford, and Howard Counties. Baltimore City has the lowest median income in the region.

B. General Acute Care Hospitals

Baltimore County has four general hospitals.

Table III-2: Baltimore County General Hospitals, Licensed Acute Care Bed Inventories, FY2020*

Hospital	Location	MSGA	Obstetric	Pediatric	Psychiatric	Total
Greater Baltimore Medical Center	Towson	189	60	8	0	257
MedStar Franklin Square Medical Center	Baltimore	261	37	0	40	338
Northwest Hospital Center	Randallstown	153	0	0	37	190
University of Maryland (UM) St. Joseph Medical Center	Towson	177	20	4	18	219
Total		780	117	12	95	1,004

Source:https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Licensed_Acute_Care_Beds_by_Hospital_and_Service_%20Maryland_FY2020.pdf.

* Due to the COVID-19 State of Emergency, FY 2020 licensed acute care hospital beds were not adjusted and remain in place in FY 2021, by Notice of the Secretary of Health.

C. Hospital Utilization Trends – Baltimore County Hospitals

Table III-3: Acute Care Average Daily Census, Baltimore County General Hospitals FYE March 31, 2013 – FYE March 31, 2020

Hospital	2013	2014	2015	2016	2017	2018	2019	2020
Greater Baltimore	192.9	182.1	175.0	165.0	165.7	165.0	170.7	183.6
MedStar Franklin Square	253.6	247.9	252.9	260.0	252.1	248.6	247.9	241.4
Northwest	160.7	173.6	175.0	142.1	137.1	144.3	135.0	135.7
UM St. Joseph Medical Center	176.4	165.7	170.0	176.4	165.7	160.0	155.7	156.4
Total	783.6	769.3	772.9	743.6	720.7	717.9	709.3	717.1

Source: Maryland Discharge Data Base.

[5] https://planning.maryland.gov/MSDC/Documents/pop_estimate/ARS/table7.pdf

[6] https://planning.maryland.gov/MSDC/Documents/HH_Income/ACS-1yr-Household-Median-Income-2016.pdf

Table III-4: Acute Care Average Length of Stay (Days), Baltimore County General Hospitals CY 2013 – CY 2020

Hospital	2013	2014	2015	2016	2017	2018
Greater Baltimore	3.8	3.7	3.8	3.8	3.9	4.1
MedStar Franklin Square	4.3	4.3	4.4	4.4	4.1	4.3
Northwest	4.6	4.7	4.7	4.9	4.7	5.1
UM St. Joseph Medical Center	4.0	3.9	3.9	3.9	3.8	3.9

Source: Maryland Discharge Data Base.

Demand for hospital bed capacity has been broadly declining throughout the State in recent years. The number of licensed acute care beds in Maryland, which directly reflects this decline in patient census, dropped from 10,827 in FY2009 to 9,401 in FY2020, a 13 percent decline.[7]

Between 2016 and 2018 hospital discharges in Maryland declined by 3.23 percent and patient days declined by 2.4 percent. In contrast, the four acute care hospitals Baltimore County saw acute care discharges increase by 1.2 percent and patient days declined by 0.4 percent. The engine of that growth was GBMC – its discharges increased by 6.7 percent and its patient-days by 11.4 percent. MedStar Franklin Square showed an increase of 3.9 percent in admissions while both Northwest Hospital (-5.6 percent) and UM St. Joseph Medical Center (-3.8 percent) had declining discharges.

IV. REVIEW AND ANALYSIS

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

A. The State Health Plan

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

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

COMAR 10.24.10.04A — General Standards.

(1) 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] MHCC Annual Reports on Selected Maryland Acute Care and Special Hospital Services, FY 2009 to 2018, and Licensed Acute Care Hospital Beds, FY 2020, published at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Licensed_Acute_Care_Beds_by_Hospital_and_Service_%20Maryland_FY2020.pdf.

(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;

GBMC submitted its policy regarding hospital charges (DI #2, p. 19, Exh. 5). It states and Commission staff confirmed that a Representative List of Services and Charges is available on its website at the following link: https://www.gbmc.org/hospital-charges. It also states that charges receive quarterly updates. (DI #2, Exh.5). Within the hospital, this information is available at all patient registration areas. (DI #8, p.3).

Staff concludes that GBMC complies with Paragraph (a) of the standard.

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

Staff notes that section B of GBMC's policy entitled Hospital Charges states that the hospital's Patient Financial Services Department is the contact for inquiries regarding charges. GBMC's policy provides contact information and states that it will respond to all requests within two business days. (DI #2, Exh. 5).

Staff concludes that GBMC's procedures comply with Paragraph (b) of the standard.

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

Staff confirmed that GBMC's policy states that its Patient Services Department is responsible for training staff to ensure that the hospital can respond to inquiries and address price estimates. (DI #2, Exh.5).

GBMC documented compliance with Paragraph (c) of this standard.

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

(a) The policy shall provide:

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

The charity care policy, procedures, and implementing documents that GBMC initially submitted did not comply with the requirement that a determination of probable eligibility be made within two business days of a patient's request because the process relied upon completion of an application form rather than a simple request. Before the hospital would make such an initial determination, a patient had to complete the form, which required information regarding

residency status as well as detailed financial information that includes the current balances of liquid and other assets. The form also required the patient to sign an attestation, which implied that the information had to be an exact tally, information that may be difficult for a patient to obtain. The residency question is also out of bounds, as charity care policies cannot discriminate on the basis of citizenship.

In response to staff's request to modify the policy, the applicant provided a simpler application form that asks the patient to provide information about family size, income, and an estimate of assets, does not inquire about the patient's residency status, and does not require an attestation. The procedure also provides an option for the patient to provide this information verbally, including by phone, to a member of the hospital staff.[8] (DI #21, p. 2). Additional changes were made to the revised policy which included greater clarification of hospital procedures considered elective as well as the later location of collection efforts in the timeline of the charity care process. (DI #29, pp.1-5).

Staff concludes that GBMC has met Subparagraph (i) of the Charity Care Policy standard.

(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;

GBMC's charity care policy states that it

> will give notice of its Financial Assistance Policy ... on its website and patient portal; ... in a newspaper with circulation in GBMC's service area on an annual basis; [by] providing hard copies upon request and by mail ...; by providing notice and information about the policy as part of the pre-admission, registration, and discharge processes; [by] providing information on billing statements; and by displaying information about the policy at the Billing Office and all hospital registration points, which includes the Emergency Department. GBMC states that it will make English and Spanish versions of the Financial Assistance Policy and related documents available on the hospital website and at all hospital registration points, ... [and], upon request, will translate the policy into the primary languages of all significant patient populations in the community with limited English proficiency. (DI #21, p.1).

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[8] The policy provides that,

> [f]ollowing a patient's or a patient representative's request for financial assistance, application for medical assistance, or both, GBMC will render and communicate to the patient or patient representative a determination of probable eligibility within two business days. To obtain a determination of probable eligibility ..., a patient or patient representative may complete and submit a Request for Determination of Probable Eligibility or call and speak with a GBMC Financial Assistance representative.
>
> (DI #21, p.2).

The applicant provided photographs evidencing these English and Spanish language postings in the hospital. (DI #2, Exh. 8).

Staff concludes that GBMC has complied with Subparagraph (ii)1 of the standard.

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

The applicant states that notices of the financial assistance policy are at "all hospital registration points (inpatient and outpatient), the business office, and the Emergency Department." (DI #2, p.20).

Based on GBMC's representation, staff concludes that it has complied with Subparagraph (ii)2 of the standard.

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.

GBMC states that information about the charity care policy is given as part of pre-admission registration. (DI #21, p.1). In addition, on admission, the applicant notes that it provides notice of its financial assistance policy to each patient who seeks services at GBMC. (DI #2, p.20). Based on these representations, staff concludes that GBMC has complied with Subparagraph (ii)3.

(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.

In 2018 GBMC provided charity care that with a value equivalent to 0.3 percent of its total operating expense. According to the most recent Health Services Cost Review Commission's (HSCRC) FY 2018 Community Benefit Report, that was one of the lowest levels of charity care provided by a Maryland hospital, 43rd out of 46 total hospitals in FY 2018. The average for all Maryland hospitals in that fiscal year was 2.18 percent, and the fourth quartile was comprised of hospitals whose charity care as a percent of operating expenses was 1.1 percent or lower.

Because it ranked in the bottom quartile the standard requires that the applicant demonstrate that its level of charity care is appropriate to the needs of its service area population. To that end, GBMC points out that, although it ranks in the bottom quartile "[w]hen only Charity Care is considered as a percent of Total Operating Expenses," it ranks much higher when ranked according to its "Total Community Benefit Expense" (12th) and by "Total Community Benefit as

a % of Total Operating Expense." (DI #10, p.5). GBMC described a number of its "investments in the community," several of which are guided by its Community Health Needs Assessment (https://www.gbmc.org/chna), which prioritized health issues such as behavioral health/substance abuse, access to care, and obesity.

The applicant states that it is addressing these needs by implementing several programs, including: behavioral health practitioners embedded in primary care offices; elder medical care at home; and an expansion of care coordination/care management outside the acute care setting. GBMC credits these programs for contributing to its achieving a readmission rate (9.46%) that it described as one of the lowest in the State. In addition, the applicant described how it is increasing patients' access to care through the Patient-Centered Medical Home model, in which its "integrated, multi-specialty medical group manages patient's health across GBMC's system of care, with a focus on prevention and wellness, evidenced based care and active management of chronic diseases." (DI #2, pp. 20, 21).

Further, GBMC attributed its lower level of charity care provision to its primary service area with a higher socio-economic status than enjoyed by many other hospitals in the State. To back up that assertion, the applicant provided the following information:[9]

- GBMC has an uncompensated care (UCC) rate of 3.2 percent, which ranks as the fourth lowest level of UCC in the state. The applicant states that its UCC standing is due not only to a low level of charity care, but also because it enjoys a low level of bad debt;
- GBMC's Area Deprivation Index is 27.0, ranking it as the hospital whose clientele were the 17th least deprived (out of 46 service area populations) in the State;[10] and
- GBMC experienced the 13th lowest percentage of self-pay charges as a percent of total charges in the State in 2018.

(DI #10, Exh.20).

GBMC also noted that the Maryland Health Services Cost Review Commission (HSCRC) "provides for funding of charity care across all Maryland hospitals" through its administration of the Uncompensated Care Pool. (DI #2, p. 21). Under that policy "Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC." [11]

Finally, GBMC states that, going forward, it is committed to identifying underinsured patients who may qualify for charity care and thus increasing its provision of charity care, committing to reach 0.57 percent (a 90 percent increase) in 2021 and maintaining that percentage through its 2026 projections. (DI # 28, Table G).

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[9] Source: *Rate Year 2020 Uncompensated Care Report* - HSCRC

[10] The Area Deprivation Index (ADI) allows for rankings of neighborhoods by socioeconomic status disadvantage in a region of interest (e.g., at the state or national level). Health systems and healthcare providers can use the ADI to target program delivery by geographic location based on the area of greatest disadvantage.https://www.hsag.com/es/medicare-providers/patient-and-family-centered-care/disparities/area-deprivation-index/

[11] Citing HSCRC's *Rate Year 2020 Uncompensated Care Report* https://hscrc.maryland.gov/Documents/Hospitals/gbr-tpr-update/FY-2020/UCCCareReport.pdf, at p.3

Staff Analysis

GBMC made changes to its charity care policy to become compliant with all parts of Paragraph (a) of this standard. Its status under Paragraph (b)(emphasis added), which requires it to "*demonstrate that its level of charity care is appropriate to the needs of its service area population*" because its level of charity care is in the fourth quartile for all Maryland general hospitals, is an issue of concern.

Because GBMC attributed its lower level of charity care provision to its location in a service area with a higher socio-economic status than that of many other hospitals in the state, staff examined the charity care level, and service areas, of a close neighboring hospital, University of Maryland St. Joseph Medical Center, which Google Maps shows as separated by a 2-3 minute drive.

The value of University of Maryland St. Joseph Medical Center's reported charity care in 2018 was equivalent to 1.6 percent of its total operating expenses, a level five times that of GBMC, even though the service areas of these two hospitals significantly overlap.[12] This undercuts the rationale offered by GBMC that its service area needs less charity care. However, there are mitigating factors GBMC has pointed out, including:

- In contrast to its low charity care rank, its Community Benefit ranking is at the top of the second quartile for all Maryland hospitals;
- As the hospital with the fourth lowest UCC rate, it pays into the Uncompensated Care Pool, subsidizing hospitals with a higher level of uncompensated care.
- GBMC has committed to identifying underinsured patients who may qualify for charity care and thus increasing its provision of charity care, although a level of 0.57 percent of total operating expenses, if achieved in 2019, would have still placed GBMC in the fourth quartile of all hospitals.

Staff believes that it is appropriate to address the relatively low level of charity care provided by GBMC and has concluded that GBMC did not make a convincing case that this level of charity is appropriate to the socio-economic characteristics of its service area population, as required by the standard. Staff recommends that the Commission attach the following condition to an approval of the project:

> Prior to its request for first use approval, Greater Baltimore Medical Center shall provide information, acceptable to Commission staff, that details the activities it has undertaken following approval of the Certificate of Need application to increase the amount of charity provided to patients and demonstrates its progress toward achieving a level of charity care that places it in at least the third quartile of charity

[12] Of the top twenty zip code areas contributing inpatients to each of the two hospitals in 2019, which cumulatively approximate a 60% relevance "primary service area," as defined in the SHP, for each hospital, the hospitals share 15 of the 20 zip code areas. (MHCC staff analysis of the Maryland Discharge Data Base.)

care provision among all Maryland general hospitals as documented in the HSCRC Community Benefit Report. If staff concludes that Greater Baltimore Medical Center's demonstration of progress is not satisfactory, further action regarding this Certificate of Need may be considered by the Commission at a public meeting before staff issues first use approval.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

GBMC states that it is in compliance with all mandated federal, State, and local health/safety regulations and applicable State certification requirements. The applicant has provided copies of its license from the Maryland Department of Health (MDH) and documentation of its most recent accreditation by the Joint Commission. MHCC staff confirmed with MDH's Office of Health Care Quality that GBMC is in compliance with the conditions of participation of the Medicare and Medicaid programs.

Staff concludes that GBMC has met the requirements of Paragraph (a) of this standard.

(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 in recent years because of the way that the Maryland Hospital Performance Evaluation Guide (HPEG) has evolved. HPEG is the hospital consumer guide component on the MHCC website that includes quality measures. However, since this standard was adopted, 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 a 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." To comply with the standard as it is currently being interpreted applicants are asked to identify any "below average" rating and discuss its approach to upgrading.

GBMC reports that the most recent Hospital Quality Measures available online illustrate that its performance was "better than average" for 15 of the measures, "average" for 27 of the

measures, and "below average" for 20 of the measures. (DI #2, Exh.12, pp.1-4). For every measure that was marked as "below average" the hospital provided an action plan to improve performance. (DI #2, pp. 21-22).

Table IV-1: Quality Measures with Below Average Performance Ratings at GBMC

Measure	Action Plan
Percentage of births that are cesareans	GBMC serves patients who have had multiple births, women of advanced age, and patients with complications that contribute to the overall percentage.
How often babies are delivered vaginally when the mother previously delivered by cesarean section with no complications	GBMC continues to educate practitioners and patients on the safest form of delivery after a delivery by C-section.
How often babies in the hospital are delivered using cesarean section when it is the mother's first birth	GBMC serves patients who have had multiple births, women of advanced age, and patients with complications that contribute to the overall C-section percentage. GBMC continues to educate practitioners and patients on the safest form of delivery for both mother and baby.
How often babies are born vaginally when the mother has had a cesarean in the past including complications	GBMC continues to educate practitioners and patients on the safest form of delivery after a delivery by C-section.
How often did staff always explain about medicines before giving them to patient	GBMC plans to implement performance improvement initiatives designed to increase the amount and quality of the communication between providers and patients including "language of caring" for all employees.
How often were the patients' rooms and bathrooms always kept clean	GBMC plans to implement initiatives designed to improve the job instruction in the cleaning of patient rooms by using a checklist and implementing rounding by managers. *The hospital is meeting with its vendor.*
How often was the area around patients' rooms always kept quiet at night	GBMC continues to educate providers and staff about the importance of quiet and rest for patients, especially in the night.
How long patients spent in the ED before leaving for their hospital room	GBMC plans to auto-generate bed availability for faster transitions to the hospital bed when a decision to admit is made. It will work with nursing to expedite the report that the patient is ready to move.
How long patients spent in the ED after the doctor decided the patient would stay in the hospital before leaving for their hospital room	GBMC plans to expedite discharges so that there are more beds for admissions on a timely basis and will recruit a capacity command position to more efficiently allocate beds with clear admission guidelines.
How long patients spent in the ED before being sent home	GBMC plans to identify common reasons for delayed discharges and work with physician groups/discharge planners to create an action plan.
How long patients spent in the ED before they were seen by a healthcare professional	In June 2019, the new triage unit in the ED opened to reduce wait time. The applicant is seeing positive results.
Patients who left the ED unseen	The new triage unit in the ED will reduce the wait time of the first initial contact.
Patients in the hospital who got the flu vaccine if they were likely to get flu	The electronic medical record system has reminders that include ordering flu vaccines. Every patient is questioned about the flu vaccine a during stay.
Patients with a heart attack who receive aspirin on arrival to the hospital	GBMC will continue work in stroke/chest pain management and the delivery of aspirin on arrival.
How long patients who come back with chest pain /heart attack waited to get a test that detects heart damage	GBMC plans to place a second EKG machine in the triage area to account for multiple chest pain patients.
Contrast material dye used during an abdominal CT scan	The selection of the use of the contrast dye changed in July of 2019. A new manual process better reflects what is on the physician order.
Contrast material dye used during a thorax CT scan	same as above
Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	The GBMC team has mandated perioperative prophylaxis through a standard order set. A newly formed committee to examine blood clots will serve all areas of the hospital.
Percentage of patients who received appropriate care for severe sepsis	GBMC is now using an electronic medical record to help practitioners identify and treat sepsis earlier. There is also a sepsis alert shown in lactic acid levels greater than or equal to four.
How often patients in the hospital get a blood clot in the lung or leg vein after surgery	The GBMC team has mandated perioperative prophylaxis through a standard order set. A newly formed committee to examine blood clots will serve all areas of the hospital.

Source: DI #2, Exh.12; DI #10, pp.6-8.

Staff concludes that GBMC has provided sufficient explanation and performance improvement plans for any measures with a "below average" rating on the Maryland Hospital Performance Evaluation Guide. The applicant has demonstrated its commitment to the quality improvement process; therefore, staff concludes the standard is met.

COMAR 10.24.10.04B-Project Review Standards

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

This standard is not applicable, as the applicant is not building a new hospital or replacing a hospital.

(2) Identification of Bed Need and Addition of Beds

Only medical/surgical/gynecological/addictions (MSGA) beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

The proposed project would add two 30-bed units with larger beds meeting contemporary design requirements, resulting in 60 beds of "slack" bed capacity that will facilitate GBMC's ability to modernize existing patient room space over the next ten years and use existing patient

room space for other needs. (DI #2, p.5). Staff concludes that, in the short-term, prior to renovation and reconfiguration of space in existing units, the project will increase physical bed capacity at GBMC by 72 beds.

GBMC has identified 20 MSGA beds and 10 obstetric beds that, while physical bed capacity, will not be used under any scenario without approval by MHCC.

Staff recommends that this project be approved even though the Commission has not projected a need for additional MSGA beds in Baltimore County. This recommendation is based on staff's belief that modernization of the nursing units at GBMC is needed[13] and because GBMC is adding bed capacity in order to make modernization of fairly dated nursing units (30 to 50 years old) achievable on a more efficient basis, with minimal disruption of operations, and less risk that bed supply shortages will occur during the modernization process. This approach to allowing increases in physical bed capacity to better achieve modernization objectives has been regularly used by MHCC in the past, especially with respect to the transition of hospitals to all private rooms. Staff recommends that the following condition be attached to any approval given to this project:

> Prior to its request for first use approval, GBMC will outline a plan for phased modernization of its nursing units that will identify the bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan should specifically address GBMC's assessment of the need for surge bed capacity and GBMC's plan to maintain and deploy adequate surge capacity when needed.

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

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

This standard is not applicable, as GBMC is not establishing a pediatric unit.

(4) Adverse Impact

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

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted

[13] As previously noted, many of the existing MSGA patient rooms do not meet current FGI Guidelines for space and most do not provide the clear space around beds that is called for in current design guidelines.

average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

Paragraph (a) is not applicable because the applicant does not plan to request an increase in rates to fund the project, thus this subpart is not applicable.

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

Paragraph (b) is not applicable in this review, as the project will not reduce services.

Staff concludes that, because there will not be unwarranted adverse impact on hospital charges nor a change in the availability or access to services resulting from this project, it complies with the standard.

(5) Cost-Effectiveness

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

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

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches.

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

GBMC is proposing a project that can be viewed as involving limited objectives. The applicant states that the project's objective is to expand MSGA patient room space to improve safety and enhance the patient experience. It states that its current inpatient rooms lack the space needed to be consistent with the current *FGI Guidelines* and that the size of the rooms are a cause of patient and family dissatisfaction. (DI #2, pp. 28, 29).

The applicant notes that it considered a number of options, the first of which was limiting the project to renovation of existing space within the hospital. After reviewing current usage patterns, the applicant concluded that renovation in place was not feasible, as it would require the closure of three medical units in multiple phases of construction. Such a closure would extend the duration of construction and adversely impact hospital operations, including the quality of patient care in adjacent units. This option would also rreduce the number of available beds during construction, potentially leaving GBMC in a position of being unable to meet demand for admission. It stated that renovation in place would result in fewer beds because semi-private rooms would have to be converted to private rooms to provide for larger, *FGI Guidelines*-compliant patient rooms. Therefore, the applicant concluded that renovating within its existing space was not a feasible option. (DI #2, pp. 28-29).

GBMC then considered locations for new construction. The alternative it described was an addition at the end of Building Five. This location was rejected because it would require: longer travel distances from the hospital core for patients, family members, visitors, and staff; significantly longer runs for the utilities needed to serve the space; and permanent relocation of clinical functions, thereby increasing costs for the project. Finally, it noted that the topography in the area around Building Five would present challenges and result in additional construction costs. (DI #2, pp.28-29).

The applicant concluded that constructing the project in the proposed location at the main entrance to the hospital was the only practical location for the addition, because it will:

- Provide the proper physical environment for modern medical patient rooms;
- Provide new inpatient units in close proximity to the hospital core and improve patient, visitor, and staff circulation within the building;
- Maintain the existing hospital inpatient bed count through construction;
- Support the operational concept of integrated care teams and provide sufficient support space for these multi-disciplinary teams;
- Provide sufficient space for proper medication practices;
- Use existing hospital utility infrastructure to support the expansion;
- Provide vacated space for future renovation projects at the appropriate time; and
- Fit within GBMC's budget.

(DI #2, p. 29).

Staff concludes that GBMC has met the requirements of Paragraph (b) of the standard.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital...

Paragraph (c) is not applicable, as GBMC is not proposing the establishment of a new

hospital or relocation of an existing hospital to a new site.

In summary, staff concludes that the proposed project meets the cost-effectiveness standard.

(6) Burden of Proof Regarding Need

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

GBMC states that the driver of this project is a need to replace patient rooms that are smaller than the size required by contemporary standards and the need to make future reconfiguration of existing space to expand the size of patient rooms faster and less difficult to accomplish. The need for the project is discussed at the Need criterion, COMAR 10.24.01.08G(3)(b), *infra,* p.31.

Staff recommends that the Commission find that GBMC has demonstrated a need for the proposed project.

(7) Construction Cost of Hospital Space

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

This standard requires a comparison of the project's estimated construction cost, adjusted for specific construction characteristics of the proposed project, with a benchmark, or expected cost, derived using the cost-estimating methodology provided by the Marshall Valuation Service (MVS). Theoretically, the cost per SF arrived at by using this methodology reflects what a building of the type and quality described should cost to construct. The purpose of this standard is to exclude any excess costs from any future rate increase to cover the cost of the project. The MVS methodology includes a variety of adjustment factors related to the specific characteristics of the project, *e.g.,* timing of the project, the locality, the number of stories, height per story, shape of the building (*e.g.*, the relationship of floor size to perimeter), and departmental use of space.

GBMC states that it arrived at an adjusted MVS benchmark cost of $347.80 per SF and compared it to the actual projected cost per SF of $404.46, yielding an overage of $56.66.[14] Commission staff also calculated an MVS benchmark, arriving at a slightly lower benchmark of $346.95.[15] This results in an excess cost of $57.51 (16.6 percent).

Table IV-4 shows staff's calculation of the amount by which the projected construction cost exceeds the MVS benchmark, and the portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditures that are tied to the excess construction cost.

Table IV-4 : MHCC Staff Analysis of the Construction Cost – Cost in Excess of MVS Benchmark

1	Construction cost exceeding benchmark (106,093 x $57.51)	$6,101,408
2	The portion of the contingencies that should be excluded ($8,330,798 x 16.6%)	$1,382,912
3	The portion of the interest that should be excluded ($5,825,354 x 16.6%)	$ 967,008
4	Total to be excluded from any future rate increase proposed by the hospital related to the capital cost of the project	$8,451,328

Based on this analysis, staff recommends that, if the Commission approves the project, approval should be accompanied by the following condition, in accordance with the standard:

1. Any future changes relating to this project that result in adjustments in rates set by the Health Services Cost Review Commission shall exclude $8,451,328, which is the estimated new construction cost that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

(8) Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest

[14] GBMC explained that it was conservative and used the highest of three construction cost estimates to "protect against the need to seek a post-approval project change for cost modification," and that it expects a cost reduction once a final construction bid is accepted. GBMC also attributed the overage to the fact that it designed Level 3, the new main entrance to the hospital, to a higher quality than the other three levels since it will provide many patients and visitors with the first impression of the hospital facility. This level is planned to have premium finishes and was designed to the "excellent" quality benchmark of the MVS, rather than the "good" quality assumed in the MVS benchmark. (DI #14, p. 1).

[15] See Appendix 2.

expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

This standard is not applicable, as the project does not include construction costs of non-hospital space.

(9) Inpatient Nursing Unit Space

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

This standard specifies that inpatient nursing units should not exceed reasonable space standards, defined as Inpatient Unit Program Space in excess of 500 SF per bed, and that if they do, there would be an associated penalty assessed against any rate adjustment sought by the applicant to cover the cost of the project. "Inpatient unit program space per bed" is defined in the Acute Hospital Chapter, at COMAR 10.24.10.06B(16), as:

> a measure of space in a given patient care nursing unit of a hospital, such as a general medical/surgical unit, which includes patient rooms, family space, and support space. Family spaces include visitor lounges, family toilets, and consult rooms. Support space includes staff work stations, nourishment areas, medication areas, physician work areas (dictation, picture archiving and communication system reading station, reporting, Health Insurance Portability and Accountability Act), clean supply areas, soiled utility areas, equipment/cart alcoves, equipment storage areas, exam rooms, environmental services, offices, staff lounges, staff toilets, and staff lockers. Patient rooms include anterooms, satellite workstations, and patient toilets/showers. Inpatient unit program space does <u>not</u> include space for intra departmental circulation, walls, structural space, building envelope and mechanical and electrical support space (shafts, closets, and chases) or space for vertical and building circulation. Vertical circulation space includes stairs and elevators. Building circulation space includes corridors that connect departments.

The space allocated to the nursing units amounts to 502 SF per bed, slightly exceeding the standard of 500 SF, and triggering the requirement to exclude the costs associated with this excess space from any rate increases associated with the project. The calculation of that penalty is shown in the table below.

Table IV-5: MHCC Staff Analysis of Costs Attributed to Excess Inpatient Nursing Unit Space

1	Average SF per bed	502
2	Excess SF per bed (over 500 SF)	2
3	Number of Beds	30
4	Total Excess SF (2 x 3)	60
5	Total Cost per SF	$404.46
6	**Total Excess Cost per SF**	**$24,268**
7	Excess SF as a percent of total (60/106,093)	0.06%
8	**Contingencies to be excluded $8,330,798 x 0.06%)**	**$4,998**
9	**Capital Construction Interest to be excluded ($5,825,354 x 0.06%)**	**$3,495**
10	**TOTAL COSTS TO BE EXCLUDED (6+8+9)**	**$32,770**

Because this excess cost factor is so negligible, staff does not recommend that the Commission attach a condition to any approval of the project concerning exclusion of these costs.

(10) Rate Reduction Agreement

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

This standard is no longer applicable because the Global Budget Revenue (GBR) model has replaced the rate reduction agreements referenced by the standard. Staff will consider the ongoing validity and/or revision of this standard in its next iteration of COMAR 10.24.10, the Acute Hospital Chapter. However, In order to provide some insight into the information related to the original purpose of this standard, Staff will provide a summary of the applicant's standing in HSCRC's Integrated Efficiency Policy.

In 2019, HSCRC staff developed "an integrated efficiency methodology" as an approach to incorporating per capita efficiency measures into overall efficiency analyses in line with the Total Cost of Care (TCOC) Model. The methodology uses "volume-adjusted interhospital cost comparisons" and Medicare TCOC growth calculations. HSCRC staff notes that "incorporating the traditional cost per case analysis with total cost of care growth analyses ensures that HSCRC still adheres to its statutory mandate to ensure that cost are reasonable and charges are reasonably related to costs, while at the same time incorporating new population based measures of reasonable cost in line with the per capita tests of both the All-Payer Model initiated in 2014 and the successor Total Cost of Care Model initiated in 2019."[16] This methodology replaces the identification of "high-charge" hospitals, referenced in the standard and used under the former cost per case model of hospital rate regulation, with identification of hospitals that are "relative efficiency outlier,"

[16] *Final Recommendation on Integrated Efficiency Policy for RY 2020: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue Enhancements*, HSCRC, October 16, 2019.

subject to lower inflation adjustments in annual updates of their GBR to bring their charges in line rather than the rate reduction agreements of the past.

The October 2019 report on the new methodology did not identify GBMC as one of nine hospitals that met HSCRC's initial categorization of "outliers," and thus, potentially subject to lower inflation adjustments in annual updates of its GBR to bring its charges in line with its peer hospitals. GBMC was also not found to be in the best quintile of performance as evaluated in the methodology's "Efficiency Matrix" (better than one standard deviation from the average volume-adjusted interhospital cost comparison performance) and, thus, not eligible to apply for a GBR enhancement in RY 2020. Three hospitals were found to meet this criteria: Anne Arundel Medical Center; Atlantic General Hospital; and Mercy Medical Center.

(11) Efficiency

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

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

The applicant identifies four domains in which various features of the project's design will foster efficiencies: unit design; patient room design; individual and team workspace; and transport (additional elevators).

Unit Design. Features in the unit design that that GBMC states will augment efficiency include:

- A racetrack layout and central core is designed to bring support spaces closer to the bedside to make patient care easier and more efficient;
- Each unit will be divided into three "cluster nurse stations," or pods, and staff workstations will be sited immediately outside each pair of rooms. This will reduce walking between the nurse station and the patient bedside;
- Each unit will have two medication, nourishment, clean supply, and equipment storage rooms which will facilitate access to key supplies; and
- A staff lounge within each patient unit will provide allow access for staff without having to leave the unit.

Patient Room Design. Features in the patient room design that the applicant designed to augment efficiency include:

- Standardized room design, location of supplies and medical equipment will reduce staff time spent adjusting to various configurations;
- Larger patient rooms will accommodate a variety of patients, equipment, and family needs, reducing the number of patient transfers required;
- Having sufficient in-room space for portable equipment will reduce the amount of nursing time spent looking for and transporting equipment from one room to

another; and

- Providing additional resources in each patient room, such as a computer at every bedside, will reduce staff time spent retrieving portable computers and devices.

Workspace for Integrated Care Teams. Each unit will have workspace for integrated care teams, which are comprised of nurses, nurse leaders, technicians, case managers, social workers, physician assistants, nurse practitioners, and hospitalists. These teams are intended to foster collaboration, improve care, and reduce inefficiencies caused by trying to locate the appropriate staff. In addition to dedicated workspace, each unit will have collaboration space in the form of small-team huddle rooms dedicated to the unit and a conference room immediately outside of each unit that can be shared between units.

Dedicated Patient and Material Transport Elevators. Currently several banks of elevators serve to transport both inpatients and visitors. Dedicated elevators will improve the efficiency of transport. The proposed project will also provide dedicated visitor elevators that will reduce the load on existing elevators. (DI #2, pp.33-34).

Staff concludes that the project complies with Paragraph (a) of the standard. The applicant has designed this project to increase efficiency.

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or
(c) Demonstrate why improvements in operational efficiency cannot be achieved.

Responding to Paragraph (b) of the standard, GBMC states that the project will not increase bed capacity, and that despite modest volume increases projected over time, that increase will not be attributable to the proposed project. (DI #2, p. 34). The applicant projects that MSGA discharges will grow from 11,531 in 2019 to 12,763 in 2026 (10.7 percent) and that the combined MSGA acute care and observation patient days will grow from 61,955 to 64,370 (3.9 percent) over the same timeframe. Despite these increases, the applicant projects its workforce will grow by just one FTE (support staff). Staff notes that these assumptions could be viewed as optimistic in terms of longer-term trends experienced in most areas of the State.

Staff concludes that the applicant meets Paragraph (b) of the standard. Paragraph (c) of the standard is not applicable.

(12) Patient Safety

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

The applicant states that the project design incorporates safety features at both the unit and individual room level.

Safety Features in Unit Design

GBMC states that evidence-based best practices informed the design of the new units. It notes that each unit includes two negative pressure airborne isolation rooms for preventing the spread of infection and two bariatric rooms featuring special safety accommodations for patients who weigh more than 300 pounds. The design also includes medication rooms on each unit that are sized to accommodate automated medication dispensing units that will reduce medication errors while also boosting efficiency. A pneumatic tube system will provide safe and easy transport of critical medications and other supplies and facilitate timely turnaround of lab results. Finally, the unit design will incorporate work alcoves for staff that will allow a direct line of sight for staff monitoring high-acuity cases. (DI # 2, pp. 35-36).

Safety Features in Room Design

GBMC states that its current inpatient rooms lack:

- Modern safety features such as insufficient clearance around the bed to accommodate equipment and allow access to patients from all sides;
- Appropriate access to handwashing sinks, which can increase the spread of germs;
- Sufficient workspace for nurses in both patient rooms and on the units to perform their tasks appropriately; and
- Space to safely accommodate family members in the rooms. (DI #2, pp.35-36).

The project will incorporate a standardized room design that will meet current *FGI Guidelines* [17] and will promote standardization of patient care. It will meet code-minimum patient *clearances* on all sides of the bed and include handwashing sinks that are immediately accessible upon entering, and located on the wall opposite the patient to minimize the risk of infection. A bedside computer will be located in every room to minimize the risk of cross-contamination caused by sharing computer equipment.

GBMC notes that each room will have an air filtration system to help prevent the spread of infection that can be easily decontaminated and cleaned. Headwall design will provide easy reach to critical infrastructure such as access to medical gasses and emergency power. Bathrooms will be large enough to allow staff to assist patients, and there will be ample family space to encourage family members to safely remain at the bedside as much as possible, which will promote faster patient healing. (DI #2, pp. 35-36).

Staff concludes that the project design is likely to aid in the prevention of errors and adverse events and that that the applicant has met the requirements of the standard.

(13) Financial Feasibility

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

[17] See Appendix 3

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

The applicant provided assumptions upon which its revenue and expense projections were based. (DI #28, Tables G and H). Staff concludes that GBMC complies with Paragraph (a) of the standard.

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

Staff believes that the applicant's utilization projections show modest, incremental growth that is consistent with observed historic trends. (DI #2, Exh.1, Table F). Thus, staff concludes that GBMC has met the requirements of Subparagraph (b)(i) of the standard.

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

The applicant states that its revenue estimates are consistent with utilization projections and are based on its current Global Budget Revenue (GBR), rates of reimbursement, contractual adjustments/discounts, bad debt, and charity care provision, as experienced by GBMC. In the application, GBMC assumed a 3.2 percent GBR increase in both FY 2019 and FY 2020 as well as 2.5 percent annual increases after FY 2020. (DI #2, p. 38 and DI # 28, Tables G and H).

Staff concludes that GMBC has met Subparagraph (b)(ii) of the Financial Feasibility standard.

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

The applicant states that its staffing and overall expense projections are based on historical experience and current staffing and expenditure levels and are consistent with utilization projections. (DI #2, Exh.1, Table L).

Staff concludes that GBMC has met Subparagraph (b)(iii) of the Financial Feasibility standard.

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a

project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

Table IV-6 excerpts key actual and projected utilization and financial statistics from the application.

Table IV-6: Selected Actual and Projected Utilization and Financial Statistics FY 2017 to FY 2024

	Actual		Projected					
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Discharges								
Acute	16,305	17,205	17,575	17,924	18,070	18,241	18,379	18,541
Comprehensive Care	554	558	556	557	559	560	562	564
Observation	5,860	5,670	5,999	6,013	6,028	6,045	6,062	6,081
Bed Occupancy								
Acute (includes Observation)	75.0%	78.4%	80.0%	75.1%	78.9%	78.8%	78.5%	78.0%
Comprehensive Care	97.6%	89.1%	88.3%	88.3%	88.8%	89.0%	89.3%	89.3%
Income from Operations ($ 000s)								
GBMC	($5,958)	($9,112)	($5,614)	($5,139)	($4,272)	($4,703)	($4,932)	($5,151)
GBMC Healthcare Inc. and Subsidiaries	$1,200	$4,126	$8,013	$6,350	$7,484	$5,468	$3,582	$1,625
Non-Operating Income	$14,355	$18,237	$16,891	$10,374	$10,124	$10,689	$11,070	$11,663
Net Income	$8397	$9125	$11,277	$5235	$5852	$5987	$6138	$6513

DI #2, Table F and G ; DI #28, Table G.
Note: financial projections are uninflated, i.e., stated in current year (FY 2019) dollars.

This data shows that GBMC, as a stand-alone entity, loses money from operations. The system as a whole operates with a positive bottom line, which is also supplemented by healthy investment income.

Staff concludes that GBMC is consistent with Subparagraph (b)(iv) of the standard.

In summary, staff concludes that the applicant has submitted realistic assumptions based on its historic utilization trends and staffing patterns and that its project is financially feasible because its projections show a positive operating margin for the system as a whole.

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

These standards are not applicable. The project does not involve the GBMC emergency department.

(16) Shell Space

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

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that

(i) considers the most likely use identified by the hospital for the unfinished space and

(ii) considers the time frame projected for finishing the space and

(iii) demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

The applicant reports that the proposed project will not create any new shell space. (DI #2, p.40). However, to implement the project, several areas within the existing building will be vacated, including:

- An inpatient Unit on the Third Floor of Building Four (9,100 SF) – vacated for construction access;
- An inpatient Unit on the Fourth Floor of Building Six (9,270 SF) – 30 rooms will be vacated after replacement by rooms in the new building addition;
- An inpatient Unit on the Third Floor of Building Eight (15,230 SF) – 30 rooms will be vacated after replacement by rooms in the new building addition; and
- Existing Main Lobby Support Space (1,910 SF) – The existing gift shop will be vacated, and service will be moved to the main floor of the new addition.

The cost associated with vacating these spaces is minimal. GBMC states that it will simply be made safe and locked off. The vacated space will provide flexibility for future renovation projects. Possible future uses include renovating the vacated units to house new, FGI-compliant inpatient rooms or renovation of the existing main lobby support space to provide additional ED space. (DI #2, p.40). These possible future projects may occur within the next several years, after the completion of the proposed project. (DI #2, p.40).

Staff concludes that the standard is not directly applicable in the review of this project. The applicant has adequately described the status of space that will be vacated, in the short-term, as a result of the proposed project. Staff recommended, under the Identification of Bed Need

Standard,[18] that the Commission require as a condition of a CON that GBMC identify existing physical bed capacity that is being replaced by the bed capacity constructed in this project, and that the physical bed capacity that is being vacated shall not be used for inpatient care without Commission approval.

B. COMAR 10.24.01.08G(3)(b) Need

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

The applicant has stated that the need for this project is driven by a need to modernize patient rooms to bring them up to current standards. GBMC states that existing patient rooms on the third and fourth floors of the facility will be vacated once the proposed project provides modern replacement rooms. The hospital's Master Facility Plan envisions future renovation of vacated space to create larger but fewer patient rooms. GBMC acknowledges that its physical bed capacity will increase because the vacated patient rooms will retain headwalls, but states that these spaces will not be used to house operational patient beds without approval from the Commission. (DI #10, p.1).

In its response to the Need criterion, the applicant summarizes the need to modernize the hospital:

> All of the acute care beds are either original to the hospital or were constructed in additions more than 25 years ago. No significant renovations have been performed on any of the patient units, other than to refresh the materials within the patient rooms. Patient room layouts, sizes, and infrastructure have remained constant, sometimes for as long as 50+ years. (DI #2, p. 8).
>
> The vast majority of the patient rooms to be replaced through this proposed project are original to the hospital and were constructed in 1965. These patient rooms do not meet current FGI 2018 standards in numerous ways. Addressing these features will dramatically enhance square foot limitations, functional deficiencies, and inefficiencies leading to greater patient safety and provision of patient-centered care. (DI #2, p. 52).

GBMC states that its service area population will continue to see modest overall growth and significant continued aging. It notes that its service area population's hospital use rate declined by 3.3 percent between 2016 and 2018 due to a reduction in potentially avoidable utilization and expects the use rate to decline slightly more through 2020, when it expects that use rates will level off in each age cohort. However, as the population ages into age cohorts with higher use rates, GBMC projects that the aggregate use rate will increase 5.1 percent between FY 2018 and FY 2026. (DI #2, p. 47).

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[18] See discussion at COMAR 10.24.10. Identification of Bed Need Standard, *supra* p.17

GBMC states that its service area market share increased by 9.4 percent in fiscal year 2018 as a result of market shifts in the orthopedic and general surgery service lines and the closure of MedStar Franklin Square Medical Center's pediatric unit. It projects that its MSGA market share in its service area will increase by an average of 2.3 percent in both 2019 and 2020 and stabilize in the out years. GBMC's actual and projected volume statistics are shown in Table 1V-7.

Table: IV-7 Actual and Projected Utilization Statistics, FY2017 – FY2025

	Actual		Projected						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Discharges									
General MSGA	11,220	11,112	11,531	11,842	11,983	12,129	12,279	12,435	12,596
ICU/CCU	934	1,762	1,676	1,721	1,741	1,762	1,783	1,805	1,828
Observation Cases	5,860	5,670	5,999	6,013	6,028	6,045	6,062	6,081	6,100
Patient Days									
General MSGA	45,705	48,531	51,391	53,390	51,775	50,506	51,216	51,948	52,703
ICU/CCU	5,666	5,943	5,595	5,811	5,635	5,496	5,572	5,650	5,732
Observation Cases	5,649	4,747	4,969	4,981	4,994	5,007	5,022	5,037	5,053
Total MSGA & Observation	57,020	59,221	61,955	64,182	62,403	61,009	61,809	62,635	63,488
Average Annual Bed Occupancy Rate - Combined MSGA and Observation	**84.4%**	**88.7%**	**90.3%**	**84.7%**	**79.5%**	**79.6%**	**79.5%**	**79.2%**	**79.4%**

DI #2, Table F, Statistical Projections.

As previously noted in this report,[19]staff concluded that GBMC has demonstrated the need to modernize its patient room space and nursing units. Staff recommends that the Commission not deny the proposed increase in bed capacity on the basis of the Acute Hospital Chapter's need standard, which does not project a need for additional MSGA bed capacity in Baltimore County. This bed addition will serve as a vehicle for modernization of inpatient space at GBMC and over time, should not result in excess bed capacity with negative cost implications or stranded capital assets. Staff recommends that the Commission find that the applicant satisfies the Need criterion.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives.
The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

The CON application instructs an applicant to discuss the planning process that resulted in the project, including the goals or objectives it is designed to meet. The applicant is also asked to discuss the alternatives of achieving the project's objectives through the use of other facilities and/or population health initiatives.

GBMC stated that a recent strategic planning initiative identified shortcomings of its

[19] See discussion at COMAR 10.24.10 Identification of Bed Need Standard, *supra*, p.17

inpatient facilities, namely, the inpatient rooms are sub-standard in size, do not accommodate modern clinical and equipment needs, and cause patient and family dissatisfaction. This led to setting three strategic objectives to address this problem:

1. Create adequately-sized inpatient units to accommodate current operational models;
2. Maximize opportunities for improved operational efficiency and patient experience; and
3. Optimize materials flow and distribution.

In order to respond to the criterion's directive to discuss the alternative of allowing the services to be provided through other existing facilities, the applicant discussed why it could not renovate in place, accepting a scenario in which GBMC would have fewer total beds as space was reallocated to make each patient room larger within the existing footprint, and allowing volume to be absorbed by existing surrounding facilities.

GBMC stated that the logistics of staging such renovations would have a severe impact on the hospital, reducing the number of patients it could serve during construction. (DI #14, p. 5). Further, not only is it not possible to undertake the project by renovating in place without taking inpatient bed units out of service during construction, but such a plan would also permanently reduce the hospital's capacity by a substantial number of beds. GBMC stated that such a plan could result in the loss of as many as 60 MSGA beds. (DI #14, p. 4).

GBMC pointed to an increasing market share in its primary service area, as well as an increase in Equivalent Case Mix Adjusted Discharges (ECMADs). Staff notes that increases in market share average length of stay are the primary factors in increased use at an institutional level, given the limited population growth and declining hospitalization rates in Maryland. Table IV-8 below illustrates GBMC's growth in ECMADs, compared to declines at some other local hospitals.

Table IV-8: Change in Equivalent Case Mix Adjusted Discharges for Select Hospitals CY 2017 to CY 2018

Hospital	Change in Equivalent Case Mix Adjusted Discharges, CY2017 – CY2018
GBMC	908
MedStar Franklin Square	(762)
Northwest	(534)
UM St. Joseph	(106)

DI #14, p. 6; https://hscrc.state.md.us/Documents/Hospitals/gbr-tpr-update/FY-2020/MarketShift-CY18.pdf.

GBMC also cited a long-standing preferred provider relationship as the acute care inpatient services for Kaiser Permanente (Kaiser) members in Baltimore County. An entire unit containing 26 MSGA beds is dedicated to Kaiser patients, which the applicant states "are fully utilized." GBMC cites news reports that Kaiser plans to increase its number of health centers in the Baltimore area from five to fifteen, including a new $247 million medical center in Timonium. GBMC expects that its volume of inpatient services derived from Kaiser membership rolls will increase. (DI #14, p. 8, Exh. 26).

Finally, the applicant questioned the premise that other hospitals would be able to absorb

additional patients if GBMC were to decrease its beds to increase room size without adding new space. The applicant states that often physical beds "are non-operational because they have been allocated for office space or other non-patient uses a common practice throughout the hospital industry." Additionally, other hospitals may not have the physical, operational, or financial means to increase staffing to handle increased admissions. (DI #14, p. 8).

As staff concluded in its discussion in the criterion on Availability of More Cost Effective Alternatives [20] GBMC described alternatives to this project and proposed a project that is cost effective in meeting its goals and objectives. Thus, staff concludes that GBMC has satisfied the criterion regarding the availability of more cost-effective alternatives.

D. Viability of the Proposal

COMAR 10.24.01.08G(3)(d) Viability of the Proposal.
The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Resources to Implement the Proposed Project

The estimated total cost of the project is $108,228,049. The applicant plans to fund it with $70,000,000 in authorized bonds, $30,000,000 in philanthropy, $6,582,643 in cash reserves, and $1,645,406 in interest income from bond proceeds. The financing will be timed to coincide with the payoff of other existing debt and will be "styled to lower GBMC's current overall annual debt services without extending the term of its existing debt." GBMC anticipates maintaining its A/A2 rating ("A" rating with Standard and Poor, "A2" rating with Moody) throughout this process, "based on strength of its balance sheet." (DI #2, p. 58). Audited financial statements for GBMC Healthcare, Inc., and its Subsidiaries showed a healthy excess of assets over liabilities as well as healthy net income in 2017 and 2018.

A fundraising campaign, called "The Promise Project," is currently underway by the hospital. At the time the CON application was filed, GBMC had raised 10 percent of the goal. GBMC cites "a rich heritage of philanthropic support from the local community" as reason for confidence in the campaign's ultimate success, and states that its last two formal campaigns (40th and 50th Anniversary Campaigns in 2005 and 2015) raised $35,000,000 and $55,000,000, respectively. (DI #2, pp. 58-60).

Resources to Sustain the Proposed Project

As discussed earlier under the financial feasibility standard, although GBMC as a stand-alone entity loses money from operations, the system as a whole operates with a positive bottom line, which is also supplemented by healthy investment income. That is projected to continue after

[20] See discussion at COMAR 10.24.10 Criterion on Availability of More Cost Effective Alternatives, *supra*, p. 32.

project implementation.

As is standard practice in a hospital CON review, Commission staff sought an opinion regarding the financial feasibility and viability of the project from HSCRC staff. That review led to a decision that GBMC did not qualify for the increase to its GBR to cover interest and depreciation expenses related to the project that it had built into its assumptions.

As a result GBMC revised its revenue projections accordingly and revised its expense projections to reflect "operational improvements" each year of 1 percent ($7 million) annually. HSCRC staff stated that the resubmitted financial projections of the applicant seem reasonable and achievable, but noted that "[e]ven with these cost reductions, the Hospital is still showing a negative 1% Operating Margin each year," but that on a consolidated basis the organization shows "a positive 1.5% Operating Margin...[and that] Balance Sheet strengths have allowed the System to receive a favorable rating of A2 with a Stable Outlook from Moody's and a rating of A with a Stable Outlook from Standard and Poors" (see Appendix 4). (DI # 26, pp.1-2).

Staff concludes that the applicant has proposed a project that can be implemented with resources that should be available to GBMC and sustained. Therefore, staff recommends that the Commission find the project to be viable.

E. Compliance with Conditions of Previous Certificates of Need

COMAR 10.24.01.08G(3)(e), Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

GBMC has obtained one in the last 20 years. This was an expansion and renovation project (Docket No. 01-03-2082) that did not include any conditions and was successfully completed. The applicant attached the order as Exh. 16. (DI #2, p.60, Exh.16).

Staff concludes the applicant has met this criterion.

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

COMAR 10.24.01.08G(3)(f): An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

GBMC reports that it does not anticipate the project will have an impact on the volume of service provided by other existing health care providers, as the project is designed to modernize acute care beds without increasing the number of operational beds at GBMC. (DI #2, pp. 61-63). Similarly, the applicant states that the project will have a positive impact on the access to health care services for the service area population. (DI #2, pp. 61-63).

Staff concludes that there will not be a negative impact on other providers or the health care delivery system as a result of this project and thus recommends that the Commission find that the project's impact is acceptable. The staff and patients of GBMC will benefit from modernization of the hospital's facilities.

V. SUMMARY AND STAFF RECOMMENDATION

This proposed project by Greater Baltimore Medical Center is part of a long-term master facilities plan to renovate the hospital's patient rooms and nursing units. GBMC characterizes its patient rooms as old and out-of-compliance with *FGI Guidelines* and sized in a way that does not support current technology and clinical practices or patient expectations. The project would create space for 60 new MSGA beds. However, over time, GBMC will be undertaking renovations projects that are likely to reduce physical bed capacity.

Staff recommends that the Commission find that the proposed capital project complies with the applicable State Health Plan standards, that it is needed, that it is a cost-effective alternative, that it is viable, and that it will not have a negative impact on service accessibility, on costs and charges of other providers, or on the health care delivery system. Accordingly, staff recommends that the Commission **APPROVE** the proposed GBMC modernization project with the following conditions:

1. Any future changes relating to this project that result in adjustments to rates set by the Health Services Cost Review Commission must exclude $8,451,328, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

2. Prior to its request for first use approval, Greater Baltimore Medical Center shall provide information, acceptable to Commission staff, that details the activities it has undertaken following approval of its Certificate of Need application to increase the amount of charity provided to patients and demonstrates its progress toward achieving a level of charity care that places it in at least the third quartile of charity care provision among all Maryland general hospitals as documented in the HSCRC Community Benefit Report. If staff concludes that Greater Baltimore Medical Center's demonstration of progress is not satisfactory, further action regarding this Certificate of Need may be considered by the Commission at a public meeting before staff issues first use approval.

3. Prior to its request for first use approval, GBMC will outline a plan for phased modernization of its nursing units that will identify the bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan should specifically address GBMC's assessment of the need for surge bed capacity and GBMC's plan to maintain and deploy adequate surge capacity when needed.

IN THE MATTER OF THE	*	
	*	**BEFORE THE**
GREATER BALTIMORE MEDICAL	*	
	*	**MARYLAND HEALTH**
CENTER, INC.	*	
	*	**CARE COMMISSION**
DOCKET NO. 19-03-2439	*	

****

FINAL ORDER

Based on the analysis and conclusions in the Staff Report and Recommendation, it is, this 20th day of August 2020:

ORDERED, that the application for a Certificate of Need by Greater Baltimore Medical Center for a project that will modernize the hospital, adding 72 MSGA beds at an estimated project cost of $108,228,049 be **APPROVED,** subject to the following conditions:

1. Any future changes relating to this project that result in adjustments in rates set by the Health Services Cost Review Commission shall exclude $8,451,328, which is the estimated new construction cost that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

2. Prior to its request for first use approval, Greater Baltimore Medical Center shall provide information, acceptable to Commission staff, that details the activities it has undertaken following approval of its Certificate of Need application to increase the amount of charity provided to patients and demonstrates its progress toward achieving a level of charity care that places it in at least the third quartile of charity care provision among all Maryland general hospitals as documented in the HSCRC Community Benefit Report. If staff concludes that Greater Baltimore Medical Center's demonstration of progress is not satisfactory, further action regarding this Certificate of Need may be considered by the Commission at a public meeting before staff issues first use approval.

3. Prior to its request for first use approval, GBMC will outline a plan for phased modernization of its nursing units that will identify the bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan should specifically address GBMC's assessment of the need for surge bed capacity and GBMC's plan to maintain and deploy adequate surge capacity when needed.

APPENDIX 1

RECORD OF THE REVIEW

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Letter of Intent received and acknowledged	6/14/19
2	Certificate of Need Application filed	8/9/19
3	Revised Exh. 2 for Certificate of Need Application	8/9/19
4	Receipt of Certificate of Need Application acknowledged by MHCC staff	8/14/19
5	Request to publish notice in Baltimore Sun by MHCC staff	8/14/19
6	Request to publish notice in Maryland Registrar by MHCC staff	8/14/19
7	Notice published in the Baltimore Sun	8/22/19
8	MHCC staff requests completeness information	9/13/19
9	Request for and grant extension to file completeness until 10/4/19	9/19/19
10	GBMC submits completeness information	10/4/19
11	Maryland State Uniform Financial Assistance Application	10/4/19
12	Request for second round of completeness information	10/25/19
13	Request for and grant extension to file second completeness until 11/15/19	10/29/19
14	Second round of completeness response submitted	11/27/19
15	Request for additional information and formal start of the review on 1/31/2020	1/17/20
16	MHCC staff requests to publish notice of formal start of review in Baltimore Sun	1/17/20
17	MHCC staff requests to publish notice of formal start of review in Maryland Registrar	1/17/20
18	Request local health planning comments	1/17/20
19	Notice of formal start of review published in Baltimore Sun	1/30/20
20	Baltimore County Health Officer chooses not to comment on application	2/10/20
21	Additional charity care information requested in docketing letter submitted by applicant	2/18/20
22	Request for HSCRC comments on application	2/28/20
23	Additional population data provided by applicant	6/24/20
24	GBMC organizational chart provided by applicant	6/25/20
25	GBMC revised physical bed capacity provided by applicant	6/25/20
26	HSCRC response on GBMC project financial feasibility	7/17/20
27 A	GBMC updated financial projection	6/12/20
27 B	GBMC response to HSCRC questions	6/12/20
28	GBMC updated financial projection	7/2/20
29	GBMC revised Financial Assistance Policy	8/4/20

APPENDIX 2

GBMC MVS Analysis by Commission Staff

GBMC MVS Analysis by Commission Staff

	New Construction		
Class	A		
Quality	Good		
Type Structure	Hospital	Mechanical Penthouse	Total Hospital Building
Floors	3	1	
Square Footage	92,601	13,482	106,083
Average Perimeter	922	812	
Weighted Average Wall Height	12.7	20	
Stories	3	1	
Average Area Per Floor	30,867	13,482	
As Outlined in Section 1, Page 11			
Base Cost (15.24, 19) November 2019	398	97	
Elevator Add-on or Deduction (15.36)	0	28.48	
Heating, Cooling, Ventilation adjustment	0		
Adjusted Base Cost	$ 398.00	$ 125.48	
Adjustment for Differential Cost By Departme	0.970	1	
Gross Base Cost	$ 386.06	$ 125.48	
Perimeter Multiplier (15.38)	0.920	1.002	
Story Height Multiplier (15.38)	1.016	1.184	
Multi-story Multiplier (15.19)	1	1.005	
Multipliers	0.93	1.19	
Refined Square Foot Cost	$ 360.86	$ 149.61	
Sprinkler Add-on (15.37-11/2015)	$ 3.24	$ -	
Adjusted Refined Square Foot cost	$ 364.10	$ 149.61	
Current Cost Modifier (99.3) Nov 2019	1.02	1.02	
Local Multiplier (99.8) Baltimore Nov 2019	1.01	1.01	
CC & Local Multipliers	$ 1.03	$ 1.03	
MVS Building Cost Per Square Foot	$ 375.02	$ 154.13	
Building Square Footage	92,601	13,482	106,083
MVS Building Costs	$ 34,727,314	$ 2,077,954	36,805,268
Final MVS Cost Per Square Foot	$ 375.02	$ 154.13	$ 346.95

APPENDIX 3

GBMC Patient Rooms and Compliance with FGI Guidelines

GBMC Patient Rooms and Compliance with FGI Guidelines

FGI 2018 Guideline Reference	Guideline Requirement	Current State
2.2-2.2.2.2 (1) (a)	Single patient rooms shall have a minimum clear area of 120sf.	Typical patient rooms are 107sf – 111sf. The clear floor area does not facilitate the number of clinicians necessary for patient-centered care.
2.1-2.2.5.1 (1)	A hand-washing station shall be located in each patient room, at or adjacent to the door to provide unobstructed access to staff entering and leaving the room.	The sink in the patient room is not near the door. The bed blocks the sink. There is very limited access by staff.
2.1-2.2.6.3 (2)	Every patient toilet room requires a hand-washing station.	There are no sinks in the patient toilet rooms.
2.1-2.3	Hospitals must provide rooms designed to accommodate patients of size (300lbs or heavier), with additional clearances and safety features.	This project will add four patients of size rooms. No rooms in the hospital currently meet this guideline.
2.1-2.8.8	Medication safety zones require that medication be prepared in controlled rooms or from automated dispensing units.	Due to the small size of the medication room, most drugs are located immediately outside of patient rooms in locked boxes. In addition, these alcoves are multi-purpose and are not dedicated to medication dispensing.
2.1-2.8.13.2	At least 10 sf / bed of clean supply and equipment storage is required on the unit.	Due to the size of the unit, only approximately 160sf of storage is provided on the typical 30 bed unit (*i.e.*, approximately 5 sf / bed).
2.1-7.2.2.3 (2)(a)(1)	Minimum patient room door opening shall be 45.5" clear width.	Actual patient room door opening is approximately 44" clear width.
2.2-2.2.2.2 (2) (b)	Require 3' between the side and foot of the bed and any fixed obstruction.	Typical patient room width ranges from 8'-0" to 9'-0", with a 3'-6" bed that leaves 2'-3" to 2'-9" clear on each side. Typical patient room length is 10'-5", assuming 7'-10" bed that leaves 2'-7" clear.
2.2-2.2.3.1 (1) (a)	Family Support - Space shall be provided in the patient room for moveable seating with a minimum of one seat for a family member or visitor and one seat for the patient.	There is insufficient space for multiple chairs in the room.

Source:(DI #2, pp.53-54).

APPENDIX 4: HSCRC Opinion Letter

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

MEMORANDUM

TO: Kevin McDonald, Chief, Certificate of Need Division, MHCC
Jeanne-Marie Gawal, CON Analyst, MHCC

FROM: Katie Wunderlich, Executive Director, HSCRC
Gerard J. Schmith, Director, Revenue & Regulation Compliance, HSCRC

DATE: July 17, 2020

RE: GBMC
Expansion Hospital Project
Docket No. 19-03-2439

****

Consistent with your request dated February 28, 2020:

- Greater Baltimore Medical Center (GBMC) has applied for a Certificate of Need (CON) to modernize its facility by expanding and renovating its existing space. GBMC proposes to add 106,083 square feet (SF) and renovate 11,587 SF.

- GBMC describes its need to modernize the current patient rooms and make them compliant with Facility Guidelines Institute (FGI) standards. GBMC states that its current rooms are of sub-standard size and do not accommodate modern clinical needs such as clearance around the bed and proximity of handwashing sinks, and are a cause for patient dis-satisfaction. The proposed project will not increase operational bed capacity or add new services, and volume increases are not expected as a result of the project.

- The project's total cost is estimated at $108,228,049, and will be funded through $70,000,000 in authorized bonds, $30,000,000 in philanthropy, $6,582,643 in cash reserves and $1,645,406 in interest income from bond proceeds.

- MHCC requests that HSCRC staff review the financial projections provided in the CON application and subsequent filings, and advise MHCC whether the project is financially feasible. Commission staff believes that the utilization projections presented in the application are reasonable, and would advise HSCRC's staff, in making comments on the revenue and expense projections and financial feasibility of the proposed project, to assume that volumes projected by the applicant will be achieved.

- Please review and remark on any other pertinent aspects of this application.

HSCRC staff has reviewed the CON application dated August 9, 2019, and the subsequent GBMC Completeness Responses dated October 4, 2019 and November 27, 2019, and the related GBMC responses to HSCRC inquiries and requests for revised and updated financial projections dated June 12, 2020 and July 2, 2020.

We reviewed the projections of patient revenues after removing any additional adjustment anticipated from the HSCRC to cover the cost of the project. The projected P&L reflects Fiscal 2026 Part B & Non Patient Care Revenue of $125.4 million on a consolidated basis, and $106.8 million for GBMC only, the related expenses are not segregated on the P&L. The HSCRC does not regulate such activities, nor does it collect detail cost reports on such, accordingly the HSCRC makes no judgement on these activities. Otherwise, the overall Net Patient revenue increases seem reasonable and achievable.

We reviewed the projections of expenses. While the original application requested rate support from HSCRC to fund this project, GBMC has since revised its application to remove HSCRC capital rate support because the hospital did not qualify for capital support at this time. Instead, GBMC has included a decrease to expenses for "Operational Improvements" each year of approximately 1% or $7 million on a consolidated basis ($42 million over the projection period). The cost projections seem reasonable and achievable only if the hospital can achieve the "Operational Improvement" reductions as planned. Even with these cost reductions, the Hospital is still showing a negative 1% Operating Margin each year and a positive 1.5% Operating Margin on a consolidated basis. Otherwise, Balance Sheet strengths have allowed the System to receive a favorable rating of A2 with a Stable Outlook from Moody's and a rating of A with a Stable Outlook from Standard and Poors.

Based upon staff's review of this information, the HSCRC believes that the modernization project as described in the CON is financially feasible based of the consolidated financial performance of the System if the Hospital is able to achieve the cost reductions as planned.