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July 10, 2019

Lyle E. Sheldon, F.A.C.H.E.
President and Chief Executive Officer
University of Maryland Upper Chesapeake Health System, Inc.
500 Upper Chesapeake Drive
Bel Air, Maryland 21014

RE: Conversion of UM Harford Memorial Hospital to a Freestanding Medical Facility
Consolidation of UM Harford Memorial Hospital and UM Upper Chesapeake Medical Center
Establishment of a Special Psychiatric Hospital

As a follow-up to our June 25 meeting concerning the three Upper Chesapeake Health ("UCH") projects under review by the Maryland Health Commission ("MHCC" or "the Commission"), I am writing to summarize the issues of concern to Commission staff with the intention of providing guidance on the additional information and further analysis that will address these concerns.

Facilities for Observation of Patients

MHCC has found that UCH's two general hospitals are among the highest users of observation status, in terms of reported observation patient visits. We have also found that the plan for the proposed Aberdeen freestanding medical facility and the related expansion of the University Chesapeake Medical Center ("UCMC") reflect the need for unusually large levels of observation bed capacity in line with the historic pattern of high use.

We are interested in understanding why the service area population of the two UCH hospitals requires this high level of observation status use and why this pattern of use should be viewed in a positive light by MHCC and the Health Services Cost Review Commission ("HSCRC"). With respect to this latter question, we are interested in any evidence that UCH can provide about the benefits of admitting so many patients for observation. Can UCH show that this high level of observation use reduces the need to admit patients for inpatient hospitalization when adjusted for case mix? Does it produce a lower case-mix adjusted average length of stay for discharged patients? Does greater observation bed use reduce emergency department visits or readmissions to the hospital? Are there other benefits, in terms of reduced hospital expenses and/or

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the health of the service area population that UCH can demonstrate to be related to this high frequency of admissions to observation status?

The Need for Acute Psychiatric Bed Capacity for Adults and the Setting for this Service

As you know, all 29 of the general hospitals currently providing acute psychiatric services in Maryland provide this service within the general hospital rather than through a separate special psychiatric hospital.

MHCC has authorized two general hospitals to establish special hospitals for psychiatric services in recent years. In the first case, the hospital, Washington Adventist, abandoned this alternative, ultimately electing to provide acute psychiatric inpatient care within its relocated hospital and consolidating the balance of its special hospital psychiatric facilities within the general hospital setting, at Shady Grove Medical Center. It is notable that the approval of a special psychiatric hospital in the case of the relocated WAH was actually the low-cost alternative, given that the facilities for the special hospital were already in place and only required minor renovation.

In the second case, MHCC authorized Anne Arundel Medical Center ("AAMC") to establish a 16-bed special psychiatric hospital approximately two miles from the AAMC campus on the site of a drug treatment facility operated by AAMC. In this case, AAMC outlined the alternatives for establishing the bed capacity within the hospital and made the case that the options were poor alternatives, from the standpoint of cost and location within the hospital. The special hospital authorized by MHCC, unlike that proposed by UCH, will not be an Institute for Mental Disease, as defined in federal law.

MHCC has observed a gradual decline in the use rate of adult psychiatric beds in Maryland during the last ten years and has also modeled demand for adult psychiatric hospitalization based on the psychiatric service area observed for University of Maryland Harford Memorial Hospital. This analysis does not support the need for 40 beds. We also note that UCH initially proposed development of a 40-bed psychiatric hospital to replace two hospital psychiatric services which, at that time (FY 2018) had a total of 40 licensed psychiatric beds. The current proposal is unchanged, with respect to proposed bed capacity, but is now replacing a single hospital service that experienced an average daily census of less than 21 patients in CY 2018.

It is a combination of factors that drive our concern with the choice of alternatives made by UCH for psychiatric hospital care:

- First, reducing the observation bed capacity being developed at UCMC to more normal levels would provide an opportunity to create a replacement psychiatric unit on one of the three additional building floors proposed for construction, with only modest changes in project cost (i.e., the difference between fitting out the floor as an acute psychiatric unit rather than an observation unit) while saving the $53.9 million estimated expense of building a special psychiatric hospital;

- Additionally, there should be significant operating costs savings over time if the psychiatric beds are operated at UCMC, avoiding the administrative and support cost overhead of a separate special hospital campus; and

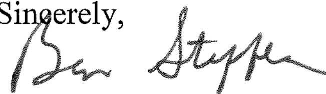
Finally, the special hospital alternative will be more costly for Maryland taxpayers, given that charges for Medicaid patients suffering from behavioral health problems without comorbid substance abuse conditions, will be fully funded by the state without the cost share by the federal government that would occur in the general hospital setting. This concern would remain even after accounting for the savings due to the lower Medicare reimbursement levels at a special psychiatric hospital compared to a psychiatric unit in a general hospital.

We respect your position that consolidating acute psychiatric inpatient care services at UCMC would create an over-compression of services at that campus, as you outlined at our meeting. Those concerns are considerations on the placement of inpatient psychiatric services. We note that UCH is projecting an average daily census ("ADC") of over 61 observation patients at UCMC, an average of over 30 patients per observation floor. Thus, in terms of ADC, downsizing observation bed capacity in line with the overall experience of Maryland hospitals, and using one of the proposed observation floors for adult psychiatric services, would not increase the anticipated average daily patient census on the Bel Air campus and would still leave an additional floor of shell space. With respect to your concern for retaining more options for expansion in Bel Air, it would seem that centralizing acute inpatient care at what is proposed to be the single general hospital campus in Harford County is a logical high priority for using space that can be made available in Bel Air, from an efficiency and access perspective. Decentralizing outpatient facilities and services to decompress the Bel Air campus and provide more flexibility for future expansion on this campus would seem to be a more efficient alternative to operating multiple inpatient facilities in the County.

We recognize the enormous amount of time and expense UCH has put into these projects. MHCC respects your efforts to configure an ambulatory campus in Aberdeen that meets many of the health care needs of the residents in eastern Harford County at a modern closeby location. We understand the urgency of moving forward with this project given the continued deterioration of Harford Memorial.

Thank you for your willingness to meet with MHCC and HSCRC staff to hear and discuss our concerns. We are eager close-out the Aberdeen and Bel Air project reviews with approved plans that reflect an efficient and effective reconfiguration of hospital services for Harford County residents.

Sincerely,



Ben Steffen

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