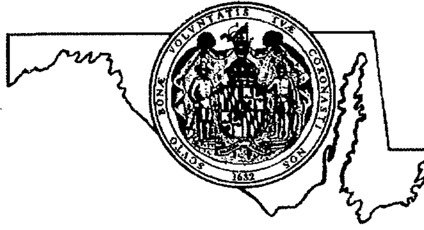
STATE OF MARYLAND



Andrew N. Pollak, MD
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

December 16, 2019

VIA E-MAIL AND REGULAR MAIL

James C. Buck, Esquire
Gallagher, Evelius & Jones, L.L.P.
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

Re: Modified Request for Exemption from Certificate of Need Review for the Merge and Consolidate of UM Upper Chesapeake Medical Center and UM Harford Memorial Hospital – Docket No. 17-12-EX003

Dear Mr. Buck:

Maryland Health Care Commission staff has reviewed the above-referenced request for an exemption from Certificate of Need ("CON") review, and has the following completeness and additional information questions.

Charity Care

1. Based on staff review of the Charity Care policy submitted, the UCHS charity care policy is ambiguous with regard to its compliance with the "Determination of Probable Eligibility" subpart of this standard, because it states that bank statements or other types of documentation "may be required" in order to render a "Determination of Probable Eligibility". Charity care policy and/or procedures that require documentation for a determination of probable eligibility

will not pass muster with this standard.[1] Please amend your policy and any related documents or forms to comply with this portion of the standard.

See the attached guidance for applicants and staff, which is meant to clarify the requirements.

2. Please complete the table below so that MHCC staff can confirm compliance with each section of the charity care standard. For each of the following subparts of this standard, quote the language from the policy that meets each provision, and give a citation to the section of the policy where that language can be can be found.

Standard	Quote from the policy	Section citation
10.24.19.04C Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. (a) The policy shall provide:		
(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.		
(ii) Minimum Required Notice of Charity Care Policy.		

[1] Requiring a completed application with documentation does not comply with this standard, which is intended to ensure that a procedure is in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application for Medicaid based on a simple and expeditious process.
A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;		
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.		
3.Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.		

Observation and Inpatient Bed Need

At our meeting of June 25, 2019 MHCC staff presented data showing that HMH and UCMC were extreme outliers in their use of Observation status, both in the number of patients admitted to Observation and in length of stay.

In its modified exemption request, UCHS UCHS responded to this critique with an internal review of its utilization processes, described as follows: "[our] clinical staff has considered implementation of clinical practices…[Using] enhanced case management, utilization review, and triage evaluation processes, UM UCH estimates that it may be able to slightly reduce its observation utilization through either direct patient discharges or transitions of care to other outpatient departments or providers [and] that through implementation of such clinical practices, approximately 34% of historic observation cases that lasted 24 or more hours will result in direct inpatient admissions from the emergency department at UCMC and from the proposed freestanding medical facility in Aberdeen."

However, the following questions remain:

3. On pages 14-15 of the modified exemption request you state that *"with the shift of observation patients from HMH to UC FMF, it is expected that approximately 400 patients that stay greater than 48 hours at UC FMF will be transferred to UCMC. Approximately one-half of those transfers will become observation patients at UCMC,"* i.e., about 200 patients who have spent more than two days in observation at the FMF will be transferred to observation status at UCMC.
   a) If their status has not yet been determined, why are they moved at all? Why not let them continue in observation at the FMF?
   b) Is it intended that the clinical changes that you describe will be put in place at UCMC to improve the processing of observation patients also be implemented at the FMF?

4. In FY2024 in Table F, you project 15,984 observation stays, and 15,864 MedSurg discharges, a ratio of 1.01. This is still far above the statewide average (CY2017) of 0.40. What factors explain this high ratio remaining for UM UCHS?

5. Provide a more detailed plan to attack this apparent overuse problem that offers a realistic expectation that the observation use rate will come into closer alignment with other UMMS peers and the state average.

6. Why does the UCHS need to replace HMH's total of 51 med/surg inpatient beds with 59 observation beds and 33 inpatient beds, a "swap" of 51 beds for 92 beds?

Construction Costs and Cost Effective Alternatives

7. On Table E, the Project Budget please define the line item called *Escalation* (listed as $4.8 million). Also, describe any assumptions and the calculations related to that item as well as the line items *Gross Interest during construction* ($6.6 million) and *Inflation Allowance* ($2.2 million).

8. It appears that the "12,000 sq. ft. on the existing Hospital Garden (Ground) Level will be renovated to expand support services and the food services department (kitchen)" described on pp. 3 and 4 of the exemption request is not reflected on Table B or C. Please submit corrected tables including it.

9. On p. 31, under the table for departmental differential, you identify Food Service & EVS Expansion as one single department containing 8,960 BGSF and having a cost factor of 1.2. Please provide a breakdown of the total space by its expected utilization in the table below (Add additional services if applicable):

Department/Service	Square Footage	Cost Factor
Dietary		1.52
Dining Room		0.95
Dishwashing Kitchen		1.59
Mechanical Equipment		0.70

10. Option 2 discussed in this proposal would locate the additional inpatient and/or observation beds in the Ambulatory Care Center ("ACC"), which is connected to the hospital, and replace the ambulatory care space with a new medical office building. The applicant states that the ACC space can accommodate 54 to 60 inpatient beds, and the cost of this option was estimated at $38.1 million. Given that it has more than enough space to accommodate the 33 psychiatric beds planned for the Aberdeen site – which is projected to cost far more to build (nearly $63 million) – why was this option not considered as an alternative to the proposed Aberdeen behavioral health proposal?

Application Table Package

11. As per our earlier conversation, there has been several iterations of various application tables submitted over the course of this review, as they were corrected or enhanced with additional information. So that reviewers can be certain they are examining the final version, please submit a complete and final set.

Please submit four copies of your response within ten working days of receipt. Also, please submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov) and Eric Baker (eric.baker@maryland.gov). If/when you feel that additional time is required to prepare a response, please let us know.

As with the request itself, all information supplementing the request must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, please contact me at (410) 764-3324 or Kevin McDonald at (410)764-5982.

Sincerely,

Eric Baker
Program Manager
Health Care Facilities Planning & Development

cc: Lyle E. Sheldon, President and CEO, UM Upper Chesapeake Health System
Kevin McDonald
Russell Moy, M.D., Acting Health Officer, Harford County

REQUIRED PROVISION	GUIDANCE FOR APPLICANTS, STAFF
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. **(a) The policy shall provide:**	**Provide exact quote from the policy that covers this provision, and provide the section citation…in addition, provide the responses indicated in each cell below.**
(i) Determination of Probable Eligibility. **Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.**	Policy must guarantee a determination of probable eligibility within two business days of request for charity/reduced fee care or application for Medicaid Quote the specific language from the policy that describes the determination *of probable eligibility* (and give a citation to the location within the policy). Provide copies of any application and/or other forms involved in the process for making a determination of probable eligibility within two business days. Describe your procedure for making a final determination, including defining any documentation required. *Note that requiring a completed application with documentation does not comply with this standard, which is intended to ensure that a procedure is in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application for Medicaid based on a simple and expeditious process.* *A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility.*
(ii) Minimum Required Notice of Charity Care Policy. **1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**	Quote the specific language from the policy that describes the method of implementing, and provide a sample for each communications vehicle(s). Provide examples of the public information tools.
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business	Provide copies of postings.

office, and emergency department areas within the hospital.	
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.	Quote from policy with section citation
(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.	If level of charity care is in bottom quartile, provide rationale/explanation for this variance.