MARYLAND Health Care Commission

Randolph S. Sergent, Esq, Chairman
Ben Steffen, Executive Director

MEMORANDUM

TO: Commissioners

FROM: Jeanne-Marie Gawel, Acting Chief Certificate of Need

DATE: July 18, 2024

SUBJECT: Merging and Consolidating Portions of the University of Maryland Rehabilitation and Orthopaedic Institute and the University of Maryland Medical Center
Docket No. 23-24-EX017

Enclosed is the staff report and recommendation for an Exemption from Certificate of Need (CON) application filed by James Lawrence Kernan Hospital, Inc., d/b/a University of Maryland Rehabilitation and Orthopaedic Institute (UMROI) and University of Maryland Medical Center, LLC (UMMC), (collectively, the applicants), both hospitals within the University of Maryland Medical System, Inc. (UMMS). The Exemption seeks to relocate and consolidate acute inpatient rehabilitation and chronic care beds between two of its facility sites in Baltimore City. UMROI will relocate 25 acute inpatient rehabilitation traumatic brain injury (TBI) beds, 18 acute inpatient rehabilitation spinal cord injury (SCI) beds, five chronic care beds, and ten dually licensed acute inpatient rehabilitation and chronic care beds to UMMC. The project will result in an expansion of UMMC's Roslyn and Leonard Stoler Center for Advanced Medicine (the Stoler Center), through the construction of four additional floors: 10, 11, 12, and 13. The new units will also occupy a portion of existing space in the North Hospital, which UMMC will renovate to accommodate the services.

The applicants state that this Exemption request is an extension of Phase One and Phase Two of the "UMMC Stoler Center Unification Schedule". (DI #12, Exh.15). Phase One includes a nine-story addition to the Stoler Center (Cancer Center Project) as approved in August 2020 by the Maryland Health Care Commission (MHCC or Commission).[1]

This project's additional four floors will be built on top of the first nine floors of the Cancer Center Project, currently under construction. These additional floors of the Stoler Center will obstruct windows in existing patient rooms in the North Hospital, rendering rooms on floors 10 and above non-compliant with the natural light standards as specified by the Facility Guidelines Institute (FGI). Therefore, the applicants must move existing medicine and psychiatry beds in the North Hospital. (DI #2, p.11). Consequently, floors 10 and 11 will accommodate the existing medicine and psychiatry beds that must be moved to preserve natural light and floors 12 and 13 will accommodate the relocated rehab and chronic care beds.

The applicants state that because the Stoler Center is already under construction due to the Cancer Center Project, the proposed project can be completed on a shorter construction schedule as opposed to an undeveloped site. The coordination of these two projects will result in cost savings

[1] Docket No. 19-24-2438

due to a shorter construction schedule, buying materials at higher volumes, and mobilization costs for subcontractors. Further, if they were to stagger the projects as opposed to doing them simultaneously, they would need to vacate occupied floors creating serious disruptions to patient care. The total cost of the project will be $235,855,047. The applicants plan to finance the project through bonds, interest on bond proceeds, and state funding. (DI #2, Exh.1, Table B Revised).

Of note, due to this new project, UMMC has filed a second project change for the Cancer Center Project due to plant design changes and additional expenditures.

Staff concludes that this Request for an Exemption from a Certificate of Need is in the public interest, is not inconsistent with the State Health Plan, and will result in the delivery of more efficient and effective health care services. Therefore, staff recommends that the Commission **APPROVE** the project with the following conditions:

1. Prior to its request for First Use approval, UMMC shall provide information that details the activities it has undertaken following approval of this Exemption request to increase the amount of charity care 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 UMMC's progress is not satisfactory, further action regarding this Exemption request may be considered by the Commission at a public meeting before the issuance of First Use approval.

2. The applicant shall submit documentation of CARF accreditation to the Commission within a year of opening.

3. Any future change to the financing of this project involving adjustments in rates set by the HSCRC must exclude $8,318,812, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that is based on the excess construction cost.

4. The applicants shall document transfer and referral agreements, prior to First Use approval by the Commission.

IN THE MATTER OF THE	*	**BEFORE THE**
MERGER AND CONSOLIDATION	*	**MARYLAND**
OF PORTIONS OF	*	**HEALTH CARE**
UNIVERSITY OF MARYLAND REHABILITATION	*	**COMMISSION**
AND ORTHOPAEDIC INSTITUTE AND THE	*	
UNIVERSITY OF MARYLAND MEDICAL CENTER	*	
Docket No. 23-24-EX017	*	

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STAFF REPORT AND RECOMMENDATION
REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW

I. INTRODUCTION

A. Background

The applicants seek an Exemption from Certificate of Need (CON) review to relocate and consolidate acute inpatient rehabilitation and chronic care beds from University of Maryland Rehabilitation and Orthopaedic Institute (UMROI) to University of Maryland Medical Center (UMMC). Both hospitals are within the University of Maryland Medical System, Inc. (UMMS). To approve an Exemption request, the Commission must find that the project:

(1) is in the public interest;

(2) is not inconsistent with the State Health Plan; and

(3) will result in the delivery of more efficient and effective health care services.[2]

The applicants propose to move 58 beds from UMROI to UMMC. The total capital cost of the project will be $235,855,047. UMMS plans to finance the project through bonds, interest on bond proceeds, and state funding. Because UMROI and UMMC are both hospitals within the UMMS merged asset system, the relocation of acute inpatient rehabilitation and chronic care bed capacity from UMROI to UMMC constitutes a consolidation or merger in accordance with Health-General § 19-120(a)(2) and COMAR 10.24.01.04(E). Thus, the project is eligible for consideration for Exemption from CON review.

As specified in Health-General §19-301, an "acute rehabilitation hospital" is an institution "devoted to therapy that is designed to facilitate the process of recovery from illness or injury for patients with various neurological, muscular-skeletal, orthopedic, and other medical conditions

[2] COMAR 10.24.01.04E(1)

following stabilization of acute medical issues." Such facilities can offer specialized programs for pediatric patients or individuals with brain or spinal cord injuries. Maryland mandates that rehabilitation programs be accredited by the Commission on Accreditation of Rehabilitation Facility (CARF). COMAR 10.24.09. Acute inpatient rehabilitation services, whether conducted within a hospital or a specialized unit, deliver a rigorous regimen of coordinated medical and rehabilitative care. Further, this care is targeted at patients who are at high risk of medical instability, may require high-acuity skilled nursing, and need comprehensive service coordination and intensive care settings.

Health-Gen. §19-307(a)(1)(ii) defines "chronic services," or chronic hospitals, as those providing for patients not requiring acute care or treatment in another type of specialty hospital. These patients need more frequent physician monitoring and more intensive nursing care than what is required for comprehensive or extended care patients. Patients within chronic care have expected stays generally exceeding 25 days. COMAR 10.24.08.04.

B. **The Applicants**

University of Maryland Rehabilitation and Orthopaedic Institute (UMROI)

UMROI is Maryland's largest inpatient rehabilitation hospital. It offers acute care, specialty rehabilitation, and chronic hospital care. Located in southwest Baltimore City, it has five licensed medical/surgical/gynecological/addictions (MSGA) beds, 88 licensed acute inpatient rehabilitation beds, 40 chronic hospital beds, and 16 dually licensed chronic/rehabilitation beds. While it caters to a range of patient needs, its primary focus is on orthopedics and neurology, with both inpatient and outpatient services available.

UMROI is accredited by the CARF for programs such as Brain Injury, Spinal Cord System of Care, Comprehensive Integrated Inpatient Rehabilitation, and Stroke Specialty Programs. (DI #2, p.2; DI #10, Exh.13; DI #19, Exh.19).

University of Maryland Medical Center (UMMC)

An academic medical center on the west side of downtown Baltimore, UMMC includes a 710-bed downtown campus, which has 579 MSGA beds, 30 obstetric beds, 59 pediatric beds, 42 acute psychiatric beds. The medical center is a hub for medical education and research. (DI #2, p.1). UMMC states that it focuses on providing highly specialized tertiary and quaternary care for the entire state and region. At the downtown campus, clinical programs include the Cancer Center, the R Adams Cowley Shock Trauma Center, and the University of Maryland Hospital Children's Hospital. UMMC also offers organ transplantation, neuroscience, heart, and vascular care. (DI #2, p.1).

University of Maryland Medical System (UMMS)

UMMS is the largest health system in Maryland with an extensive network of health care facilities across the state. It operates 13 acute care facilities and more than 150 ambulatory and physician practice sites, including UMMC and UMROI. According to the applicant, 25 percent of the State's hospital services are delivered by UMMS. (DI #2, p.2).

UMMS states that it is focused on leading the advancement of post-acute care services. (DI #2, p.2). The goal of this project is to realign its acute inpatient rehabilitation and chronic care services to better serve its patients. (DI #2, p.3).

C. The Project

The proposed project brings rehabilitation services from UMROI to UMMC's downtown campus, with the goals of improving care delivery, patient outcomes, patient safety, quality, and access. Specifically, the project involves relocating:

- 25 acute inpatient rehabilitation beds for traumatic brain injury (TBI),
- 18 acute inpatient rehabilitation beds for spinal cord injury (SCI),
- 5 chronic care beds, and
- 10 dually licensed acute inpatient rehabilitation and chronic care beds.

The bed complement summarized is illustrated in Table I-1.

Table I-1: Proposed Relocation of Beds from UMROI to UMMC

Floor	Primary Specialized Unit	Acute Inpatient Rehab Beds	Chronic Beds	Dually Licensed Beds	Total
13	TBI Unit	25	3	1	**29**
12	SCI Unit	18	2	9	**29**
Total	[redacted]	**43**	**5**	**10**	**58**

Source: DI #2, p.3.

The project builds upon UMMC's original plans for the Stoler Center Tower expansion. UMMC received CON approval on August 20, 2020 (Docket No. 19-24-2438) to build a nine-story addition to the Stoler Center to house the Cancer Center. This project will build four additional floors on top of the Cancer Center, floors 10 through 14.

These additional four floors in the Stoler Center will obstruct windows in existing patient rooms in the North Hospital, rendering rooms on floors 10 and above non-compliant with the natural light standards specified by the Facility Guidelines Institute (FGI). Therefore, the applicants must move existing medicine and psychiatry beds in the North Hospital. (DI #2, p.11). The existing medicine and psychiatry beds will be moved to the new 10th and 11th floors and the relocated beds from UMROI will occupy the new 12th and 13th floors of the Stoler Center. (DI #2, p.6). UMMC will also renovate a portion of the existing space in the North Hospital. (DI #2, p.6-10).

The applicants state that the project will improve care delivery, enhance patient safety, quality, and access. Through the build-out of the new units on floors 9, 10, and 11, UMMC will double its number of private rooms in the medicine unit. (DI #2, p.18; DI #2, Exh.21). Conversion to private rooms will be more efficient and improve access to inpatient care. Further, bed capacity will reduce the frequency with which UMMC must "block" beds, making them not available for use by other patients when one bed is occupied by a patient requiring isolation.

Upon completion of the project, the Stoler Center will house 58 acute and chronic rehab beds (including 10 dually licensed beds) on floors 12 and 13; 22 private adult, geriatric, and child psychiatry patient beds on floor 11; 22 new private medicine beds on floor 10; and 16 new private medicine beds on floor 9. (Table I-2; DI #2, Exh.3).

Table I-2: Stacking Diagram of UMMC North Hospital and the Stoler Center

Existing North Hospital				Stoler Center		
	West Wing		**East Wing**			
14	**Mechanical Penthouse**	**North Elevators**	**Emergency Electrical Penthouse**	**Mechanical Penthouse**		**14**
13*	To be relocated from UMROI **Rehab Inpatient** *17 beds*		To be renovated **Rehab Support**	**Rehab Inpatient and Gym** *12 beds*		**13**
12†	To be relocated from UMROI **Rehab Inpatient** *17 beds*		To be renovated **Rehab Support**	**Rehab Inpatient and Gym** *12 beds*		**12**
11	Existing Space **Child/Adolescent Psychiatry** *16 private beds/rooms*		To be renovated and relocated from UMMC North West Wing **Psychiatry Support**	To be relocated from UMMC North, West Wing **Adult and Geriatric Psychiatry** *22 private beds/rooms*		**11**
10	Existing Space **Inpatient Medicine**		Existing Space **Inpatient Medicine**	To be relocated from UMMC North, West Wing **Inpatient Medicine** *22 private beds/rooms*		**10**
9	Existing Space **Inpatient Medicine**		To be constructed and renovated **Cancer Center Offices**	**Inpatient Medicine** *16 private beds/rooms*	**Cancer Center Offices**	**9**

* Floor 13 will hold the TBI unit with 25 acute inpatient rehab beds including three chronic beds and one dually licensed acute inpatient rehabilitation and chronic care bed.
† Floor 12 will hold the SCI unit with 18 acute inpatient rehab beds including two chronic beds, and nine dually licensed beds.
Source: DI #2, Exhibit 3.

V. PROCEDURAL HISTORY

Docket Item #	Description	Date
1	Applicants to MHCC – request filing	November 15, 2023
2	Applicants to MHCC – Request for Exemption from CON	December 29,2023
3	MHCC to Sun paper – Request to publish notice of receipt of Exemption	January 10, 2024
4	Notice of receipt to publish notice in the Baltimore Sun paper	January 10, 2024
5	First set of completeness responses received-incomplete response	January 12, 2024
6	MHCC to Applicants – Request completeness information	January 25, 2024
7	MHCC to HSCRC – Memo: UMMC/UMROI Merger CON Exemption Request	February 15, 2024
8	MHCC to Applicants – Request additional completeness information (HSCRC questions)	February 16, 2024
9	Applicants to MHCC – Email: Request extension to file completeness until 3/15/24	February 21, 2024
10	Applicants to MHCC – Partial Completeness Information 1/25/24 questions response	February 28, 2024
11	MHCC and Applicants – Email: Follow-up regarding Project Change Status	February 21 and March 6, 2024
12	Applicants to MHCC – Partial Completeness (Supplemental) Information 1/25/24 questions response	March 15, 2024
13	Applicants to MHCC – Completeness Information HSCRC 2/16/24 questions response	March 15, 2024
14	MHCC, HSCRC, and Applicants – Email: Outstanding Questions from HSCRC, Reply regarding status of Project Change, and Miscellaneous Discussion	March 20, 2024
15	MHCC to Applicants – Email, COMAR Clarification Needed	March 25, 2024
16	MHCC to Applicants – Request additional completeness information Part 2 (Commission Staff and HSCRC questions)	April 1, 2024
17	HSCRC to Applicants (VP of Corporate Decision Support and Capital Planning at UMMS) – Email	April 5, 2024
18	HSCRC to Applicants – Email (updated May 7, 2024)	April 5, 2024
19	Applicants to MHCC – Completeness Information 4/1/24 questions response	April 12, 2024
20	Revised UMROI UMMC Exemption Tables	April 30, 2024
21	UMD Cancer Center Project Change (19-24-2438)	April 26, 2024
22	MHCC to Applicants – Email, Re: Revised Tables	April 30, 2024
23	Applicants to MHCC – Revised UMROI UMMC Exemption Tables	April 30, 2024
24	HSCRC to MSCC – HSCRC response to Feb. 7, 2024, Memo request from MHCC	May 14, 2024

VI. DETERMINATION OF EXEMPTION FROM CERTIFICATE OF NEED REVIEW

Pursuant to COMAR 10.24.01.04E(1), the Commission may approve an Exemption from CON review for the relocation of acute rehabilitation and chronic care beds along with the capital expenditure of approximately $235 million if the merged asset system proposing the project has provided the required information, and the Commission, in its sole discretion, finds that the proposed action:

(a) Is in the public interest;
(b) Is not inconsistent with the State Health Plan; and

(c) Will result in more efficient and effective delivery of health services.

In this matter, the applicable State Health Plan Chapters are:

- COMAR 10.24.08: Special Hospital – Chronic Care
- COMAR 10.24.09: Specialized Health Care Services – Acute Inpatient Rehabilitation Services
- COMAR 10.24.10: Acute Care Hospital Services

A. <u>Is in the Public Interest</u>

The applicants state that the relocation of rehabilitation services within its system is in the public interest. Ultimately, the project objective is to improve the quality of care and access by providing more integrated care at a single location.

The proposed project relocates 58 acute rehabilitation and chronic care beds from UMROI to the downtown UMMC campus. (DI #2, pp.9,38,41). By relocating these beds to UMMC, they will be co-located in the same facility that offers trauma care and other essential services for these patients. (DI #2, pp.9-10). Patients at UMMC have access to a spectrum of medical services on one campus. The project eliminates the need for transfers between facilities for different aspects of their care. (DI #2, pp.12-16,31). This consolidation offers convenience and continuity of care, particularly for patients with TBI, SCI, and complex medical rehabilitation needs, minimizing disruptions to their treatment plans. (DI #2, pp.13,17,31-32).

Moreover, the applicants state that the project aims to broaden patient access to acute rehabilitation and chronic care services, such as for individuals undergoing cancer treatments, transplants, and patients with multiple comorbidities. (DI #2, pp.3,15,31,38,40-41). These patients have unique physical and cognitive needs and will benefit by having access to the relocated specialized rehabilitation staff and equipment at UMMC. (DI #2, pp.27,38-39). Integrating these specialized services at UMMC contributes to timely treatment, removes barriers to access to rehabilitation due to the complexities of patients' medical conditions, and overall improves quality of care. (DI #2, p.31).

Staff agrees that the project is in the public interest, as it aims to consolidate and enhance rehabilitation services within a centralized location at UMMC. This consolidation not only improves access and convenience for patients but also integrates specialized care, potentially leading to better outcomes and quality of life for individuals requiring complex medical rehabilitation and chronic care. The proposed project also introduces structural improvements, including private patient rooms and "neighborhood designs"[3] within the new units. These designs enhance patient comfort, safety, and workflow efficiency for staff, thereby fostering an environment conducive to healing and recovery. (DI #2, pp.8, 10, 16-18, 28-31, 55, 65; Exh.1).

[3] The "neighborhood design" refers to a specific layout and organizational structure of patient care units within the proposed UMMC rehabilitation units. This setup aims to create a patient-centered environment that "optimize room workflow for staff, patients, and family" and enhances the overall patient experience by bringing essential services, such as the gym and dining rooms, closer to where patients are located within the facility. (DI #1, p. 16).

B. Is not inconsistent with the State Health Plan

The applicable standards of the SHP for this Exemption include the Chronic Care, Acute Inpatient Rehabilitation Services, and Acute Care Hospital Services Chapters. Refer to Appendix 1 for an in-depth analysis of each standard with staff analysis of compliance with these standards.

The following is a brief summary of standards requiring conditions, briefly noting what must be met to comply with each.

Charity Care

In response to the Charity Care standard requirements, UMMC asserts its commitment to providing care to all patients regardless of their ability to pay. (DI #2, Exh.4). The policy ensures timely determination of eligibility, notification of charity care availability upon admission, and visible notices throughout the hospital. However, historical data shows UMMC allocated approximately one percent of its operating expenses to charity care in FY 2022. (DI #2, p.21-23). If a hospital has a level of charity care which falls within the bottom quartile of all hospitals, it shall demonstrate that its level of charity care is appropriate to the needs of its service area hospital.

UMMC states that its low ranking is partially due to its success in enrolling uninsured individuals in Medicaid. While that may provide some context, it does not fully excuse the low level of charity care provided by UMMC. Many patients may still face financial hardships or medical expenses not fully covered by Medicaid, necessitating charity care as a safety net. Staff believe that UMMC did not make a strong enough case that this level of charity is appropriate to the socio-economic characteristics of its service area population.

Staff recommends a condition to require the applicants to detail its efforts to increase the amount of charity provided to patients and demonstrate 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.

Transfer and Referral Agreements

According to the applicants, consolidation of rehabilitation services to UMMC's downtown campus streamlines care delivery and eliminates access barriers associated with patient transfers between facilities. (DI #2, pp.12-16). If a patient's needs surpass the unit's capabilities, they will be transferred to UMMC's acute care units or other UMMS facilities. The applicants have also established referral relationships with home health agencies and skilled nursing facilities for alternative treatment options. (DI #2, p.59; DI #10, p.11-12). To ensure a seamless transition for patients requiring a higher level of care or alternative treatment, the applicants shall document transfer and referral agreements, prior to First Use approval by the Commission.

Cost-Effectiveness and Construction Costs

The applicants' capital expenditure of approximately $235 million will facilitate structural improvements and prove to be cost-effective. This investment in the relocation of beds will enable the development of private patient rooms and neighborhood designs within the newly constructed

units, aligning with the SHP objectives to promote patient safety and quality of care. (DI #2, pp.55-56). Moreover, the decision to proceed with the relocation of the TBI and SCI beds concurrently with the build out of the Stoler Center is an efficient use of resources. By leveraging the ongoing construction of the Stoler Center, the applicants aim to capitalize on product deliveries, use of heavy equipment, minimize planned patient flow disruptions, and altered traffic patterns. (DI #2, p.11). Submitting the proposed project after the completion of the Stoler Center would likely inflate costs by approximately 150 percent. (DI #2, p.11).

Staff conducted a Marshall & Swift Valuation Service (MVS) benchmark analysis to compare the project's estimated construction costs. Staff analysis identified excess costs of $5,316,564, recommending $8,318,812 be excluded from future rate adjustments, as compared to applicants' calculation that identified only $476,172 in excess costs. This exclusion includes contingency, inflation, and capitalized interest allowances based on the excess costs. A proposed condition was made stating that any future change to the financing of this project involving adjustments in rates set by the HSCRC must exclude $8,318,812.

C. <u>Will result in the delivery of more efficient and effective health care services</u>

The bed relocation from UMROI to UMMC is a strategic initiative aimed at enhancing the efficiency and effectiveness of health care services. (DI #2, pp.3,65; DI #10, p.8). Placing TBI and SCI units near UMMC's acute and trauma care units streamlines care delivery, improves patient flow, and provides immediate access to the trauma team. For the hospital, closer proximity optimizes UMMC's resources, increases throughput, and reduces care delays. (DI #2, pp.15-18). Additionally, rehabilitation patients will benefit from being located alongside associated chronic care beds.

Rehabilitation patients often require regular follow-up appointments and ancillary services that are not available at UMROI. By co-locating these services, patients can attend appointments and receive necessary care promptly and more efficiently, without the inconvenience of traveling to other facilities. For example, the applicants note that transplant, oncology, TBI, and SCI patients, can all benefit from UMMC's array of physician subspecialties, including neuro-hospitalists, neuro-intensivists, brain tumor neurosurgery, brain tumor neuro-oncology, spine neurosurgery, and physiatry. (DI #2, p.31). The range of specialists on UMMC's campus removes the need for inter-campus medical transport and better allows providers to attend to medically complex comprehensive rehabilitation patients. For patients, medical transportation can be disruptive in the rehabilitation process. The improvement in clinical contact will promote health outcomes reflecting in more effective care services, according to the applicant. (DI #2, pp.31-32, Table 5).

Moreover, the construction related to UMROI's bed relocation enables UMMC to convert most semi-private rooms to private rooms, updating the space to meet the latest standards. (DI #2, pp.8, 10,16-18,28-31,55,65, Exh.1). Upgraded infrastructure design helps patients and staff alike, improving the effectiveness of care delivery and enhancing the overall quality of care provided.

In terms of financial feasibility, the applicants initially anticipated $55 million in state funding for the additional floors, however, this funding has not yet been realized. (DI #19, Table E). Also, the Maryland Department of Budget and Management (DBM) did not include the

requested funding in the 2025-2029 Capital Improvement Program (CIP) budget. Despite ongoing discussions and applicants' efforts to secure funding for the 2026-2030 CIP, the absence of confirmed state support raises some concerns about potential delays and the need for alternative funding sources. The applicants state that should it be unable to obtain state funding, it will consider contingent sources, such as combining cash from the balance sheet of UMMS, philanthropic support, and the issuance of additional long-term debt. (DI #19, p.2-4).

Staff notes that the Health Services Cost Review Commission (HSCRC) staff evaluation opined that the Exemption project request was feasible.[4] Specifically:

> *The construction and operation of the new Len Stoler tower are not without challenges. Based upon review of all the information provided, Staff believes that with proper management (focused upon internal operational performance, controlling construction costs in an inflationary marketplace, and maximizing third party funding) the new tower project, inclusive of the UMROI merger for beds and services, and exclusive of an incremental GBR award for capital, continues to be initially feasible and viable through to completeness and going forward for at least the two (2) operating cycles represented in the projections. (Appendix 4, p. 5).*

Despite financial uncertainties related to State funding, staff recommend approval based on the applicants' contingency plans and the HSCRC's financial feasibility analysis. The contingency plans outline potential alternative funding sources such as leveraging UMMS's balance sheet, seeking philanthropic support, and possibly issuing additional long-term debt should state funding not materialize.

Overall, the relocation of beds from UMROI to UMMC will improve patient safety, elevate quality of care, and boost accessibility through centralized resources, eliminating time-consuming transfers and lowering costs for individuals and the health care system. In light of these considerations, staff recommends that the Commission find that the project will result in the delivery of more efficient and effective health care services.

VII. STAFF RECOMMENDATION

The applicants propose relocating 58 acute rehabilitation and chronic care beds from UMROI to the UMMC. The total cost of the project will be $235,855,047 with the applicants financing the project through bonds, interest on bond proceeds, and state funding. This project will be achieved through the construction of additional floors to the UMMC's Stoler Center.

The proposed project will enhance health care services for patients by making comprehensive rehabilitation care more accessible and improving the quality of services provided within the UMMS system. Relocating rehabilitation services to UMMC's downtown campus will integrate care at one site, eliminating the need for patient transfers between facilities. This consolidation will specifically benefit patients with TBI, SCI, and complex medical rehabilitation needs by providing convenience and continuity of care. Additionally, the project will expand

[4] Health Services Cost Review Commission Meeting, February 14, 2024: https://hscrc.maryland.gov/Documents/February%202024%20HSCRC%20Public%20Post-Meeting%20Materials%20-FINAL.pdf

access to specialized services at UMMC while simultaneously contributing to structural enhancements of the Stoler Center. With the addition of four floors, UMMC will be able to convert most of the hospital's existing semi-private rooms to private ones to meet modern standards, contributing to more effective care. The design improves workflow, patient comfort, safety, and staff efficiency. In summary, the relocation of beds from UMROI to UMMC is likely to benefit the quality of care, accessibility, and efficiency through centralized care resources.

Staff recommends that the Commission **APPROVE** the applicants' request for an Exemption from a CON review to relocate acute rehabilitation and chronic care beds from UMROI to UMMC, with the following conditions:

1. Prior to its request for First Use approval, UMMC shall provide information that details the activities it has undertaken following approval of this Exemption request to increase the amount of charity care 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 UMMC's progress is not satisfactory, further action regarding this Exemption request may be considered by the Commission at a public meeting before the issuance of First Use approval.

2. The applicant shall submit documentation of CARF accreditation to the Commission within a year of opening.

3. Any future change to the financing of this project involving adjustments in rates set by the HSCRC must exclude $8,318,812, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that is based on the excess construction cost.

4. The applicants shall document transfer and referral agreements, prior to First Use approval by the Commission.

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OF PORTIONS OF	*	**HEALTH CARE**
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UNIVERSITY OF MARYLAND REHABILITATION	*	**COMMISSION**
	*	
AND ORTHOPAEDIC INSTITUTE AND THE	*	
	*	
UNIVERSITY OF MARYLAND MEDICAL CENTER	*	
	*	
Docket No. 23-24-EX017	*	

* *

ORDER

Having reviewed and considered the information and analysis contained in the Staff Report and Recommendation, it is, this 18th day of July 2024, hereby:

ORDERED that that findings of fact and conclusions of law included in the Staff Report and Recommendation are adopted by the Maryland Health Care Commission and incorporated into this order; and it is further

ORDERED that this request for Exemption from Certificate of Need review filed by James Lawrence Kernan Hospital, Inc., d/b/a University of Maryland Rehabilitation and Orthopaedic Institute (UMROI) and the University of Maryland Medical Center, LLC (UMMC), which will relocate and consolidate 58 acute rehabilitation and chronic care beds from UMROI to the UMMC with a total cost of $235,855,047 is hereby **APPROVED** with the following conditions:

1. Prior to its request for First Use approval, UMMC shall provide information that details the activities it has undertaken following approval of this Exemption request to increase the amount of charity care 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 UMMC's progress is not satisfactory, further action regarding this Exemption request may be considered by the Commission at a public meeting before the issuance of First Use approval.

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4. The applicants shall document transfer and referral agreements, prior to First Use approval by the Commission

APPENDIX 1

CONSISTENCY WITH THE STATE HEALTH PLAN

COMAR 10.24.08: Special Hospital – Chronic Care Standards

COMAR 10.24.09: Specialized Health Care Services – Acute Inpatient Rehabilitation Services

COMAR 10.24.10: Acute Care Hospital Services

COMAR 10.24.08.03: Special Hospital – Chronic Care Standards

A. Project Review Standards

(1) Need. An applicant shall quantitatively demonstrate the specific unmet needs it proposes to meet in its service area, by number of patients, principal and additional diagnoses, and expected length of stay.

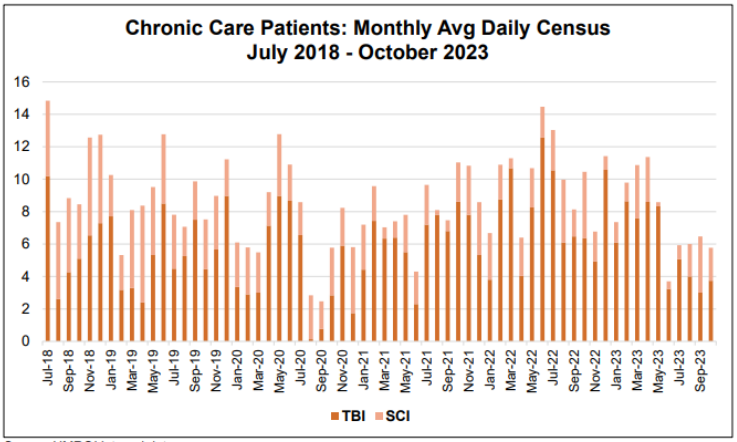
Applicants' Response

The applicants state that there is a need to relocate five chronic care beds and 10 dually licensed rehabilitation and chronic care beds from UMROI to UMMC based on several considerations.

First, regarding the use of chronic care beds, the applicants state that patient census fluctuates throughout the year, pointing to historical bed utilization and seasonal fluctuations in services such as TBI and SCI programs at UMROI. (DI #2, Table 9, p.41; DI #2, Table 18, p.60; DI #2, Table 10, p.44). Relocating these beds to UMMC would be beneficial, especially during the summer months when trauma events are most prevalent. Additional beds provide the capacity to accommodate the increased number of patients during these peak times. During times of lower patient volumes for TBI and SCI cases, such as in the winter months, the applicants will utilize the beds to accommodate more medically complex comprehensive medical rehabilitation (CMR) patients. (DI #2, pp.41-43).

The applicants state that the relocation is necessary to best provide care for chronic patients. (DI #2, p.38). The chronic care beds are intended for patients with multiple comorbidities, those undergoing transplants, and oncology patients. (DI #2, p.38). These patients present with unique physical and cognitive needs that will benefit when relocated and introduced to the broader medical offerings based at UMMC. The relocation of chronic care and dually licensed beds to the same unit, with specialized staff and equipment, benefits both acute and chronic patients and also contributes to more timely treatment. (DI #2, p.38-39).

Figure 10
UMROI Chronic Care Patients: Monthly Average Daily Census July 2018 – October 2023



Source: UMROI internal data.

The average length of stay (ALOS) for chronic TBI and SCI patients at UMROI over the last five fiscal years has ranged from 23.5 to 30.17 days. (DI #2, p.62, Table 19). Average daily census for TBI and SCI patients since July 2018 ranged from approximately two to 15 patients. (DI #2, Fig.10).

Based on the applicants' chronic care bed utilization projections, staff calculated that the ALOS and ADC will average 28.5 days and approximately 6 patients, respectively. (DI #19, Exh.20; DI #2, Table 10). According to the applicants, these projections indicate that allowing the relocated beds to part of the integrated health system at UMMC can enhance the hospital's ability to manage patient flow efficiently and ensure that resources are utilized. (DI #2, p.9).

Staff Analysis

Staff concludes that the applicants have justified the need for relocating five chronic care beds and 10 dually licensed rehab and chronic beds to UMMC.

The applicants note that patient census increases in the summer months when trauma events occur most frequently, and conversely, during periods when acute patient volumes are lower, beds that are relocated to UMMC can be utilized for medically complex patients. This flexibility in bed utilization optimizes hospital resources and ensures the need for continuous care for all patients.

The integrated system located on UMMC's campus allows for health coordination, facilitating the transfer of patients to appropriate levels of care within the facility when needed. This interconnectedness can balance the patient load across the system, reduce bottlenecks, and ensure that the need for chronic care services is neither overwhelmed nor underutilized. Moreover, relocating the chronic care beds allows for patients requiring long-term care to be accommodated without delay.

The applicants' ALOS projections of 28.5 days for chronic TBI and SCI patients reflect similar needs documented currently at UMROI. Given this extended duration of chronic care stays, maintaining 28.5 days ensures that there is capacity to accommodate the continuous and long-term care needs of these patients. The projection aligns with historical data and helps address any unmet need within the community; if patients require long-term, specialized care for chronic conditions or complex medical needs, they then will have access to the resources at UMMC, thereby reducing wait times and other interruptions in care.

Staff concludes that the applicants meet this standard.

(2) Financial Access. An applicant shall agree to accept patients whose primary payer source is Medicare and Medicaid.

Applicants' Response

The applicants state that they will comply with the requirement to accept patients whose primary payer source is Medicare and Medicaid. (DI #2, p.62). Both applicants currently accept patients whose primary payer source is Medicare and Medicaid and provided its documentation that they comply with Medicaid and Medicare standards. (DI #2, Exh.7).

Staff Analysis

As evidenced by the applicants' documentation of currently providing Medicare and Medicaid services and their commitment to do so in the future, staff concludes that the applicants meet this standard.

(3) Facility Occupancy. An applicant shall propose to serve and maintain at least an 85 percent average annual occupancy level.

Applicants' Response

The applicants propose to maintain chronic care occupancy levels above 85 percent annually. Their projections indicate an occupancy rate of 93.8 percent in FY 2027, increasing to 97.5 percent in FY 2029 at full utilization. (DI #2, Exh.1, Table I; DI #2, p.62). The ability to maintain these occupancy levels through the proposed relocation of 58 beds from UMROI to the UMMC campus is demonstrated by UMROI's historical utilization of beds and the Commission's 80% target optimal occupancy rate for acute inpatient rehabilitation beds. (DI #2, p.38). Between July 1, 2018, and October 31, 2023, UMROI's SCI and TBI programs' acute care patients' monthly average daily census (ADC) often met or exceeded the Commission's optimal 80% occupancy rate.

The new acute inpatient rehabilitation units at UMMC will also cater to medically complex CMR patients, including those undergoing chemotherapy and radiation, who currently cannot be accommodated at UMROI. (DI #2, pp.40-41). Based on a manual chart review performed by the Medical Director of UMROI, the projected average daily census of medically complex CMR patients at the UMMC acute inpatient rehabilitation units is 12. This includes eight patients requiring the intensive medication management, infusions, blood transfusions, and nursing care available at UMMC, as well as four oncology patients who currently cannot be transferred to UMROI for rehabilitation services due to their ongoing chemotherapy or radiation. (DI #2, p.41).

Staff Analysis

The applicants state that they will maintain an occupancy level above 85 percent annually, showing a projected occupancy rate of 93.8 percent in FY 2027 and 97.5 percent in FY 2029. These projections exceed the Commission's 80% target optimal occupancy rate for acute inpatient rehabilitation beds.

The applicant's assertions that they will meet the occupancy goals is supported by historical data. The applicants detail and illustrate high utilization rates currently at UMROI. (DI #2, Fig.9-10). The applicants expect such census data to continue once those beds are relocated to UMMC. Additionally, the inability of UMROI to accommodate patients undergoing chemotherapy and radiation, described as medical complex CMR patients, underscores the demand for rehabilitation services on the UMMC campus. By co-locating rehabilitation units with the Cancer Center at UMMC, the applicants effectively address the gap in services for patients as those needing acute inpatient rehabilitation patients will have access to it on the same campus where they receive their treatments. Together, this positions the applicants to achieve and maintain occupancy levels above the 85 percent threshold.

Thus, staff concludes that the applicants meet this standard.

(4) Jurisdictional Occupancy.

(a) The Commission may approve a Certificate of Need application for a new chronic hospital or a new chronic hospital service at an existing health care facility only if every chronic hospital in the jurisdiction has maintained, on average, an 85 percent or higher occupancy level, for the most recent fiscal year, as shown in the Chronic Hospital Occupancy Report published by the Commission in the Maryland Register. Each December, the Commission will issue a report on chronic hospital occupancy.

(b) The applicant may show evidence of why this standard should not apply.

This standard is not applicable. The applicants do not propose a new chronic hospital or new chronic care services. They propose relocating existing chronic care services from UMROI to UMMC, within the same health system and same jurisdiction.

(5) Financial Viability. Any applicant proposing to develop a new chronic hospital or a new chronic hospital service at an existing health care facility must demonstrate that it can meet the Medicare Conditions of Participation as a Long-Term Care Hospital consistent with 42 CFR Part 412.

The applicants plan to establish chronic care services at UMMC by relocating that existing care from UMROI. The applicants note that UMMC currently participates in the Medicare program and complies with the requirements outlined in 42 CFR Part 412. UMMC's projected average length of stay for chronic care patients (28.5 days) exceeds the 25-day minimum to qualify as a long-term care hospital. (DI #2, Exhibit 1).

Staff concludes that the applicants meet this standard.

(6) Expansion.

(a) The Commission may approve a chronic hospital for expansion only if all of its beds are available for use and it has been operating at 85 percent or higher average occupancy for the two most recent fiscal years, as shown in the Commission's Chronic Hospital Occupancy Report.

(b) An applicant may show evidence why this standard should not apply.

The applicants do not propose expansion of chronic hospital bed capacity. Thus, staff concludes that this standard is not applicable.

COMAR 10.24.09.04: Acute Inpatient Rehabilitation Services

A. – General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

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

(ii) *Notice of Charity Care Policy*. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and, in a format, understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) *Criteria for Eligibility*. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

(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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the number of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicants' Response

Regarding the Charity Care policy requirements in paragraph (a) of this standard, the applicants state that UMMC provides care to all patients regardless of their ability to pay. They provide a copy of the Financial Assistance Policy, which outlines the specifications for patients seeking assistance at all UMMS clinical facilities. (DI #2, Exh.4).

The policy includes the following provisions:

- Determination of probable eligibility is provided within two business days following a patient's request for charity care services or application for medical assistance.
- Patients are advised of the charity care policy at the time of admission or outpatient registration.

- That the applicants post notice regarding the availability of charity care throughout areas of the hospital, including the Emergency Department, the admission area, and the business offices. (DI #2, p.20; Exh.5).

Information and the application for charity care is also provided on UMMC's website. UMMC states that financial counselors are available to assist individuals in preparing and filing all documents required to seek charity care as well.

The applicants state that it adjusts the sliding scale of reduced-cost care to align with the Federal Poverty Level, which is included in its policy. (DI #2, Exh.4). Individuals with family incomes below 100 percent of the federal poverty guideline, lacking health insurance, and ineligible for public coverage qualify for charity care. Those with family incomes between 100 percent and 200 percent of the federal poverty guideline qualify for services at reduced charges.

Regarding paragraph (b), in FY 2022 UMMC provided charity care of approximately 1 percent. According to the most recent Health Services Cost Review Commission's (HSCRC) FY Community Benefit Report, UMMC would be in the bottom quarter of all Maryland hospitals. 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.

UMMC states that its lower ranking may be due to the high Medicaid enrollment among Baltimore City residents, where the hospital is located. According to Medicaid data presented by the applicant, Baltimore City had the highest percentage of Medicaid enrollment of all jurisdictions in Maryland in 2019, at 36.3 percent. (DI #2, p.22-23). Additionally, the applicants state that UMMC actively evaluates and helps to enroll uninsured individuals in Maryland's Medical Assistance program at the time of service, thus reducing patients' use of charity care. The applicants also state that UMMC often writes off and categorizes the costs of care given to patients with incomplete financial aid applications as bad debt, rather than charity care. (DI #2, p.23).

The applicants state that it is addressing these needs by implementing several programs that can be found in its Community Benefit Report including: community health education, outreach, career training for future health care providers, and other programs addressing various aspects of social determinants of health. (DI #2, pp.24-25). They state that this focus on community initiatives was part of UMMC's Community Health Needs Assessment for FY 2022-24. (DI #2, p.24, Exh.6).

Paragraph (c) is not applicable because this project is a merger and consolidation, not a new hospital or subunit acute inpatient rehabilitation services proposed in the project will be subject to rate regulation by the HSCRC.

Paragraph (d) is not applicable because the applicants are not a Health Maintenance Organization (HMO).

Staff Analysis

While the applicant's explanation for its low level of charity care due to high levels of Medicaid enrollment provide some context, it does not fully excuse the low level of charity care

provided by UMMC. Many patients may still face financial hardships or medical expenses not fully covered by Medicaid, necessitating charity care as a safety net. Further, bad debt is excluded from the definition of charity care and does not act as its substitute. Similarly, community benefit spending, though valuable and includes various initiatives addressing social determinants of health, differs from charity care in that it may not directly alleviate the financial burden on low-income patients who cannot afford medical services. Staff believes that it is appropriate to address the low level of charity care provided by UMMC and concluded that UMMC did not make a strong enough case that this level of charity care is appropriate to meet the socio-economic characteristics of its service area population. Staff recommends that the Commission attach the following condition to an approval of the project:

> *Prior to its request for First Use approval, UMMC shall provide information that details the activities it has undertaken following approval this Exemption request to increase the amount of charity care 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 UMMC's demonstration of progress is not satisfactory, further action regarding this Exemption request may be considered by the Commission at a public meeting before the issuance of First Use approval.*

(2) Quality of Care. A provider of acute inpatient rehabilitation services shall provide high quality care.

(e) 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 Commission for Accreditation of Rehabilitation Facilities.**
- **(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.**

(f) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

(g) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital, or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

Applicants' Response

For UMMC, the applicants provide:

- A copy of UMMC's licensure as an acute general hospital and the results of its last Joint Commission survey completed in May 2021 as evidence of licensing, accreditation, and compliance with the conditions of participation of the Medicare and Medicaid programs. (DI #2, Exh.7; DI #10, Exh.12).

For UMROI, the applicants provide:

- A copy of its current accreditation by the Commission for Accreditation of Rehabilitation Facilities (CARF) and by the Joint Commission. (DI #10, Exh.13).

UMMC states that it plans to pursue accreditation by CARF once the inpatient rehabilitation beds are open for service. (DI #2, p.26).

The applicants state that paragraphs (b) and (c) are not applicable because the applicants do not propose a new location or expansion of services, and the UMMS system currently operates an inpatient rehabilitation unit.

Staff Analysis

The applicants are currently licensed, in good standing, with the Maryland Department of Health (formerly the Department of Health and Mental Hygiene) and follow the conditions of participation of the Medicare and Medicaid programs. UMROI is currently accredited by CARF, and the applicants state that UMMC will seek accreditation by CARF when rehabilitation services are relocated to that facility.

Since UMMC will be establishing its own rehabilitation care after the relocation of beds from UMROI, UMMC will obtain its initial CARF accreditation. In doing so, the applicants must collect data for six months after opening, at which time a site survey will occur for sub-specialty accreditations for inpatient medical rehabilitation across various programs and data collection.

UMMC will contact its CARF representative to schedule the site survey after six months of operations and plans to obtain CARF accreditation. Since UMMC does not currently have CARF accreditation, Staff therefore requests the following condition:

The applicant shall submit documentation of CARF accreditation to the Commission within a year of opening.

B. Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access. A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

Applicants' Response

The applicants state that the proposed project offers improvements to existing health care barriers, such as the need to transfer patients from UMROI to UMMC for specialized ancillary services and physician subspecialties. The relocation of rehabilitation and chronic care beds from UMROI to UMMC will streamline access to ancillary and subspecialty services, eliminating the need for medical transport between the two facilities and preventing admission delays. (DI #2, p.31-32). In FY 2023, UMROI's TBI and SCI patients required 366 one-way trips (183 round trips) to receive specialized care. (DI #2, p.31).

UMROI and UMMC are approximately seven miles, or 20-25 minutes, apart. (DI #2, Fig.4). The relocated services will remain near UMROI's current service area. More than 80 percent of UMROI's patients from Maryland reside in the Central Planning Region, and 90 percent reside in the Central Planning Region or contiguous counties of Frederick, Montgomery, and Prince George's. Thus, the proposed relocation will remain geographically accessible for patients. (DI #2, pp.31-33).

Additionally, this project will reduce barriers to access by reducing the amount of semi-private rooms. (DI #2, pp.28-34). Currently, 88 percent of UMROI's rehab and chronic care beds are in semi-private rooms, often restricting health access due to pre-admission considerations such as gender, medical conditions, complexities of health status, co-morbidities, mental status, and the necessity for isolation. (DI #2, p.28). Due to the presence of shared rooms instead of private beds at UMROI, patients were delayed 390 patient days in total in FY 2023. This caused undue delays in acute rehabilitation care for patients. (DI #2, Table 5). At UMMC, when patients requiring isolation are admitted to a semi-private room, the hospital must "block" the second bed in that room. (DI #2. p.8).

Staff's Analysis

The proposed project will alleviate existing access barriers for patients. Patients at UMMC will have improved access to specialty services on-site, instead of the need for medical transport between UMROI and UMMC. Currently, UMROI is prevented from fully utilizing semi-private rooms due to patient-matching challenges. The construction of private acute rehabilitation rooms at the Stoler Center will improve the applicants' ability to admit patients more quickly.

The new location in Baltimore is unlikely to affect geographic accessibility since it is seven miles away from UMROI and located in the same city. Staff concludes that the applicants meet this standard.

(2) Need. A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Applicants' Response

Regarding paragraph (a), the applicants state that the proposed project does not add new beds to the region, so the paragraph is not applicable. (DI #2, p.44).

Regarding paragraph (b), the applicants state that in-migration and out-migration patterns have remained consistent year-over-year and are expected to continue after the relocation of rehabilitation programs to UMMC. Table II-1 shows the data the applicants provided for existing patient population origin at UMROI. As shown, 80 percent of patients originate from within the Central Planning Region, and 90 percent originate from that region and the next contiguous counties.

Table II-1: UMROI FY23* Inpatient Origin for Adult Specialized Programs Proposed to be Relocated to UMMC

Counties	TBI Program	SCI Program	CMR Program
Central Planning Region†	79.1%	78.2%	80.9%
Contiguous to Central Planning Region‡	13.5%	12.0%	11.2%
Combined	92.6%	90.2%	92.1%

Source: DI #2, Table 6 (p.34) using UMROI internal data.
* FY23 is July 1, 2022 – June 30, 2023.
Notes: percentages are based on Maryland residents, excluding out-of-state patients.
† Central Planning Region includes Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Cecil County, Harford County, and Howard County.
‡ Contiguous Counties include Frederick County, Montgomery County, and Prince George's County.

The applicants state that the two facilities are a 20-to-25-minute drive from one another and both within Baltimore City. (DI #2, Fig.4). Due to this, the applicants do not expect that future migration patterns among Maryland health planning regions and bordering states will change. (DI #2, p.34; DI #2, p.37, Table 8).

The applicants state that paragraphs (c) and (d) are not applicable to the proposed project.

Regarding paragraph (e), the applicants intend to relocate 58 beds from UMROI to UMMC.

Table II-2: Proposed Number of Beds to be Relocated from UMROI to UMMC

Number of Beds Relocated to UMMC	
Bed Type	**Number of Beds**
Traumatic Brain Injury: Acute Rehab	25
Spinal Cord Injury: Acute Rehab	18
Dually Licensed: Acute and Chronic Rehab	10
Chronic Care	5
Total	**58**

Source: DI #2, Figure 9, p.41

The applicants presented historical utilization data by month at UMROI, as illustrated in Figure 6 and 7 below, with seasonal fluctuations.

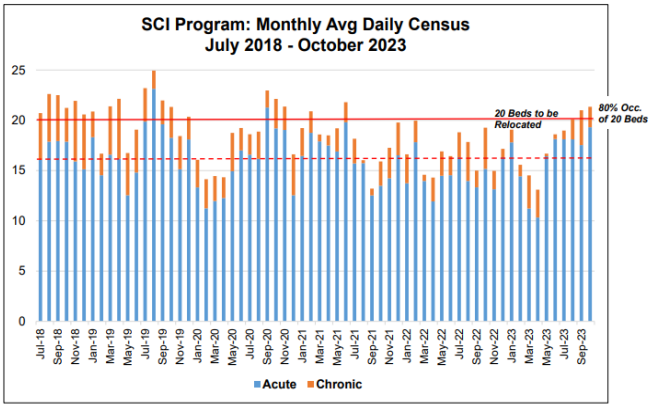
Overall, the data shows that UMROI had at least 80 percent occupancy for 43 dedicated acute rehabilitation care beds since July of 2018 for every month but one (March 2023). (DI # 2, p.42). When the applicants present data for SCI and TBI patients separately, data shows that those

units often have not reached 80 percent occupancy throughout the year, particularly in non-summer months. (DI #2, pp.39-40).

In addition to the oncology patients currently receiving care at UMMC, the needs of medically complex CMR patients can also be addressed by the availability of relocated beds at UMMC. (*infra*, p. 16). The applicants project an average daily census of 12 medically complex CMR patients that may utilize the relocated beds in UMMC. (DI #2, p.40, Fig.7). Due to COVID-19 causing volumes to temporarily decline, the applicants expect the volumes this fiscal year-to-date (since July 1, 2023) to be the best indicator of need for the relocated programs in the future. (DI #2, p.40).

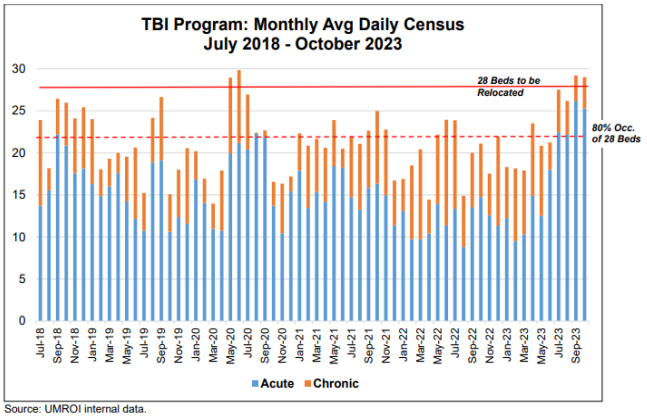
The applicants state that should patients exceed the unit's level of care capabilities, that circumstance would necessitate transfer to an acute general hospital unit, with UMMC facilitating admissions to its inpatient general hospital unit or arranging transfers to other UMMS hospitals if necessary. (DI #10, pp.10-11; refer to COMAR 10.24.09.04(B)(8), *infra,* pp.22-23).

Figure 6
SCI Program: Monthly Average Daily Census July 2018 – October 2023



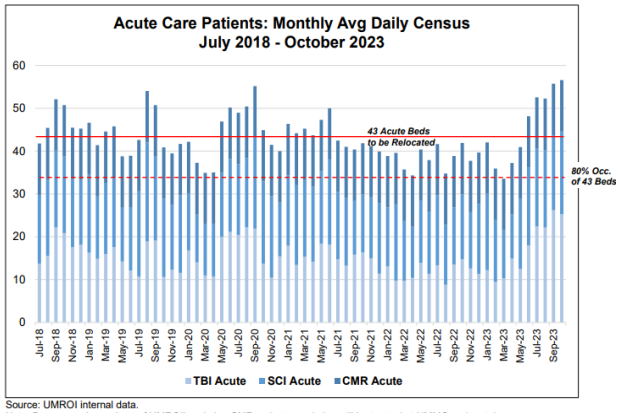
Source: UMROI internal data.

Figure 7
TBI Program: Monthly Average Daily Census July 2018 – October 2023



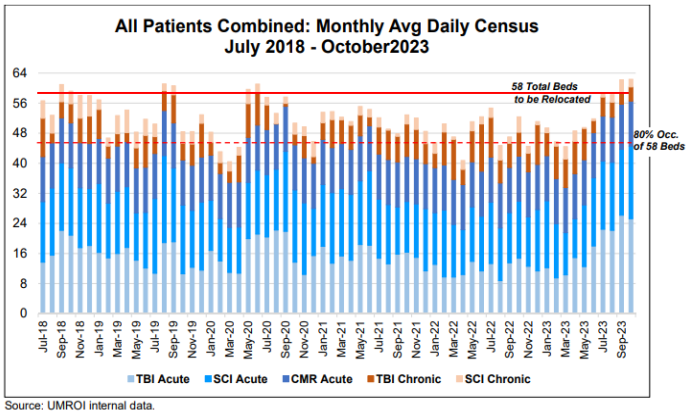
Source: UMROI internal data.

Figure 8
UMROI Acute Care Patients: Monthly Average Daily Census July 2018 – October 2023



Source: UMROI internal data.
Note: Because only a subset of UMROI's existing CMR patient population will be treated at UMMC and certain patients to be accommodated at UMMC are oncology patients who cannot currently be accommodated at UMROI, the "CMR Acute" portion of the bars are held constant at 12 to represent the Applicants' assumption of an ADC of 12 for medically-complex CMR patients to be treated at UMMC.

Figure 9
All Patients Combined: Monthly Avg Daily Census



Source: UMROI internal data.
Note: Chronic care bed need addressed in response to COMAR 10.24.08.03A.

Paragraph (f) is not applicable. The applicants plan to relocate existing acute inpatient rehabilitation beds from UMROI to UMMC, without adding new beds or establishing a new facility.

Staff Analysis

Staff concludes the applicants' responses sufficiently show the need for the acute rehabilitation beds and further highlight the ongoing benefits of transferring beds from UMROI to UMMC. There is a programmatic need for TBI, SCI, and medically complex CMR beds and the relocated beds will help to preserve flexibility in patient care. The projected need is corroborated by historical data which shows a minimum occupancy standard of 80 percent. (DI #2, p.38-43; Fig.6-9). Year-over-year patient visits are expected to remain consistent after the beds are relocated to UMMC.

The relocation to UMMC ensures the capacity to care for TBI, SCI, and medically complex comprehensive medical rehabilitation patients year-round. This care capacity takes into consideration the seasonal fluctuations in certain services, especially as the number of TBI and SCI acute and chronic patients increase during the busy summer months and care for the most medically complex acute comprehensive medical rehabilitation patients increases during winter months. (DI #2, p.38; Fig.6,7). The submitted data indicates that UMROI's programs often met or exceeded the optimal occupancy rate, further supporting the need for relocation. (DI #2, pp.41-44; Fig.8,9).

Thus, staff concludes that the applicants meet this standard.

(3) Impact. A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

- **(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;**
- **(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;**
- **(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and**
- **(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.**

Applicants' Response

The applicants state that they do not anticipate any adverse impact on patient volume, average length of stay, or case mix at other existing acute inpatient rehabilitation providers. Given

the close proximity of UMROI to UMMC, patient volumes are unlikely to change significantly, and patient demographics are projected to remain consistent. (DI #2, pp.33-45). Moreover, a majority, 80 percent, of referrals to UMROI come from within UMMS, while 20 percent originate from outside the health care system. (DI #2, p.45, Table 11).

Likewise, the relocation of UMROI services to UMMC is not projected to reduce the availability or accessibility of services for any patient population, including indigent, uninsured, or charity patients. In fact, the applicants project that the relocation of UMROI services to UMMC will enhance patient access to highly specialized subspecialty services.

Regarding paragraph (c), the relocation of select UMROI services to UMMC will not affect the quality of care at other providers, as it involves only specific service lines and leaves the remaining service lines unaffected at UMROI.

UMROI intends to shift full-time equivalents (FTEs) from its current staffing plan to UMMC to support the relocated inpatient rehabilitation services. FTEs remaining at UMROI will be adequate to manage the care of patients in programs staying at the current facility and not be part of the relocation project. (DI #2, p.46).

Staff Analysis

The proposed project's primary aim is to relocate the existing highly utilized rehabilitation program from UMROI to UMMC, and to enhance the quality and continuity of care for the applicants' existing patient population. The origin of admissions is predominantly referral-based, from within UMMS thus there should not be any adverse impact to other providers. The applicants will adequately maintain staff levels for programs remaining at UMROI.

Staff concludes that the applicants meet this standard.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, 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.

Commission staff and UMMC each calculated the Marshall & Swift Valuation Service (MVS) benchmark analysis that compared the project's estimated allowable new construction costs for the five-story addition plus mechanical penthouse to The Stoler Center derived using the MVS guide. See Appendix 3 for more details on the MVS analysis.

Table II-3 below provides the comparison of both the MHCC's and UMMC's MVS allowable new construction costs with the MVS benchmark value as reported in the MVS guide for a good quality Class A hospital.

Table II-3: MHCC and UMMC Comparison Table
Calculation of Excess Construction Cost Over MVS Benchmark Value

	Key	MHCC MVS Calculations	UMMC MVS Analysis
Project Cost for MVS Comparison (SF)		$581.37	$567.72
Less MVS Benchmark Cost (SF)		$529.45	$563.28
Over (=Project Cost - MVS Benchmark Cost)	a	$51.92	$4.44
Square Footage (UMROI addition)	b	102,402	107,246
Construction Costs over MVS Benchmark (Total Dollar Amount)[1]	c = (a * b)	$5,316,564	$476,172
Percentage Construction Cost over MVS Benchmark [2]	d	9.81%	0.79%
Inflation Allowance (Project Budget)	e	$12,105,952	$12,105,952
Amount Inflation Allowance excluded	f = (d * e)	$1,187,594	$0
Contingency Allowance (Project Budget)	g	$18,498,005	$18,498,005
Amount Contingency Allowance excluded	h = (d * g)	$1,814,654	$0
Total to be excluded from any rate increase proposed by the hospital	i = c + f + h	$8,318,812	$476,172

[1]Includes portion capitalized construction interest expenditure
[2]Using Percentage Construction Cost over MVS Benchmark

MHCC staff and UMMC each calculated allowable new construction costs used in comparison with the MVS benchmark values for the proposed UMROI project. MHCC staff calculated an estimated allowable new construction cost of $581.37 per SF and an MVS benchmark of $529.45 per SF. Comparably, the applicant arrived at an estimated MVS allowable new construction cost of $567.72 per SF and an MVS benchmark value at $563.28 per SF. See Appendix 3 for an analysis of the discrepancies.

MHCC's analysis showed that $8,318,812 should be excluded from any future rate increase due to construction of the five floors plus mechanical penthouse to The Stoler Center. Staff recommends adding a condition to exclude the following amount from any partial rate adjustment applications submitted to HSCRC in the future:

Any future change to the financing of this project involving adjustments in rates set by the HSCRC must exclude $8,318,812, which includes the estimated new

construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that is based on the excess construction cost.

(5) Safety. The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

Applicants' Response

According to the applicants, patient safety will improve with the availability of fully private rooms. (DI #2, pp.55-56). At UMMC, patients will have direct access to specialized services on-site, eliminating the need for transfers and ensuring timely delivery of care. A summary of the safety benefits, as described by the applicants, is shown in Table II-4.

Table II-4: Summary of Features and Benefits Associated with the Proposed New Construction

Feature	Evidence
Private Rooms for Enhanced Infection Control and Medication Safety	Decreased infection risk and reduced potential for medication errors due to isolation provided by private rooms.
Ceiling Tracking Systems and Teleport Devices	Increased staff compliance with safety equipment use and decreased transfers, benefiting both patients and staff. The use of teleport devices highlights the commitment to leveraging technology for patient safety monitoring.
Unit Design for Specific Patient Populations	Minimization of harm through unit design tailored for TBI and SCI patients, reducing wandering and flight risk.
Smoke Compartment Zones and Rehabilitation Gyms	Reduction in patient travel distances during emergencies or therapy sessions, enhancing safety.
Access to Specialty Services on Campus	Convenience and safety benefits for patients, particularly those requiring advanced imaging and 24-hour laboratory services, without the need for transfers.

Source: DI #2, pp.55-56.

The designs for new acute and chronic care beds at UMMC are in line with safety codes currently accepted by Baltimore City Building, Fire, and Related Codes 2020. (DI #10, Table 21). The new hospital construction will adhere to the 2022 FGI Guidelines, which outline the minimum requirements for basic rehabilitation facilities. The applicants state that the designs incorporate feedback from UMROI clinicians regarding space requirements for proper care, rehabilitation, and maneuverability of patients with severe, life-altering injuries. (DI #10, p.10). Many of the rehabilitation patients rely on powered wheelchairs, so storage space and gym facilities will be built beyond the FGI Guidelines minimums.

Staff Analysis

The applicants demonstrate consideration for patient safety by incorporating fully private rooms, specialized unit design, and access to specialty services directly on campus in the design.

Construction plans adhere to city codes, FGI guidelines, and incorporate feedback from clinicians. The applicants' response shows a proactive approach to designing a facility that meets the specific needs of patients with severe injuries. Considering these factors, staff concludes that the applicants meet this standard.

(6) Financial Feasibility. A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

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

(b) Each applicant must document that:

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

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

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

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Applicants' Response

For paragraph (a), the applicants included assumptions along with its financial statements. (DI #2, Exh.1).

For paragraph (b), the applicants provided projections that future utilization align with historical trends for existing services at UMMC and relocated services from UMROI. In forthcoming years, they project a volume growth of 2 percent. (DI #2, Exhibit 1, Tables I, F). Additionally, they foresee revenue increases consistent with utilization projections that are grounded in the current Global Budget Revenue (GBR), reimbursement rates, and ongoing negotiations with the HSCRC. (DI #2, Exhibit 1, Tables G, H, J, and K). The applicants based staffing and overall expense projections on current expenditure levels and reasonably anticipated future staffing levels as experienced by UMROI. (DI #2, pp.57-58; Appendix 4). The hospital

expects to generate excess revenues over total expenses, including debt service expenses and depreciation of plant and equipment. (DI #2, Exhibit 1, Tables G, H, J, and K).

Staff Analysis

Staff requested a review of the applicants' financial projections from HSCRC assessing the financial feasibility of the project. (DI #7). HSCRC's response is found in Appendix 4.

Per HSCRC's review, the applicants' projections for future utilization are consistent with observed historic trends in the use of the applicable services by service area populations and the SHP. The applicants' net revenues, based on the GBR, and projections are provided in revised Tables G, H, J, and K. In the last year of projection, FY 2029, the applicants' net operating revenue is expected to be $2,538,049 in FY 2029, increasing from the net operating revenue of $2,021,095 in FY2022 and $2,092,116 expected in the current FY 2023. This is compared to net operating expenses of $2,452,759 in FY 2029 and a net income of $85,290 in that same year (DI #2, Exh.1, Table H). Further summaries of its findings are below:

- HSCRC's review finds that the average annual operating income and cash basis operating margin support will help UMMC generate excess revenues over total expenses, including debt service expenses and plant and equipment depreciation, within five years of initiating operations, even under conservative assumptions without incremental GBR awards for capital-related expenses. (Appendix 4).

- HSCRC's review of revised Table F shows inpatient days growing at an average rate of 1.6% per year over the seven years ending FY 2030, with a higher growth during the initial operational years of the project. This supports the applicants' utilization projections. (Appendix 4).

- HSCRC's review of financial projections in revised Table G (P&L Entire Facility/Services Uninflated) and Table H (P&L Entire Facility/Services Inflated) reflect positive operating margins and cash basis operating margins, indicating sound financial health and feasibility. (Appendix 4).

- HSCRC's review of Tables J (P&L Uninflated, New Facility or Services) and K (P&L Inflated, New Facility or Services) shows that the merged operation will result in operating losses initially but will maintain positive cash basis operating margins. (Appendix 4).

- According to HSCRC's letter, despite potential risks in grant funding, the overall financial health "may be optimistic." HSCRC acknowledges potential risks exist relating to grant funding and inflation. They note that these risks, however, do not jeopardize the project's financial viability. (Appendix 4).

HSCRC's review and positive opinion supports the project's financial soundness. HSCRC is satisfied that the project will be financially feasible.

Staff has evaluated the feasibility of the applicants' project. Considering the comprehensive review and positive opinion provided by HSCRC regarding its financial soundness, staff agrees with the conclusion that the project meets the required financial standards.

Of note, the 2025 Governor's Capital Budget, as submitted in January 2024, does not include the $55 million of funding for the proposed project. (DI #19, pp.4). However, the applicants state that they have accounted for risk management by preparing contingency plans. These plans address factors such as labor shortages, disruptions in the supply chain for construction materials, enhancements in moveable equipment, contingency funds, capitalized interest expenses, early procurement efforts, and other related expenses. (DI #19, pp.4-5).

Staff agrees with HSCRC's assessment and acknowledge the proactive measures taken by the applicants to manage project risks effectively. Thus, staff concludes that the applicants meet this standard.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

Applicants' Response

The inpatient rehabilitation unit will contain 53 beds, of which 43 are acute inpatient rehabilitation beds and 10 are dually licensed acute inpatient rehabilitation and chronic care beds. Although the minimum occupancy standard is 80 percent, the applicants project an average occupancy of more than 90 percent, *supra*, pp.4-5. (DI #2, p.58; Exh.1, Table G; Table I-1).

Staff Analysis

The inpatient rehabilitation unit will contain 53 beds, which exceeds the minimum size requirement of 10. Additionally, the applicants project an average occupancy of more than 90 percent, surpassing the minimum 80 percent occupancy stipulated in COMAR 10.24.09.05D(5)(a).

Staff concludes that the applicants meet paragraph (a) of the standard and concludes that paragraph (b) is not applicable, as the applicants do not propose an acute inpatient rehabilitation specialty hospital.

(8) Transfer and Referral Agreements. Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

Applicants' Response

The applicants state that UMMC's acute inpatient rehabilitation unit will possess the highest level of care capabilities among all inpatient rehabilitation units in the State. (DI #10, p.11). Consequently, the applicants do not expect to encounter any acute inpatient rehabilitation patients exceeding the care capabilities at UMMC. (DI #10, p.11). Should a patient surpass the capabilities of the care level provided by UMMC's inpatient rehabilitation unit, they will be transferred to an acute general hospital inpatient unit within UMMC or to other acute care facilities within the UMMS system. (DI #10, pp.11-12).

If needed, for urgent concerns, UMMC could provide treatment in its Critical Care Resuscitation Unit. (DI #10, p.11). In cases where UMMC lacks available inpatient beds, the University of Maryland Access Center identifies suitable beds. Patients may then be transferred to other UMMS acute general hospitals, including University of Maryland Midtown, University of Maryland St. Joseph's Medical Center, and University of Maryland Baltimore Washington Medical Center. (DI #10, p.11-12).

For alternative treatment programs, the applicants state that they have established referral relationships with various organizations, including home health agencies and skilled nursing facilities. Specific home health agencies include: Amedisys Home Health, Centerwell Home Health, Bayada Home Health Care, VNA of Maryland, All about Home Care, PB Home Health, Homecall, and Medstar Health VNA. In addition, the applicants work with skilled nursing facilities, including Westgate Hills Rehab and Healthcare-Marquis, FutureCare, Lorien Bulle Rock, Citizens Care & Rehabilitation Center, Sterling Care Riverside, and Autumn Lake Healthcare. By referring patients to these alternative programs, the applicants aim for patients to receive appropriate care. (DI #2, p.59).

Staff Analysis

The applicants have identified facilities and organizations that will assist in managing care, should cases exceed UMMC's inpatient rehabilitation or acute inpatient capabilities. The applicants also provided a list of organizations with which they intend to maintain referral relations.

Because the applicants are required to provide documentation of these agreements, staff recommends the following condition:

The applicants shall document transfer and referral agreements, prior to First Use approval by the Commission.

(9) Preference in Comparative Reviews. In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

There is no comparative assessment of applications. Thus, staff concludes that this standard does not apply to the applicants' proposal for Exemption.

COMAR 10.24.10.04: Acute Care Hospital Services[1]

A. General Standards.

(1) Information Regarding Charges. Information regarding hospital charges shall be available to the public.

(a) At a minimum, a hospital shall:

(i) Comply with requirements of the HSCRC regarding posting or providing charge information; and

(ii) Comply with requirements of CMS for surprise billing and price transparency, including Code of Federal Regulations, Title 45, Parts 149 and 180.

(b) A hospital shall demonstrate compliance with price transparency laws and regulations. Commission staff may request information about the hospital's compliance with price transparency laws and regulations from the applicant hospital, HSCRC, the Consumer Protection Division of the Attorney General's office, and other entities as appropriate.

Applicants' Response

The applicants submitted information regarding charges for inpatient and outpatient services, available online on the UMMS website.[2] (DI #12, p.2). They state that they adhere to federal and State regulations, complying with the requirements of both the HSCRC and CMS on price transparency. The applicants also provide a copy of the UMMS Financial Assistance Policy. (DI #2, Exh.4).

Staff Analysis

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

Staff reviewed the information found on UMMS' website regarding charges and UMMS' Financial Assistance Policy submitted in the application. The applicants comply with the posting requirements of the HSCRC to provide charge information; this information is found within the hospital and published for the public online. They also comply with the requirements of CMS for price transparency. Staff concludes that the applicants comply with this standard.

(2) Charity Care and Financial Assistance Policy. Each hospital shall have a written policy for the provision of charity care and reduced cost care to patients who lack health care coverage or whose health care coverage is insufficient.

(a) The hospital's policy shall comply with Health-General §19-214.1.

[1] The applicants requested that MHCC staff evaluate the Exemption Request under the revised Acute Care Hospital State Health Plan Chapter effective March 18, 2024. (DI #19, p.3).

[2] https://www.umms.org/ummc/patients-visitors/for-patients/financial-assistance-billing/price-transparency

(b) The policy shall provide that the hospital makes a determination of eligibility within 14 days following a patient's completion of an application for charity care services, application for medical assistance, or both.

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

(d) A hospital shall demonstrate compliance with laws and regulations for financial assistance. Commission staff may request information about the hospital's compliance with laws and regulations for financial assistance from the applicant hospital, HSCRC, the Consumer Protection Division of the Attorney General's office, and other entities as appropriate.

This standard is duplicative of the Charity Care Policy Standard found at COMAR 10.24.09.04(A)(1) of the Acute Inpatient Rehabilitation Services Chapter, discussed *supra* pp.6-9.

Regarding subparagraph (b), refer to the applicants' response *supra*, p.7. The applicants note that determination of eligibility is provided within two business days following a patient's request for charity care services or application for medical assistance.

Regarding subparagraph (c), refer to the applicants' response *supra*, pp.7-8.

Regarding subparagraph (d), refer to the applicants' response *supra*, p.8 and *infra* p.27.

Staff concludes the applicants meet various aspects of this standard. The applicants have appropriately addressed all but one of the subparagraphs of the standard, *supra*, p.9. The applicants provided historical charity care data showing that charity care comprised 1.13% of total operating expenses at UMMC in FY 2022. This places the hospital in the bottom quartile for charity care expenditures among all Maryland hospitals. (DI #2, p.21). To address subparagraph (c) effectively, the applicants should provide more detailed information on specific actions and programs aimed at increasing the provision of charity care to financially disadvantaged patients. These efforts should align with the hospital's broader community benefit goals. Staff recommends that any approval of this exemption request include the following condition:

> *Prior to its request for First Use approval, UMMC shall provide information that details the activities it has undertaken following approval of this Exemption request to increase the amount of charity care 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 UMMC's demonstration of progress is not satisfactory, further action regarding this Exemption request may be considered by the Commission at a public meeting before staff issues First Use approval*

(3) Quality of Care. An acute care general hospital shall provide high-quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission, or other accreditation organization recognized by CMS, as acceptable for obtaining Medicare certification and approved by the State of Maryland; and

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

(b) Each hospital shall explain how the hospital is taking steps to improve its performance for each Quality Measure on which the hospital performed below the statewide average, as reported on the Commission's Maryland Quality Reporting website with respect to measures for patient satisfaction, patient safety, infections, and any other quality measures the Commission deems relevant to a hospital's proposed project.

(c) Each hospital shall:

(i) Explain its efforts to address measures of quality tracked by the HSCRC; and

(ii) Demonstrate that it has implemented a credible plan for achieving progress towards benchmarks for quality established by HSCRC.

Applicants' Response

Regarding paragraph (a), the applicants submitted to the Commission documentation of the applicant's licensure, accreditation, and compliance with the conditions of participation in the Medicare and Medicaid programs.

For UMMC, the applicants provided the following documents:

- Copy of UMMC's licensure as an acute general hospital, and
- A current letter of accreditation from the Joint Commission.

(DI #2, Exh.7; DI #10, Exh.12).

For UMROI, the applicants provided the following documents:

- A copy of its accreditation report by the Commission for Accreditation of Rehabilitation Facilities (CARF), and
- A current letter of accreditation from the Joint Commission.

(DI #10, Exh.13,14).

Regarding paragraphs (b) and (c), the applicants state that UMMC and UMROI actively engage in enhancing their performance across various quality measures, employing several strategies to achieve this goal.

First, the applicants state that UMROI is a leader in delivering high-quality rehabilitation care, as evidenced by its 2023 internally published program reports for TBI, SCI, and complex medical rehabilitation (DI #2, Exh.8). UMROI reports a case mix index significantly higher than regional and national averages, which it states shows proficiency in handling highly medically complex cases. For instance, approximately 58 percent of SCI patients and 60 percent of TBI

patients require rehabilitation care due to traumatic injuries, compared to national averages of 23 percent and 31 percent, respectively. (DI #2, p. 27). These statistics contextualize UMROI's performance within a broader framework. For instance, it indicates that they treat a larger proportion of patients with highly complex medical needs, suggesting that UMROI has the resources to manage and rehabilitate highly complex cases.

UMROI also submits outcome comparative data through Uniform Data Systems and reports patient satisfaction data through Press Ganey, a nationally recognized company specializing in patient satisfaction surveys.[19] (DI #10, pp.9-10). The information displays the historical performance, patient satisfaction, functional outcomes, and specialized care capabilities. (DI #10, Exh.8). According to comparative data received through the Uniform Data Systems, UMROI's Inpatient Rehab Facility Patient assessment results show high marks in patient quality and satisfaction in the treatment of SCI and TBI patients. (DI #2, p.27; DI #10, Exh.8). According to the applicants, UMROI also exceeds expectations in functional outcomes, particularly for SCI and medically complex patients such as oncology patients. (DI #2, p. 27).

The applicants indicate that UMROI has the only secured TBI unit in the state; this allows the facility to effectively treat behaviorally complex patients with serious cognitive impairments (DI #2, p. 27). Due to the unique nature of its specialized care, the applicants surmise that UMROI's performance, particularly concerning TBI patients, may not be accurately reflected when compared with other rehabilitation providers. Nonetheless, the applicants are confident that UMROI's consistently high patient satisfaction marks serve as a reliable measure of its performance (DI #2, p. 27). The applicants expect that they will obtain the same patient outcomes when the beds are relocated to UMMC.

Staff Analysis

The applicants also submitted documentation that they provide high-quality care as evidenced by its licensure from the Maryland Department of Health and accreditation from Joint Commission and CARF. According to the Commission's Maryland Quality Reporting Website, UMMC performed above the State average for all patient safety metrics and for nearly all patient satisfaction and infection metrics.[3] Only very limited data is available on the Quality Reporting Website for UMROI. However, applicants report high patient satisfaction ratings at UMROI, and believe that the ratings are a reliable indicator of the performance expected to continue at UMMC once the rehabilitation beds are relocated.

UMROI reports a case mix index significantly higher than regional and national averages, demonstrating that it is able to care for the highest acuity patients. Staff notes the significance that specialized care, like the rehabilitation beds to be relocated to UMMC, can have to improve outcomes; it may allow health care professionals to gain experience and expertise in treating complex conditions, can enable specialized health programs to develop, and makes way for the implementation of best practices that result in more effective treatments and better patient recovery. The applicants have demonstrated how relocating these beds to UMMC, which provides a fuller spectrum of medical services, will improve the quality of care for rehabilitation and chronic services patients. This consolidation offers convenience and continuity of care, particularly for

[3] UMMC performed below average on room and bathroom cleanliness and central line-associated blood stream infections.

patients with TBI, SCI, and complex medical rehabilitation needs, minimizing disruptions to their treatment plans.

Staff concludes that the applicants comply with this standard.

B. Project Review Standards.

The standards in this section are intended to guide reviews of CON applications and requests for Exemption from CON review involving acute care general hospital facilities and services. An applicant for a CON shall address, and its proposed project shall be evaluated for compliance with, all applicable review standards. An applicant for an Exemption from CON review shall address, and its proposed project shall be evaluated for consistency with, all applicable 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 for the population in the likely service area. Optimal travel time for general medical, surgical, intensive care, critical care, and pediatric services shall be within 30 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region in which the new hospital is located, or in which the existing hospital will be relocated, is within 30 minutes under normal driving conditions of acute care general hospital services, or if the Commission determines that access will be substantially improved for the population in the applicant's service area, through a reduction in travel time.

The relocation of acute inpatient rehabilitation and chronic care bed capacity from UMROI to UMMC constitutes a consolidation or merger, not a new or replacement hospital. Thus, staff concludes that this standard does not apply.

(2) Non-Geographic Barriers to Access. Hospital services shall be accessible to all Maryland residents and the type, amount, or quality of hospital care provided may not be affected by the patient's gender, race, ethnicity, or ability to pay.

(a) An acute care general hospital shall only deny admission if it is unable to provide the appropriate level of care for a patient or if a psychiatric patient's admission is involuntary and the hospital or hospital unit has been issued an Exemption by the Commission that permits it to serve only voluntary psychiatric patients in accordance with COMAR 10.24.21.

(b) An acute care general hospital shall identify and explain its efforts to address non-geographic access barriers, including but not limited to barriers that stem from a patient's race, gender, ethnicity, or ability to pay. A hospital shall also present how progress has been measured and shall be measured for any access barrier identified.

Applicants' Response

The applicants highlight specific aspects related to non-geographic barriers to access. These include addressing issues such as semi-private rooms. The applicants state that, currently, 88 percent of UMROI's beds are in semi-private rooms, which limits access to services and UMROI must consider pre-admission patient-matching factors before admitting a patient in need of intensive rehabilitative and restorative services if they share a room. (DI #2, p.28).Currently, patients must be cohorted by gender. The applicants also state that semi-private rooms can also lead to violent/impulsive behaviors towards another patient's ethnic group or gender if patients are not cohorted with a similar patient. In addition, the applicants identify the specific breakdown of bed needs, including oncology, MSGA, rehabilitation, and psychiatric beds. By increasing the availability for use of various types of beds, the applicants may accommodate more patients seeking health services at UMMC. The relocated rehabilitation and chronic care beds are designed to serve medically complex CMR patients, including those undergoing chemotherapy and radiation treatments, who cannot currently be accommodated at UMROI. (DI #2, pp.40-41). The specific breakdown of these bed types is represented in Table II-6.

Table II-6: Net Bed Relocation Breakdown

Bed Type	Net Number of Beds	Project Association
Oncology	10	Cancer Center*
MSGA	12*	Cancer Center and Exemption Request†
Rehabilitation	43	Exemption Request
Psychiatric	-6	Exemption Request

Source: DI #2, Exhibit 1, Table A
* Docket No. 19-24-2438
† Docket No. 23-24-EX017
‡ The net number of MSGA beds in Acute Care will increase from 332 to 344 as a result of both Dock Nos. 19-24-2438 and 23-24-EX0172. Refer to DI #2, Exhibit 1, Table A for more information.

Lastly, the applicants state that overall, there will be no change in the availability or accessibility of services for any patient population, including those who are indigent, uninsured, or eligible for charity care, due to the relocation of UMROI's highly utilized services to the UMMC campus. (DI #2, p.45). The applicants claim that increased access to more private rooms and to highly specialized subspecialty services will be enhanced by the co-located services of UMROI and UMMC. They also note the financial challenges faced by its patient population, recognizing Baltimore City has a significantly higher percentage of Medicaid enrollees compared to the statewide average, of 36.3% and 19.8% respectively in calendar year 2019. As a result, UMMC has implemented a process of evaluating uninsured patients treated at the hospital for Medicaid eligibility. They further offer assistance with enrollment. (DI #2, pp.22-23).

Staff Analysis

The applicants identify a current non-geographic barrier to access in the use of semi-private rooms at UMROI and state that the relocation could alleviate this issue by providing more appropriate accommodations in private rooms. Staff considers this argument to be reasonable. Staff also recognizes the benefit of co-locating highly specialized subspecialty services with UMMC's other health resources.

By supporting underinsured patients in applying for Medicaid coverage, UMMC aims to mitigate financial access barriers of those receiving care. Further discussion of barriers to access is found at COMAR 10.24.09.04(B)(1) of The Acute Inpatient Rehabilitation Services Chapter, *infra,* pp.11-12.

With the above response and consistent with the previous discussion of the applicants' response, staff finds that the applicants meet this standard.

(3) Identification of Bed Need and Addition of Beds. An applicant shall demonstrate, in a service-area level needs assessment, that changes in its MSGA bed capacity and pediatric bed capacity resulting from a proposed project are needed.

(a) The applicant's service area-level needs assessment shall include the following information, separately for MSGA and pediatric bed capacity:

(i) A forecast of demand for at least five years following operation of the bed capacity by the population in its likely service area;

(ii) Market share analysis at the zip code area-level for the projected service area;

(iii) The assumptions used to define the service area of the proposed project, including the projected discharge rates;

(iv) The assumptions were used to project the hospital's market share of discharges within the service area for the proposed project; and development of the proposed project.

(b) An applicant shall demonstrate the reasonableness of all assumptions used in its needs assessment.

(c) An applicant proposing changes in MSGA bed capacity shall address the most recently published MSGA bed need projections developed by Commission staff under Regulation .05 of this Chapter. The applicant shall justify differences in its service area-level needs assessment compared to the published MSGA projections for the jurisdiction where the hospital is located, and any jurisdiction that comprises a quarter or more of the hospital's projected MSGA discharges.

This standard does not apply, as there are no changes in MSGA beds or pediatric bed capacity related to the project.

(4) Minimum Average Daily Census for Establishment of a Pediatric Unit. An acute care general hospital may establish a new pediatric service unit or, in the case of a hospital relocation, retain a distinct pediatric unit only if the projected ADC 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 does not apply, as a pediatric unit is not part of this project.

(5) Adverse Impact. A capital project undertaken by a hospital may not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a CON only if the hospital documents the following:

(a) A hospital that has permanent revenue of $300,000,000 or greater seeking an adjustment in revenue for capital projects that exceeds a 25 percent threshold of its permanent revenue and a smaller hospital with permanent revenue less than $300,000,000 that exceeds a 50 percent threshold of its permanent revenue base, shall document that its capital to operating costs ratio is below the average ratio of its peer group, per HSCRC standards. For a project that involves the replacement of physical plant assets, the hospital shall document that the average age of the physical plant assets to be replaced exceeds the average age of plant assets for its peer group, or otherwise demonstrate why the physical plant assets require replacement to achieve the primary objectives of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, adding, 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 or uninsured.

Applicants' Response

The applicants are not seeking a rate increase in connection with the project. Instead, they anticipate shifting Global Budget Revenue (GBR) revenue from UMROI to UMMC as described more fully in HSCRC's Staff Recommendation, as adopted by the Health Services Cost Review Commission on February 14, 2024.[4] (DI #12, p.7).

The applicants present information that demonstrates the geographic distribution of UMROI's patient population. (DI #2, p.33). More than 90 percent of UMROI's Maryland patients reside in the Central Planning Region or adjacent counties. The proposed relocation at UMMC is seven miles or a 25-minute driving distance away from UMROI's existing location, which is still geographically proximate to the majority of UMROI's patient population. The applicants also state that they will continue to retain and provide non-trauma rehabilitation services at UMROI while evaluating long-term plans for the hospital. (DI #10, pp.2-3).

Staff Analysis

The applicants do not seek a change in its GBR, so this capital project does not have an unwarranted adverse impact on hospital charges. Due to the increased beds at UMMC, the GBR for the hospital will increase and UMROI's will decrease accordingly. The relocation of services to UMMC will not diminish access to services. Rather, it will enhance access, while ensuring

[4] Health Services Cost Review Commission Meeting, February 14, 2024: https://hscrc.maryland.gov/Documents/February%202024%20HSCRC%20Public%20Post-Meeting%20Materials%20-FINAL.pdf

continued provision of necessary services at UMROI. Staff concludes that the applicants meet this standard.

(6) Cost-Effectiveness. A proposed hospital capital project shall 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 at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital shall:

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

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

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in §B(6)(a) of this Regulation, by demonstrating that there is only one practical approach to achieving the project's objectives.

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

(i) That it has considered, at a minimum, two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in §B (1) of this Regulation;

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;

(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

Applicants' Response

The applicants state that, for this proposed project, only paragraph (b) is applicable, as the project involves limited objectives. The primary goal of the proposed project is to consolidate acute inpatient rehabilitation services for traumatic brain and spinal cord injury patients with the trauma care provided at UMMC's downtown campus. According to the applicants, this

consolidation will improve the efficiency, quality, and effectiveness of clinical care delivery for this patient population. (DI #10, p.8). The applicants state that the only practical approach to achieve this goal is the proposed project – relocating the services from UMROI to UMMC.

The applicants point to cost savings associated with adding additional floors to the Stoler Center while it is currently under construction. Working on both projects in tandem will avoid additional project development costs. Additionally, undertaking the project now, concurrently with the construction of the original nine-story Stoler Center building, will result in savings on escalation costs. The proposed project can commence approximately 12 to 18 months sooner than a freestanding project. (DI #2, pp.4-5; DI #10, p.8).

Staff Analysis

Staff agrees that only paragraph (b) in this standard is applicable due to the narrow scope of this request. Overall, the applicants present their project as a blend of clinical effectiveness and financial prudence, positioning it as a step towards delivering enhanced care for Baltimore City patients.Staff agrees that the exemption request optimizes resources in support of improved patient care. The concurrent integration of additional floors into the Stoler Center construction acts as a strategic move to capitalize on existing infrastructure and avoid escalating project costs. Staff concludes that the applicants meet this standard.

(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 adjustment in global budget revenue proposed by the hospital related to the capital cost of the project may 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 is duplicative of the Construction Costs Standard found at COMAR 10.24.09.04B(4) of The Acute Inpatient Rehabilitation Services Chapter, *infra* pp.17-20. Consistent with the previous discussion of the applicants' response and staff analysis for that standard, staff concludes that the applicants meet this standard.

(8) Construction Cost of Non-Hospital Space. The proposed construction costs of non-hospital space shall be reasonable and consistent 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

adjustment in global budget revenue proposed by the hospital related to the capital cost of the non-hospital space may 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. In general, rate increases authorized for hospitals may not recognize the costs associated with construction of nonhospital space.

This standard is not applicable, as the applicants are not proposing to construct non-hospital space.

(9) Inpatient Nursing Unit Space. The expenditure for space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed may not be recognized in any adjustment in global budget revenue. If the inpatient unit program space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any adjustment of global budget revenue proposed by the hospital related to the capital cost of the project may not include the 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, unless the applicant demonstrates that the additional square feet per bed is necessary to meet licensure and reasonable design standards.

The applicants are not pursuing a rate increase in its GBR for this project. (HSCRC Meeting Notes, February 14, 2024; DI #19, p.7). Therefore, this standard does not apply.

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

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

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

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

The proposed relocation of existing beds from UMROI to UMMC does not require replacement or expansion of any diagnostic or treatment facilities at UMMC; thus this standard is not applicable.

(11) 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.

This standard is duplicative of the Safety Standard found at COMAR 10.24.09.04B(5) of the Acute Inpatient Rehabilitation Services Chapter, *infra* p.20. Consistent with the previous discussion of the applicants' response and staff analysis for that standard, staff concludes the applicants meet this standard.

(12) Financial Feasibility. A hospital capital project shall be financially feasible and may not jeopardize the long term financial viability of the hospital.

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

(b) Each applicant shall document that:

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

(ii) Revenue estimates are consistent with utilization projections and are based on current rates of reimbursement, or for a new hospital the anticipated rates of reimbursement, as determined through consultation with the HSCRC;

(iii) Revenue estimates account for current contractual adjustments, 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;

(iv) 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

(v) 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 CON for a project that does not generate excess revenues over total expenses, when the hospital can demonstrate that the hospital's overall financial performance will be positive and that the services will benefit the hospital's primary service area population.

(c) A hospital proposing an increase in its global budget revenue to account, in whole or in part, for depreciation or long-term interest expenses resulting from a proposed capital project shall timely file a partial rate application for review by HSCRC in conjunction with its CON application to allow an informed opinion on the financial feasibility of the proposed project and the long-term viability of the proposed or existing hospital.

This standard is duplicative of the Financial Feasibility Standard found at COMAR 10.24.09.04(B)(6) of The Acute Inpatient Rehabilitation Services Chapter, *infra* pp.21-23. Consistent with the previous discussion of the applicants' response and staff analysis for that standard, staff concludes that the applicants meet this standard.

(13) Emergency Department Treatment Capacity and Space.

(a) An applicant proposing a new or expanded emergency department shall classify the emergency department service as low-range or high-range based on the parameters in the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians Emergency Department Design: A Practical Guide to Planning for the Future, given the classification of the emergency department as low-range or high-range and the projected emergency department visit volume, unless the applicant can demonstrate a need for additional treatment space even with efficient operation of the emergency department.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

(iii) Any demographic, health service utilization data, and/or analyses that support the need for the proposed project;

(iv) The impact of efforts the applicant has made or will make to divert nonemergency cases from its emergency department to more appropriate primary care or urgent care settings; and

(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

The above standard is not applicable, as the project does not involve changes in Emergency Department facilities.

(14) Emergency Department Expansion. A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts consistent with federal and State law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum, the applicant hospital shall demonstrate that:

(a) In cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;
(b) It has effectively managed its existing emergency department treatment capacity to maximize use; and
(c) It has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

The above standard is not applicable. The project does not involve changes in Emergency Department facilities.

(15) Shell Space.
(a) Unfinished hospital shell space for which there is no immediate need or use may 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 is more cost-effective than not including the shell space based on the following:
(i) The most likely use identified by the hospital for the unfinished space;
(ii) The time frame projected for finishing the space; and
(iii) A demonstration that the hospital is likely to need the space for the most likely identified use, in the projected time frame.
(c) For shell space to be constructed on lower floors of a building addition that supports finished building space on upper floors, an applicant shall provide information on the cost, the most likely uses, and the likely time frame for using the 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 revenue adjustment for capital costs by the HSCRC.

Staff concludes that this standard is not applicable because shell space is not a part of this Exemption request.

APPENDIX 2

PROJECT BUDGET

TABLE E. PROJECT BUDGET		
INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.		
	Hospital Building	
A. USE OF FUNDS		
1. CAPITAL COSTS		
a. New Construction		
(1) Building	$	71,480,450
(2) Fixed Equipment	$	11,996,000
(3) Site and Infrastructure	$	-
(4) Architect/Engineering Fees	$	7,340,800
(5) Permits (Building, Utilities, Etc.)	$	50,000
SUBTOTAL	**$**	**90,867,250**
b. Renovations		
(1) Building	$	40,950,000
(2) Fixed Equipment (not included in construction)	$	8,000,000
(3) Architect/Engineering Fees	$	4,893,600
(4) Permits (Building, Utilities, Etc.)	$	44,000
SUBTOTAL	**$**	**53,887,600**
c. Other Capital Costs		
(1) Movable Equipment	$	30,209,240
(2) Contingency Allowance	$	18,498,005
(3) Gross interest during construction period	$	26,173,000
(4) Other (Specify/add rows if needed)		
SUBTOTAL	**$**	**74,880,245**
TOTAL CURRENT CAPITAL COSTS	**$**	**219,635,095**
d. Land Purchase		
e. Inflation Allowance	$	12,105,952
TOTAL CAPITAL COSTS	**$**	**231,741,047**
2. Financing Cost and Other Cash Requirements		
a. Loan Placement Fees	$	1,745,000
b. Bond Discount	$	-
c CON Application Assistance	$	2,369,000
c1. Legal Fees	$	-
c2. Other (Accounting, Architectural, Planning)	$	-
d. Non-CON Consulting Fees	$	-
d1. Legal Fees		
d2. Other (third party peer review of documents; third party testing & scheduling, curtain wall testing)		
e. Debt Service Reserve Fund	$	-
f Other (Specify/add rows if needed)		
SUBTOTAL	**$**	**4,114,000**
3. Working Capital Startup Costs		
TOTAL USES OF FUNDS	**$**	**235,855,047**

APPENDIX 3

MARSHALL VALUATION SERVICE REVIEW

Marshall Valuation Service Review

Marshall Valuation Service – what it is, how it works

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

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

The MVS costs *do not include* costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, general contingency set aside for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[5]

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs, the base costs are adjusted for a variety of factors (e.g., an add-on for sprinkler systems, the presence or absence of elevators, number of building stories, the height per story, and the shape of the building. The base cost is also adjusted to the latest month and the locality of the construction project.)

The MVS methodology does not offer data for renovation projects; thus, any effort to compare proposed renovation costs to a benchmark can only be made to the benchmarks for new construction.

[5] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2016).

Table III-1: MHCC and UMMC Comparison Table
Calculation of Excess Construction Cost Over MVS Benchmark Value

	Key	MHCC MVS Calculations	UMMC MVS Analysis
Project Cost for MVS Comparison (SF)		$581.37	$567.72
Less MVS Benchmark Cost (SF)		$529.45	$563.28
Over (=Project Cost - MVS Benchmark Cost)	a	$51.92	$4.44
Square Footage (UMROI addition)	b	102,402	107,246
Construction Costs over MVS Benchmark (Total Dollar Amount)[1]	c = (a * b)	$5,316,564	$476,172
Percentage Construction Cost over MVS Benchmark [2]	d	9.81%	0.79%
Inflation Allowance (Project Budget)	e	$12,105,952	$12,105,952
Amount Inflation Allowance excluded	f = (d * e)	$1,187,594	$0
Contingency Allowance (Project Budget)	g	$18,498,005	$18,498,005
Amount Contingency Allowance excluded	h = (d * g)	$1,814,654	$0
Total to be excluded from any rate increase proposed by the hospital	i = c + f + h	$8,318,812	$476,172

[1]Includes portion capitalized construction interest expenditure
[2]Using Percentage Construction Cost over MVS Benchmark

MHCC staff and UMMC each calculated an allowable new construction cost that would be used in comparison with the MVS benchmark values for the proposed five-story addition plus mechanical penthouse to The Stoler Cancer Center Tower, derived using the MVS guide.

UMMC used a total of 107,246 SF in its MVS analysis for the construction of the five-floor addition and the mechanical penthouse for the UMROI addition. (DI #19 , Exh. 20, Table C – Construction Characteristics). In its review, MHCC staff used 102,402 SF in its MVS analysis. In UMMC's Second Request for Post Project Change for the Construction of the Stoler Cancer Center (Docket No. 19-24-2418), UMMC reported in its May 17, 2024 response to completeness questions that a total of 4,844 SF for floors ten through thirteen (about 1,211 SF for lobby space on each of the four floors) was included both in construction area and in total project costs. (Exh. 18, Table C – Construction Characteristics for the Stoler Cancer Center). The construction area and project cost for the 4,844 SF in lobby space is also included in the 107,246 SF for the UM ROI merger exemption request. To reconcile the 4,844 SF in area and cost for these two CON projects, MHCC staff included the area for the 4,844 SF in the UMMC Cancer Center project, and to avoid double counting, subtracted this amount in construction area from the UMROI merger exemption. Thus, MHCC staff used 102,402 SF (i.e., subtract 4,844 SF from the 107,246 SF) for its MVS analysis. Since UMMC did not identify the costs for constructing the 4,844 SF lobby area separately in the total project cost, MHCC staff calculated the MVS analysis using UMROI's total project budget of $235,855,047. (DI #19, Exh. 20, Table D – Onsite and Offsite Costs Included and Excluded in MVS and Table E – Project Budget/Appendix 2).

MHCC staff calculated an estimated allowable new construction cost of $581.37 per SF and an MVS benchmark of $529.45 per SF. Comparably, UMMC arrived at the same estimated

allowable new construction cost of $567.72 per and an MVS benchmark value that higher at $563.28 per SF.

Comparing Estimated Project Cost to the MVS Benchmark

MHCC's analysis shows that the MVS allowable construction costs exceeded the MVS benchmark value by $5,316,564. UMMC's analysis shows that the allowable construction costs only exceed its calculated MVS benchmark value by $476,172. Besides the use of 102,402 SF in its MVS analysis, there are two differences in how MHCC calculated the exclusion amount and arrived at the $8,318,812 amount. First, MHCC staff used an MVS benchmark value of $134.00 per SF compared to $560 per SF for construction of the mechanical penthouse. The use of the higher value used by UMMC made its projected MVS benchmark value more favorable when compared to the allowable new construction costs for the 102,402 SF.

Second, as seen in Table III-1 above, MHCC staff's construction cost analysis includes calculating the portions of the contingency allowance, inflation allowance, and capitalized construction cost interest expenditure in determining costs to be excluded from future rate application increases submitted by UMMC to HSCRC. This is consistent with COMAR 10.24.09.04B(4), Construction Costs, which states that:

> 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.

While including the capitalized construction cost interest expenditure in its calculations, UMMC did not include the contingency allowance and inflation allowance in determining the total construction costs to be excluded from any proposed future reimbursement rate application increase submitted to the HSCRC by UMMC.

Please see Table III-2 below for Commission's calculation of excluded dollar amounts from HSCRC rate increases.

Table III-2 –
MHCC Staff Calculation of Excess Cost –
UM ROI Merger and Consolidation Project

Construction cost exceeding benchmark (102,402 SF x $51.92)	$ 5,316,564
The portion of future inflation that should be excluded ($12,105,952 x 9.81%)	$ 1,187,594
The portion of the contingencies that should be excluded ($18,498,005 x 9.81%)	$ 1,814,654
Total to be excluded from any rate increase proposed by the hospital related to the capital cost of the project	**$ 8,318,812**

Therefore, MHCC staff recommends that the Commission issue the following condition to exclude $8,318,812 from any partial rate adjustment application submitted to HSCRC in the future:

> *Any future change to the financing of this project involving adjustments in rates set by the HSCRC must exclude $8,318,812, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that is based on the excess construction cost.*

APPENDIX 4

HSCRC LETTER

maryland
health services
cost review commission

MEMO

To: Wynee Hawk, Director, Facilities Planning & Development, MHCC
Jeanne-Marie Gawel, Acting Chief, CON, MHCC
Rachel Bervell, Program Manager, CON, MHCC

From: Jonathan Kromm, Executive Director, HSCRC
Jerry Schmith, Director, Revenue & Regulation Compliance, HSCRC
Bob Gallion, Associate Director III, Revenue Regulation Compliance, HSCRC

Date: May 7, 2024

Re: Request for Exemption from Certificate of Need (CON) Merger of University of Maryland Rehabilitation & Orthopaedics Institute (UMROI) and University of Maryland Medical Center (UMMC)
Docket No. 23-24-EX017

This memo is in response to your request dated February 15, 2024, seeking our opinion on the financial feasibility of the planned merger, and our review of the financial projections as provided in the Request for Exemption from CON dated December 29, 2023. The merger of services and facility resources includes the relocation of 58 inpatient beds from UMROI to UMMC (25 acute inpatient rehabilitation beds for Traumatic Brain Injury, plus 18 acute inpatient beds for Spinal Cord Injury, plus 5 chronic care beds, plus 10 dually licensed acute inpatient rehabilitation and chronic care beds). UMMC plans to accommodate the increase in services and beds via renovations to certain spaces within UMMC's north hospital tower, and the construction of four (4) additional floors on top of the previously approved nine (9) floor Greenebaum Comprehensive Cancer Center (GCCC) currently under construction and located at the corner of Greene and Baltimore Streets in Baltimore City.

BACKGROUND:

As per our memo to you dated July 31, 2020, the HSCRC responded favorably to your original request to opine on the initial GCCC project costing $194,368,000, which was awarded a CON by the MHCC on August 20, 2020. As per our memo to you dated October 13, 2023, the HSCRC again responded favorably to your second request to opine on the post approval project change to the GCCC project with a revised cost of $269,190,000, which was awarded approval by the MHCC on October 18, 2023. The applicant had stated that although it did not include a GBR award for incremental capital related expenses in its P&L projections, it was reserving the option to pursue such award before the planned opening of operations, then scheduled for fiscal 2027. Additionally, on October 10, 2023, MHCC did confirm a Marshall Valuation Service (MVS) exclusion of $9,121,000 on this approved CON project.

The revised Table E (Project Budget) dated March 18, 2024, associated with the request for exemption from CON is estimated at $235,855,000. The proposed tower (the Len Stoler Center for Advanced

Medicine) for which construction has begun is currently described as having fourteen (14) floors, comprised of the original scope nine (9) floors, plus the exemption request scope of four (4) floors, plus a top floor penthouse for positioning mechanical utilities. The estimated cost of the entire Len Stoler tower now totals $505,045,000. There is the potential for additional cost considerations as noted on page 6 of the CON exemption request. Changes to the use plan for floor 9 of the approved CON (so to make such space occupiable space) and several other changes are documented in a second post approval project change request related to the approved CON project totaling $18,903,000; such change request was very recently filed April 26, 2024.

THE PROJECT:

This project (a CON exclusion request) involves the cost to change the proposed use of space at UMMC associated with the initial nine (9) floors of the approved GCCC project, and the cost to add four (4) more floors to that building to accommodate the services to be relocated from UMROI, and the cost to relocate the utilities from floor 9/10 of the initial scope to the penthouse on floor 14 of the revised scope, and the cost to renovate certain of the existing spaces in the neighboring north hospital tower. The relocated beds from UMROI are to be positioned on the 12th and 13th floors of the new tower. The construction associated with this project is scheduled for completion by late calendar 2027 (FY 2028). The first full year of operations is scheduled for FY 2029. Projected P&Ls as reflected in the revised Tables G & H for UMMC are through FY 2030, which is currently planned to be the second full fiscal year of operations.

As per the revised Table E (Project Budget), the total uses of funds amount to $235,855,000, of which capital costs are $231,741,000 and financing costs are $4,114,000. Capital costs are comprised of new construction $90,867,000, renovations $53,888,000, movable equipment $30,209,000, allowances for contingencies and inflation $30,604,000, and capitalized interest incurred during the construction period $26,173,000. The total sources of funds tallies to $235,855,000 which is comprised of $174,489,000 in bonds, $55,000,000 in state grants, and $6,366,000 for interest earnings on bond proceeds prior to their expenditure.

HSCRC STAFF REVIEW, DISCUSSION AND OPINION:

HSCRC staff (Staff) reviewed the following materials: Request for Exemption from CON dated December 29, 2023 inclusive of Tables; Responses dated February 28, 2024, to Additional Information Questions from MHCC dated January 25, 2024; Responses dated March 18, 2024, to Additional Information Questions from MHCC dated January 25, 2024; Revised CON Exemption Request Tables dated March 18, 2024; Responses dated March 18, 2024, to Additional Information Questions from HSCRC dated February 16, 2024, and Responses dated April, 12, 2024, to Additional Follow Up Questions from MHCC and HSCRC dated April 1, 2024. Relative to the CON Tables which were revised and amended following rounds of questions and responses, the Staff's opinion is limited to review of the final revised Tables as submitted by the applicant on April 4, 2024. Additionally, on April 29, 2024, MHCC did confirm a Marshall Valuation Service (MVS) exclusion value on the construction cost related to this CON Exemption Request.

Staff studied the changes to the Table E (Project Budget) between that initially submitted December 29, 2023, and that as revised and resubmitted. Uses of funds grew by $28.5 million or 13.8%. The primary drivers of the increase in costs were capitalized interest $11.3 million, allowances for contingencies & inflation $9.3 million, and movable equipment $7.9 million. The sources of funds also grew ($25.7 million on authorized bonds plus $2.8 million on interest income on bond proceeds). Staff prepared predictive tests of capitalized interest and interest earned on bond proceeds based upon the terms

suggested in the CON exemption request and deemed such values to be reasonable. It should be noted that as per the responses from the applicant, just $45 million of the $231.7 million capital costs have been supported by binding contracts. The balance is supported by vendor estimates. Design & renovation work is being bid out currently, fit out of floors 10 through 13 will be bid out in January 2026, and renovation of floors 12 & 13 will be bid out in January 2027. The bond financing is expected to be new MHHEFA borrowing, not allocations of previous UMMS borrowing, and that the bonds are to go to market in early calendar 2025. As per discussion with the applicant, the bond payments during the 3-year construction phase are to be interest only, and full payments including principal are to begin once operations commence. It should also be noted that none of the state grants have been realized, and that none have yet been budgeted by the state.

As per review of the Table E project budgets for the entire Len Stoler tower as reflected in the approved and amended CON plus this proposed CON Exemption Request, the cumulative total uses of funds ($505 million) include a cumulative allowance for contingencies of $33.5 million (or 6.6% of cumulative total cost) and a cumulative allowance for inflation of $12.1 million (or 2.4% of cumulative total cost). Staff takes note that cumulative allowances fall short of 10% of cumulative total cost for the tower and may provide less than sufficient cushion in the budgeted costs for the entire tower. Given the recent and tragic loss of the Key Bridge and impairment of harbor terminal operations which may in turn negatively impact availability of needed materials and the prices of those materials, Staff is concerned. Likewise, again referencing the Table E project budgets for the entire Len Stoler tower the cumulative sources of funds include a cumulative total for state grants or appropriations of $180 million (or 35.6% of cumulative total sources). As of most recent communications, UMMC has realized $5.2 million so far from these planned grants. Again, Staff is concerned that the state's priorities may be impacted by other financial demands (Key Bridge related or not). And again, referencing the Table E project budgets for the entire Len Stoler tower the cumulative sources of funds includes $40 million from philanthropy, and as per most recent communication, UMMC has collected $35 million so far.

As per review of the revised Table F (Statistics for Entire Facilities/Services) the projected inpatient days grow by an average of 1.6% per year over the seven years ending FY 2030, with FY2028 and FY2029 averaging 4.3% annual growth. Consistent with the text of the CON exemption request, this is the period when the 58 UMROI beds are to be relocated to UMMC and become operational, and this is the period when GCCC operations are to come online. Also, outpatient visits are projected to grow at an average annual rate of 0.7% for the seven years ending 2030, with 2026 having the greatest year over year growth at 1.8%. The growth in patient days as reflected on Table F is 20,046 days between FY 2025 and FY 2030, while the growth reflected on Table I (Statistics for New Facility/Services) for the same span of periods is 19,929 days. The added days growth on Table F are attributed to the GCCC coming online.

Review of revised Table G (P&L Entire Facility/Services Uninflated) reflects volume growth of top line patient service revenues of $94.8 million between FY 2026 and FY 2030, (annual average 1.0% growth) with the highest growth measured in FY 2028 and FY 2029 at 1.9%, consistent with Table F assumptions. The projection of operating expenses reflects an average annual growth rate of 1.0% over the same FY 2026 through FY 2030 periods. Projected annual operating income averages 2.3% of operating revenue (or $48.0 million) between FY 2026 and FY 2030, with FY 2029 and FY 2030 averaging 3.1% (or $65.8 million) with the project being fully operational. The cash basis operating margin for the two fiscal years ending 2030 reflects an average positive value of $181.6 million per year. Again, the growth in top line patient service revenues between FY 2026 and FY 2030 is $94.8 million. When compared to growth in top line revenues reflected in Table J (P&L New Facility/Services Uninflated) for the same periods, the measure is $65.8 million. The difference is attributed to the opening of operations at the GCCC. As per discussion with Brian Sturm, V.P. Capital Planning for UMMS, the bond financing is planned to be

serviced as interest only payments during the 3-year construction phase, and then full amortization with principal payments will begin when the operations commence. Interest expense on project related debt between FY 2026 and FY 2030 as per Table G is $17.3 million. Interest capitalized on project related debt during the construction between FY 2026 and FY 2030 as per Table E is $26.2 million. Therefore, interest incurred on project debt as measured by these two Tables sums to $43.5 million, which equals the amortization of the $174.5 million bond over 30 years at 5% interest with deferred principal payments for 3 years. Amortization and depreciation on project assets when placed in service is $14.4 million in FY 2030 as per Table G given an average life of 16.4 years. A high-level predictive test yielded an average expense of $14.9 million and an average life of 15.8 years. Such a test supported the conclusion that project related depreciation and amortization are reasonably stated in the projections.

Review of revised Table H (P&L Entire Facility/Services Inflated) reflects an average annual inflation rate of 3.1% applied to top line gross patient service revenues for the periods FY 2026 through FY 2030, which when added to the 1.0% average annual volume growth reflected in Table G yields a combined average annual gross change of 4.0%. Based upon review of the GBR rate file for UMMC, the inflation rate applied to revenues is judged to be reasonable. Projected operating expenses reflect an average annual growth rate of 4.0% for the periods FY 2026 thru FY 2030, which when netted against an average annual volume growth as per Table G of 1.0%, implies an average annual inflation rate of 3.0%, which is consistent with the assumptions table. Projected operating income averages 1.9% of operating revenue (or $45.1 million) between FY 2026 and FY 2030, with FY 2029 and FY 2030 averaging 2.5% (or $65.1 million) with the project being fully operational. The cash basis operating margin for the two fiscal years ending FY 2030 reflects an average positive value of $180.8 million per year. As per discussion with Brian Sturm, the applicant did not include a GBR award for incremental capital related expenses in its P&L projections; rather it limited the growth in gross patient service revenues to the amount to be transferred from UMROI for the trauma services. UMMC may still be reserving the option to pursue such a capital award before the planned opening of operations, currently scheduled for fiscal 2028.

As per review of revised Table I (Statistics, New Facility or Services) for the 58 transferred licensed beds, the projected volumes of patient days average approximately 19,700 days over projected fiscal years 2029 and 2030 with 93% occupancy, and average length of stay of 20.5 days per patient, which yields an average of 365 patient days per physical operating bed. Staff are not able to evaluate the measured need for service related to the 58 licensed inpatient beds to be transferred from UMROI. However, Staff did review the annual cost report filed with HSCRC by UMROI for fiscal 2023 and found that 148 licensed beds at UMROI led to 31,180 patient days with 58% occupancy, and average length of stay of 17.5 days per patient, which is an average of 365 patient days per physical operating bed. Staff is satisfied that the projected patient volume per physical bed is reasonable, and given that patient volumes drive operating expenses, such projected expenses have a reasonable basis.

As per review of revised Table J (P&L Uninflated, New Facility or Services) the transfer and merger of 58 beds from UMROI will result in operating losses to be absorbed by UMMC. The operating margin on the transferred resources and services is projected to result in a negative average annual operating margin of -$1.5 million (or -2.7%) over the two years ending 2030. However, the average annual cash basis margin remains positive at $12.8 million for those two years.

As per review of the revised Table K (P&L Inflated, New Facility or Services) for the two years ending 2030, the merged operation is projected to generate positive margins averaging $3.1 million (or 4.5%) annually, and cash basis operating margins of $17.4 million annually.

Staff takes note that prior to the CON exemption request, UMMC presented to commission staff on November 15, 2023, a request to retain by UMMC and transfer from UMROI a GBR value ($95.153 million) for services related to the UMROI beds transfer which differs from the value recommended by commission staff ($87.890 million) and accepted by the HSCRC commissioners on February 14, 2024. The $7.263 million difference represents additional savings to the state, and such is to be invested by UMMC on population health initiatives. Given that Table G top line revenue projections reflect growth of $94.782 million ($65.765 million from the UMROI transfer plus an additional $29.017 million from GCCC revenues) it appears that the projected P&L is presented conservatively.

Staff did share the MHCC computation for the MVS exclusion value on that portion of the construction cost that exceeds the MVS benchmark for Class A hospital construction. The MVS exclusion value for the construction scope included in the project budget for this CON exemption request (additional four floors plus mechanical penthouse) is approximately $7,265,000. The MVS exclusion value for the construction scope included in the project budget for the initially approved CON request with post approval project change request (initial nine floors) is approximately $9,121,000. Therefore, if the applicant should apply for an increase in its GBR for incremental capital related expense for the entire 14-floor Len Stoler tower such response should exclude approximately $16,386,000 of construction cost.

The risk exists that the grant funding stated in the CON applications for this tower may be optimistic in terms of dollars to be realized and/or the timing of when such dollars are to be realized. The approved CON for the first nine (9) floors included $125 million in grants, and the CON exemption request for the added four (4) floors included $55 million in grants. If the state's priorities shift to other interests, then the $180 million in grant funding for this entire Len Stoler tower may not be realized during the first five years of this project and may lead to additional borrowing to cover the financing of budgeted tower construction. If such condition should follow, then it is possible that the average annual interest incurred on this project during the five years ended 2030 may increase by up to $5.4 million per year. The P&L projections for UMMC following the commencement of operations for the new tower project (both the UMROI transfer and the GCCC) reflect an average operating margin of $65.8 million for the two years ending 2030, as measured without inflation, and an average operating margin of $65.1 million for the two years ending 2030, as measured with inflation. Both measures reflect no incremental award to GBR for the incremental capital-related expenses related to the investment in new construction. The potential for incremental interest incurred on incremental debt does not push the operating margin into dangerous measurements, and therefore would not put at risk the financial viability of this tower project.

The construction and operation of the new Len Stoler tower are not without challenges. Based upon review of all the information provided, Staff believes that with proper management (focused upon internal operational performance, controlling construction costs in an inflationary marketplace, and maximizing third party funding) the new tower project, inclusive of the UMROI merger for beds and services, and exclusive of an incremental GBR award for capital, continues to be initially feasible and viable through to completeness and going forward for at least the two (2) operating cycles represented in the projections.

MEMO

TO: Wynee Hawk, Director, Facilities Planning & Development, MHCC
Jeanne-Marie Gawel, Acting Chief, CON, MHCC
Moira Lawson, Program Manager, CON, MHCC
Rachel Bervell, Program Manager, CON, MHCC
Bill Chan, Program Manager, CON, MHCC

FROM: Jonathan Kromm, Executive Director, HSCRC
Jerry Schmith, Director, Revenue & Regulation Compliance, HSCRC
Bob Gallion, Associate Director III, Revenue & Regulation Compliance, HSCRC

DATE: July 9, 2024

RE: University of Maryland Medical Center (UMMC)
Greenebaum Comprehensive Cancer Center (GCCC)
Second Change after CON Approval for Construction
Docket No. 19-24-2438
and
University of Maryland Rehabilitation & Orthopaedics Institute (UMROI)
Request for Exemption from Certificate of Need (CON) for Merger
Docket No. 23-24-EX017

This memo serves as an addendum to the response memos previously directed to you dated May 7, 2024, and June 11, 2024, regarding the above referenced projects.

You have recently brought to our attention that subsequent to the release of the aforementioned response memos, the applicant and MHCC together reviewed the costs, intended uses, and final square footage measurements, of all the spaces included in the proposed 14-floor tower currently under construction (the Len Stoler Center for Advanced Medicine). These include the lower 9 floors to house the GCCC, the upper 4 floors to accommodate the UMROI merger, and the top floor penthouse for positioning mechanical utilities. The purpose of the review was to confirm the final determination of the Marshall Valuation Service (MVS) exclusion value of costs exceeding the MVS benchmark value. You have indicated that the applicant has attributed two thirds (2/3) of the cost of the penthouse floor to the GCCC, and one third (1/3) of that cost to the UMROI addition. As previously documented, this attribution is judged to be reasonable.

Consistent with the P&L projections as presented for the two named projects housed within this single tower construction, the applicant states that it will not be seeking an increase in its Global Budget Revenue (GBR) for incremental capital related expenses related to this tower project. However, the applicant has stopped short of pledging to forego seeking an award for incremental capital related operating expenses for the life of the tower project. The combined project budget for this Len Stoler tower is $523,948,000 (that is $288,093,000 for the GCCC project plus $235,855,000 for the UMROI project). You have confirmed to us that notwithstanding previously shared computations included in the dated response memos, the final cumulative cost of the value agreed upon between the applicant and MHCC to be excluded from any future GBR capital award computation for the incremental expense of depreciation and interest, if requested by the applicant upon completion of the Len Stoler tower, is $26,355,000 (that is $18,036,000 for the GCCC project plus $8,319,000 for the UMROI project).

This addendum does not alter the affirmative but contingent conclusions regarding initial feasibility and viability through to completion and for two years following commencement of operations of these two projects as previously documented.

Cc: Allan Pack, Director, Population-Based Methodologies, HSCRC

APPENDIX 5

PROJECT SCHEDULE

Task	Duration	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Q3 2026	Q4 2026	Q1 2027	Q2 2027	Q3 2027	Q4 2027	Q1 2028	Q2 2028	Q3 2028
Cancer Center Floors 1-9																				
CON Update	COMPLETE																			
CM Procurement	COMPLETE																			
CM Award and Contract Negotiation	COMPLETE																			
Phase 1 - New Building Construction																				
Mobilization	COMPLETE																			
Construction	26 months										substantial completion									
Phase 1 Construction Complete	**Apr-26**										Complete									
Phase 1- Activation																				
Activation/ Workflow Planning	12 months																			
Medical Equipment Delivery	6-9 months																			
Information Technology Installation	21 months																			
EUC Equipment Installation	6-9 months																			
Stocking	2 months																			
Training	3 months																			
Phase 1 Go-Live	**Jun-26**										**									
Phase 2 - Renovation Construction																				
Procurement of CM/GMP/Negotiation	4-5 months																			
Enabling - Relocate Misc Clinics to First Floor (Stoler Clinic)	9-10 months																			
Mobilization & Construction 5, 7 & 8 (CC Renov)	14 months																			
Activation/ Equipment/Stocking	6 months																			
Phase 2 Go-Live	**May-28**																		**	
Rehab Floors 10-13																				
CON Merged Asset Exemption	6 months																			
HDR Design - Core & Shell Only	4-5 months																			
Phase 2 Design - Fit Out & Renovation																				
Procure A/E Team	3 months																			
Schematic Design	3 months																			
Design Development	3 months																			
Construction Documents	6 months																			
Permitting	6 -9 months					*														
Phase 1 - Core and Shell																				
Bidding/GMP Negotiation	3-4 months		Core & Shell																	
Construction	18 months				Construction Begins					substantial completion										
Phase 1 Construction Complete	**Apr-26**										Complete									
Phase 1 Go-Live Floors 1-8, 9	**Jun-26**										**									
Phase 2 - Fit Out & Renovation	36 months																			
CM Pricing/GMP/Buyout	6-9 months						**													
Fitout Floors 10, 11, 12 (Tower), 13 (Tower)	15 months								***				substantial completion							
Activation/Equip/Stocking of Floors 10 & 11	6 months																			
Phase 1 Go-Live Floor 10-11	**Dec-26**												**							
Renovate Floors 12 (NH) & 13 (NH)	14 months																	substantial completion		
Phase 2 Construction Complete	**Feb-28**																	Complete		

Phase 2- Rehab Move & Closure Planning																					
Activation/ Workflow Planning	12 months																				
Medical Equipment Delivery	6-9 months																				
Information Technology Installation	15 months																				
EUC Equipment Installation	6-9 months																				
Stocking	2 months																				
Training	2 months																				
Phase 2 Go-Live Floors 12-13 Move UMROI	Apr-28																			**	

UMMC Stoler Center for Advanced Medicine and Rehab & Trauma Unification Schedule

* Start of Permitting for Phase 2 Fit-Out & Renovation assumes multiple/expedited permit packages and 1 year total design phase (complete no later than 3/30/2025)

** Phase 2 Fit-Out & Renovation assumed to be completed by same contractor as New Building Construction for expedited CM Pricing/GMP/Buyout Phase

*** Start of Phase 2 Fit-Out & Renovation, Fitout Floor 10, 11, 12 (Tower), 13 (Tower) assumes approval from the Fire Marshal to begin fit-out of upper floors prior to issuance of Core and Shell U&O