MARYLAND
Health Care
Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

TO: Marta D. Harting, Esquire, Counsel for Hope Health Systems, Inc.
James C. Buck, Esquire, Counsel for Sheppard Pratt Health System, Inc.
Dana Farrakhan, MHS, FACHE, Senior Vice President, University of Maryland Medical Center, Inc.

FROM: Marcia L. Boyle, Commissioner/Reviewer

RE: Recommended Decision
Hope Health Systems, Inc.
Docket No. 20-03-2444

DATE: March 30, 2022

Enclosed is my Recommended Decision in the review of the Certificate of Need (CON) application by Hope Health Systems, Inc. (Hope Health) to establish a 16-bed special psychiatric hospital for children and adolescents.

The relevant State Health Plan (SHP) chapter considered in the review of this project is COMAR 10.24.07, State Health Plan for Facilities and Services: Overview, Psychiatric Services, and Emergency Medical Services (Psychiatric Services Chapter)[1]. Also considered are the general CON review criteria at COMAR 10.24.01.08G(3)(a) through (f). I considered the comments of Sheppard Pratt Health System, Inc., an interested party, and the entire record in this review and recommend that the Maryland Health Care Commission **DENY** Hope Health's application for a Certificate of Need to establish a special psychiatric hospital for children and adolescents.

Hope Health has failed to demonstrate that its proposed special hospital is viable or that it is the most cost-effective alternative for providing additional psychiatric hospital bed capacity for children and adolescents, under the criterion at COMAR 10.24.01.08G(3)(d), "Viability of the Proposal," and the criterion at COMAR 10.24.01.08G(3)(c), "Availability of More Cost-Effective Alternatives." My attached Recommended Decision details my analysis and findings regarding applicable standards and criteria.

Project Description

Hope Health proposes to establish a 16-bed special psychiatric hospital for children and adolescents, with four single patient rooms for children and twelve single patient rooms for adolescents. The project plan is to renovate 10,134 square feet of vacant space in a building located at 1726 Whitehead Road in Woodlawn, a site close to the intersection of Interstate 695, the

[1] This application was submitted under the Psychiatric Services Chapter, COMAR 10.24.07, which was subsequently revised and replaced by COMAR 10.24.21 Acute Psychiatric Services with an effective date of August 9, 2021.

Baltimore Beltway, and Security Boulevard. The space has been previously used as offices, classrooms, and conference rooms. The renovated space will be separate and distinct from the existing outpatient services currently operated by Hope Health in the building, with a separate entrance for patients and visitors. The hospital will have physically separated units for children and adolescents.

The estimated capital expenditure for the proposed hospital project is $1.5 million.

Recommendation

I recommend that the Maryland Health Care Commission **DENY** Hope Health's application for a Certificate of Need to establish a special psychiatric hospital for children and adolescents. I have found that support for the proposed project can be found under the "State Health Plan" criterion based on consideration of the applicable SHP standards. My consideration of the "Need" and "Impact on Existing Providers and the Health Care Delivery System" criteria also led me to find that the need for the proposed project was adequately demonstrated and that the likely impact of the project is not an impediment to approval. The "Compliance with Conditions of Previous Certificates of Need" criterion is not applicable to this first-time CON applicant. I was unable to find that the applicant made a convincing case for the project under the "Availability of More Cost-Effective Alternatives" criterion and I cannot find that the applicant's project plan has been demonstrated to have the required resources necessary to implement the project and to sustain the project. Positive finding on these resource availability questions must be made under the "Viability" criterion.

To recommend establishment of a new hospital, I believe it is important to be fully confident in the applicant's financial projections and the ability of the applicant to adequately and appropriately staff and support the hospital with a strong organizational asset base, in this case, HSCRC staff was unable to confidently endorse the proposed hospital project's feasibility or long-term viability and my consideration of the record leads me to the same conclusion.

Further Proceedings

This matter will be placed on the agenda of a meeting of the Maryland Health Care Commission on April 21, 2022, which begins at 1:00 p.m. at 4160 Patterson Avenue in Baltimore. This meeting is expected to be a "hybrid" meeting at which Commissioners and persons with matters before the Commission may attend in person or attend virtually through a Zoom webinar format. However, I request that representatives who plan to speak on behalf of the applicant and interested parties attend the meeting in person. Please let the Commission know as soon as possible if there are any concerns with my request to appear in person. The link to register to attend the meeting will be placed on the Commission's meeting page: https://mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/meeting_schedule.aspx?id=0. After registering, each person will receive a confirmation email containing information about joining the

Commission meeting via the Internet. The Commission will issue a final decision based on the record of the proceeding.

As provided in COMAR 10.24.01.09B, an applicant or interested party may submit written exceptions to the enclosed Recommended Decision. Written exceptions must identify specifically those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. Copies of exceptions and responses to exceptions must be communicated to all parties, via regular mail or email, by the due date and time shown below. If the deadline is met via email, please assure that paper copies of the exceptions or response to exceptions are also mailed to the Commission the same day.

Oral argument during the exceptions hearing before the Commission will be limited to 10 minutes for the applicant, and 10 minutes for the interested party unless extended by the Chairman. The schedule for the submission of exceptions and any response to exceptions is as follows:

Submission of exceptions:	Wednesday, April 6, 2022, no later than 4:00 pm.
Submission of responses:	Monday, April 11, 2022, no later than 4:00 p.m.
Exceptions hearing:	April 21, 2022, Monthly Commission meeting starts at 1:00 p.m.

cc: Yinka Fadiora
Bryan Niehaus, Esquire
Patricia Nay, M.D., Executive Director, Office of Health Care Quality, MDH
Katie Wunderlich, Executive Director, HSCRC
Stan Lustman, Assistant Attorney General, HSCRC
Alexa Bertinelli, Assistant Attorney General, MHCC
Sarah Pendley, Assistant Attorney General, MHCC
Paul Parker, Director, Health Care Facilities Planning and Development, MHCC
Wynee Hawk, Chief, CON, MHCC
Jeanne Marie Gawel, Program Manager, MHCC
Eric Baker, Program Manager, MHCC
Nilesh Kalyanaraman, M.D., Health Officer, Anne Arundel County
Letitia Dzirasa, M.D., Health Officer, Baltimore City
Gregory W. Branch, M.D., Health Officer, Baltimore County
Sue Doyle, Acting Health Officer, Carroll County
Marcy Austin, Acting Health Officer, Harford County
Maura J. Rossman, M.D., Health Officer, Howard County

IN THE MATTER OF	*	**BEFORE THE**
	*	
HOPE HEALTH	*	**MARYLAND**
	*	
SYSTEMS, INC.	*	**HEALTH CARE**
	*	
Docket No. 20-03-2444	*	**COMMISSION**
	*	

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REVIEWER'S RECOMMENDED DECISION

March 30, 2022

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I. INTRODUCTION

A. The Applicant

Hope Health Systems, Inc. (Hope Health) is a proprietary corporation founded in 1999 that provides non-institutional behavioral health services, including services for children and adolescents. Hope Health has service locations in the Woodlawn area of western Baltimore County, northwest Baltimore City, and Eldersburg (Carroll County).[1] Hope Health is accredited through the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission.

Hope Health states that it currently provides partial hospitalization services, outpatient mental health services, expanded school mental health services, rehabilitation programs, outpatient substance abuse services, and mobile treatment services. In addition to clinical treatment services, Hope Health also provides administrative management and research consulting services. (DI #4 p. 5). Hope Health maintains a website: https://hopehealthsystems.com.

B. The Project

Hope Health proposes to establish a 16-bed special psychiatric hospital for children and adolescents, with four single patient rooms for children and twelve single patient rooms for adolescents. The special hospital unit would be established in the Woodlawn area of western Baltimore County by renovating a vacant portion of an existing building where Hope Health provides outpatient services. The building is owned by Hope Health Properties (HHP).[2]

The project plan is to renovate 10,134 square feet (SF) of vacant space in a building located at 1726 Whitehead Road in Woodlawn, a site which is very close to the intersection of Interstate 695, the Baltimore Beltway, and Security Boulevard. The space has been previously used as offices, classrooms, and conference rooms. The renovated space will be separate and distinct from the existing outpatient services, with a separate entrance for patients and visitors. The hospital will have physically separated units for children and adolescents. The project drawings are submitted in Appendix 2.

The original project budget estimate was $4,500,000 to be funded with a loan. In April 2021, in response to staff completeness questions, Hope Health re-categorized its projected expenses, resulting in a revision of the capital expenditure estimate for the hospital project to $1.5 million.[3] The original loan amount was increased and the assumed interest rate on the loan was

[1] Hope Health also had a service location in Middletown, Delaware, which was closed after the application submission.

[2] The CON application, exhibits, and subsequent responses introduced three related organizations:

1. Hope Health Systems, Inc. (Hope Health), the parent organization and applicant;
2. Hope Health Properties, LLC (HHP), a separate entity, of which HHS is the sole member. HHP owns the building and would serve as the landlord for the proposed tenant, Hope Health Hospital; and
3. Hope Health Hospital, the proposed hospital in the application, owned by Hope Health.

Appendix 1 includes more information on the organizational structure.

[3] Under this revised project plan, the HHP properties are held as collateral on the HHP mortgage debt incurred for the acquisition and renovation of the HHP properties. Hope Health, as the primary tenant of HHP, is a guarantor of the

reduced as shown in the following Table I-1 below. A side-by-side comparison of the budgets is shown in Appendix 4.

Table I-1: Project Budget Estimate, Hope Health Hospital

Uses of Funds	ORIGINAL BUDGET	REVISED BUDGET
Capital Costs		
Site and infrastructure	**$50,000**	**$0**
Architect fees	**9,400**	**0**
Subtotal-Site/Infrastructure/Architect	***$59,400***	***$0***
Renovations		
Building	**$2,287,498**	**$0**
Fixed equipment (not included in Building)	**131,250**	**0**
Architect/engineering fees	**128,500**	**0**
Permits (building, utilities, etc.)	**2,500**	**0**
Subtotal-Renovation	***$2,549,748***	***$0***
Other Capital Costs		
Contingency allowance	**$318,718**	**$0**
Movable equipment	**875,000**	**875,000**
Subtotal-Other Capital	***$1,193,718***	***$875,000***
Total Current Capital Costs	**$3,802,866**	**$875,000**
Total Capital Costs	**$3,802,866**	**$875,000**
Financing Cost and Other Cash Requirements		
CON Application Assistance		
Legal Fees	**$60,000**	**$60,000**
Other Consulting Fees	**637,134**	**565,000**
Subtotal-Financing/Other Cash	***$697,134***	***$625,000***
Total Uses of Funds	**$4,500,000**	**$1,500,000**
Sources of Funds		
Loan (original budget) and cash (revised budget)	**$4,500,000**	**$1,500,000**
Total Sources of Funds	**$4,500,000**	**$1,500,000**

Sources: DI #_4, Exh. 1; DI #35, Exh. 1.
Note: In the original budget, no figure was given for "gross interest charges on the loan" during construction, a line item under "Other Capital Costs."

Table I-2: Project Funding Plan, Hope Health Properties

	Original Plan	Final Plan
Loan Amount	$2,750,000	$5,677,866
Amortization/months	300	300
Interest Rate[4]	5.37%	4.00%
Monthly Payment	$16,803	$30,153
Annual Payment	$201,632	$361,837
Total Principal	**$3,721,156**	**$6,759,947**

Source: DI #35, p. 3.

HHP mortgage debt. HHP intends to finance the balance owed on its existing mortgage and consolidate that balance with additional borrowed funds to pay for the proposed hospital, created through building renovation on the Whitehead Road property. (DI #35, p.2).

[4] The 4.0% rate was provided on April 26, 2021 (DI #35, p. 3). Staff review of hospital bond rates in Maryland are in the range of 1.5% to 5.0%, with many between 2.0% and 3.75%.

Hope Health envisions its proposed hospital as "an integrated, comprehensive, personalized mental health treatment facility" for children and adolescents in the Baltimore area. It sees the project as a necessary approach to improving access to psychiatric hospital services for children and adolescents, particularly for "publicly insured" patients; "diversify[ing]" the hospital market; improving care coordination through improving the continuum of care for patients; and increasing the delivery of "culturally competent care." It states that its approach will, "ultimately help reduce readmission rates." (DI #4 pp. 5, 6).

C. Reviewer Recommendation

I recommend denial of the requested Certificate of Need (CON) for this project. A case can be made for the increase in child and adolescent bed capacity proposed, allowing a finding of need for the project. The impact of the project on the health care system, cost and charges, and other providers of the service is not a basis for denial of the project. However, I cannot make a positive finding with respect to viability of the project. I also cannot make a confident finding that the project is the most cost-effective approach to obtaining the greater availability of inpatient service capacity for youth, which is the primary improvement afforded by development of the project. I am concerned that the minimal physical facilities for the proposed new hospital, combined with the low-cost alternative put forth in this review may have a negative impact on the effectiveness of patient care, on the ability to have comprehensive programming addressing a broad range of patient needs, on the feasibility of serving patients with specialized needs, and on patient and family satisfaction.

A more detailed summary of the basis for my recommendation can be found at the end of this Recommended Decision.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 3 for the Record of the Review.

B. Interested Parties and Participating Entities in the Review

Sheppard Pratt Health System, Inc. (Sheppard Pratt) and University of Maryland Medical Center (UMMC) both provide acute psychiatric hospital services. Sheppard Pratt provides child and adolescent hospitalization at its special psychiatric hospital in Towson (Baltimore County) and provides services to adolescents at its hospital in Howard County (Elkridge). UMMC's psychiatric hospital services are provided as part of its academic medical center general hospital operation in the downtown area of Baltimore City. It has historically provided psychiatric hospital services to children. In 2019, UMMC was authorized to introduce psychiatric hospital services to adolescents.

Both entities have been recognized as interested parties in this review. within the meaning of COMAR § 10.24.01.01B(20). However, only Sheppard Pratt submitted comments, stating that the applicant failed to demonstrate that the project: (1) is financially viable; (2) would be cost

effective; and (3) is needed. Additionally, Sheppard Pratt commented that HHS failed to validate its effect on the costs to the health care delivery system and did not demonstrate that it had planned appropriately for patient safety and quality. For these reasons, Sheppard Pratt recommends that the Commission deny the application. (DI #22; DI # 30).

C. State and Local Government Support

Hope Health received letters of support from Antoinette McLeod, Executive Director of the Maryland Department of Juvenile Services; Gregory Wm. Branch, M.D., Baltimore County Health Officer; Earnest Carter, M.D., Prince George's County Health Officer; Mary Beth Haller, Deputy Commissioner of Health for Baltimore City; and Aliya Jones, M.D., Deputy Secretary of Behavioral Health at the Maryland Department of Health. (DI #4, Exh.5; DI #13, Exh. 12).

D. Community Support

In addition to local government support, Hope Health submitted additional letters supporting the proposed project from: Charles Sydnor II, Maryland State Senator; Nick Mosby, Maryland State Delegate; Andrea Brown, the Executive Director of the Black Mental Health Alliance; Ronald Means, M.D., the Chief Medical Officer of Catholic Charities; several community behavioral health services providers, and letters of support from patients. (DI #4, Exh. 5).

III. Background

Supply of Acute Child and Adolescent Hospital Psychiatric Services in Maryland

MHCC defines child psychiatric hospital services as services provided to patients aged 12 or younger. Adolescent psychiatric hospital services are defined as services provided to patients aged 13 to 17. While these age ranges are used to generate information on the supply and demand for hospitalization by each of these two age groups, operationally, the definitional boundaries are not rigid. Hospitals use bed capacity reported and identified as child bed capacity to serve patients in the adolescent age range, typically younger adolescents, when this modality is safe and appropriate for the needs of the specific patient and the clinical program of care for that patient. Similarly, older "children" are sometimes served in beds identified as adolescent beds. At the top of the adolescent age range, the same soft boundary must be considered in interpreting statistical sets. Information on discharges of older adolescents may be included in calculations of adolescent bed capacity use, even though the adolescent patient was accommodated in a unit identified as an "adult" psychiatric unit. And a patient considered an adult by MHCC (18+) may sometimes be served in a bed identified as an adolescent bed. Additionally, two general hospitals have hospitalization programs that allow admission of patients aged 15 and older, so these units' beds have historically been viewed as adult beds that serve some number of older adolescents within what an adult program of service is generally. For these reasons, some data analyses touching on these younger psychiatric hospital patients need to be viewed as close approximations of reality rather than precise calculations.

As noted, UMMC was authorized to introduce adolescent psychiatric hospital services in

2019. TidalHealth Peninsula Regional Medical Center (PRMC), in Salisbury (Wicomico) was also authorized to introduce both child and adolescent psychiatric hospital services in the same year. This Eastern Shore project will bring the total number of hospitals serving children in Maryland to six: Adventist HealthCare (AHC) Shady Grove Medical Center, a general hospital in Rockville (Montgomery); Brook Lane, a special psychiatric hospital in Hagerstown (Washington); the Johns Hopkins Hospital, an academic medical center general hospital in Baltimore City; UMMC; Sheppard Pratt (see interested parties above); and PRMC.

Table III-1: Inventory (Existing and Approved) Hospitals Serving Children and Adolescents January 2022

Hospital	Hospital Type	Region*	Program Type	Beds
AHC Shady Grove	General	Montgomery	Children	12
			Adolescent	24
Brook Lane	Special	Western Maryland	Children	17
			Adolescent	20
Calvert Health	General	Southern Maryland	Adolescent	8[1]
Carroll	General	Baltimore/ Upper Shore	Adolescent	4
Johns Hopkins	General	Baltimore/ Upper Shore	Children	15
			Adolescent	15
MedStar Franklin Square	General	Baltimore/ Upper Shore	Adolescent	11
MedStar Montgomery	General	Montgomery	Adolescent	5
Sheppard Pratt	Special	Baltimore/ Upper Shore	Children	20[2]
			Adolescent	71
Sheppard Pratt at Elkridge	Special	Baltimore/ Upper Shore	Adolescent	22
Suburban	General	Montgomery	Adolescent	24[3]
TidalHealth Peninsula Regional	General	Lower Eastern Shore	Children	
			Adolescent	15[4]
University of Maryland	General	Baltimore/ Upper Shore	Children	
			Adolescent	16]5]

Source: MHCC

*Five regions are established in the current SHP chapter of regulation for psychiatric hospital services effective in 2021. https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/psychiatric_services/con_comar_10_24_21_20210809.pdf.

Notes:

[1] This general hospital has eight total psychiatric beds for adults and older (15+) adolescents.

[2] Sheppard Pratt has informed MHCC staff that it uses more than 20 beds for hospitalization of patients in the age range used by MHCC to designate discharges of children.

[3] This general hospital has 24 total psychiatric beds for adults and older (15+) adolescents.

[4] The introduction of child and adolescent psychiatric hospital services was approved for this general hospital in 2019. A 15-bed unit for both age groups is under development.

[5] The introduction of adolescent psychiatric hospital services was approved for this general hospital in 2019. A 16-bed unit for both age groups is under development.

An additional six hospitals in Maryland provide adolescent psychiatric hospital services. Five are general hospitals; Calvert Health Medical Center in Prince Frederick (Calvert), Carroll Hospital in Westminster (Carroll); MedStar Franklin Square Medical Center in northeastern Baltimore County; MedStar Montgomery Medical Center in Olney (Montgomery); and Suburban Hospital in Bethesda (Montgomery). Sheppard Pratt at Elkridge (Howard) is a special psychiatric

hospital serving adolescents but not children. As previously noted, PRMC was approved for introduction of adolescent and child services in 2019. Calvert Health and Suburban report that their psychiatric hospitalization programs do not serve younger adolescents. In these hospitals, patients aged 15 and older suitable for admission are served in what is, primarily, a general hospital adult program.[5]

Table III-2: Regional Distribution of Existing and Approved Psychiatric Hospital Beds for Children and Adolescents (Approximate)

Region	Children's Beds	Adolescent Beds
Baltimore Upper Shore [1]	41	133
Montgomery [2]	12	34
Southern Maryland [3]	0	2
Western Maryland	17	20
Lower Eastern Shore [4]	5	10
Total Maryland	**75**	**199**

Source: MHCC

Notes:

[1] The 16 beds for children and adolescents approved for UMMC are allocated as ten beds for adolescents and six beds for children.

[2] Five of Suburban's 24 total psychiatric beds are allocated as adolescent beds.

[3] Two of Calvert Health's eight total psychiatric beds are allocated as adolescent beds.

[4] The 15 beds for children and adolescents approved for TidalHealth Peninsula Regional are allocated as ten beds for adolescents and five beds for children.

Demand for Acute Child and Adolescent Hospital Psychiatric Services in Maryland

Hospital use for both children and adolescents in Maryland diagnosed with mental diseases or disorders declined modestly between 2011 and 2019 for all age groups, as shown in the following table.[6] Adolescents were hospitalized at approximately six times the rate of children, and adults were hospitalized nearly four times more frequently than persons aged 12 or younger.

Table III-3: Hospital Discharge Rate of Maryland Residents by Age Discharge Diagnosis Range: Major Diagnostic Category of Mental Disease or Disorder 2011 -2019

Age Group	Discharges Per 1,000 Maryland Resident Population									Average Annual Change
	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Child (0-12)	2.08	2.15	1.99	1.91	1.81	1.76	1.86	2.01	1.93	-0.94%
Adolescent (13-17)	12.60	12.58	12.89	12.92	13.46	12.72	12.72	12.76	11.37	-1.27%
Adult (>18)	9.53	9.25	8.98	8.74	8.28	8.07	7.80	7.66	7.09	-3.62%
All Ages	8.50	8.31	8.10	7.91	7.58	7.37	7.18	7.10	6.56	-3.19%

Source Notes:

1. HSCRC and D.C. Hospital Association discharge data files (general and special psychiatric hospitals).
2. Population data retrieved from Maryland Department of Planning, State Data Center, December 2020. (Prepared from Population Division, U.S. Census Bureau, release date June 25, 2020 (for 2010 to 2019 estimates).
3. Average annual change calculated as compound annual growth rate.

[5] Calvert Health has a total of 8 licensed acute psychiatric beds; Suburban has 24 total licensed beds.

[6] Use rate trends appear to be moderating. In an MHCC *White Paper on Acute Psychiatric Hospital Services* published in 2019 that examined the ten-year span of 2008 to 2017, both child and adolescent use rates were trending upward and the adult use rate was declining at a more moderate rate.

In the years shown in Table III-4, below, use of psychiatric hospitalization by children peaked in 2012 and declined, at a rate of 3.2 percent per year between 2012 and 2019, to a level that was only 7.2 percent lower than the use rate observed in 2011. For adolescents, inpatient use peaked in 2015 and has moderated more recently. An unusually steep decline was recorded for 2019. It can be assumed that the hospital use rate for children has been flat in the last decade and that the adolescent use rate may be flat to slightly positive (see footnote 9) over a similar period.

Demand for Acute Child and Adolescent Psychiatric Hospital Services – Defined Service Area

Hope Health defines the primary service area (PSA) for the proposed child and adolescent psychiatric hospital to include six Maryland jurisdictions: Anne Arundel, Baltimore, Carroll, Harford and Howard Counties, and Baltimore City. Hope Health expects to also serve patients from across the state, southern Pennsylvania, and Washington DC, as well as parts of southern Maryland.

Table III-4 below shows a modest increase in utilization of hospitals for adolescents diagnosed with mental diseases or disorders between 2010 and 2018 in Hope Health's six-jurisdiction PSA (2%) and statewide (7%). The discharges for children in the applicant's defined PSA and statewide changed very little (less than one percent) over that same period. As previously noted, the reported discharge count dropped in 2019 for both age groups, more broadly and proportionately for adolescents.

Table III-4: Psychiatric Hospital Discharges from Maryland and D.C. Hospitals of Children and Adolescents Residing in the Defined Hope Health Primary Service Area 2010 – 2019

Jurisdiction	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Children (Aged 0-12)										
Anne Arundel	117	126	168	146	156	166	149	163	192	191
Baltimore City	497	538	560	467	429	388	344	396	384	304
Baltimore Co.	384	388	411	397	356	365	351	360	376	385
Carroll	42	40	44	43	52	34	26	37	39	52
Harford	68	61	69	73	70	70	88	85	79	61
Howard	41	57	46	83	73	62	68	111	83	96
Total Service Area	1,149	1,210	1,298	1,209	1,136	1,085	1,026	1,152	1,153	1,089
Total Maryland	1,951	2,014	2,093	1,934	1,854	1,903	1,909	1,985	1,930	1,860
Adolescents (Aged 13-17)										
Anne Arundel	417	435	481	571	556	570	579	539	549	421
Baltimore City	594	605	630	640	587	647	565	527	535	482
Baltimore Co.	840	963	987	951	912	961	926	936	831	814
Carroll	179	194	169	155	136	133	136	163	147	157
Harford	183	192	195	213	199	228	203	234	200	173
Howard	294	334	331	300	310	315	311	329	296	264
Total Service Area	2,507	2,723	2,793	2,830	2,700	2,854	2,720	2,728	2,558	2,311
Total Maryland	4,691	5,018	4,980	5,093	5,098	5,291	5,068	5,084	5,021	4,470

Source: HSCRC and D.C. Hospital Association discharge data files.

The hospitalization use rate of the six-county PSA population of children and adolescents and of the statewide population declined from 2012 to 2019, as shown in the following Table III-5. For both children and adolescents, the decline was relatively modest. The PSA population use

rate, which is higher than the statewide use rate, declined as a slightly faster rate than the statewide decline.

Table III-5: Hospital Discharge Rate of Defined Hope Health Service Area Residents by Age Discharge Diagnosis Range: Major Diagnostic Category of Mental Disease or Disorder 2012 – 2019

Jurisdiction	Discharges Per 1,000 Maryland Resident Population								Change	Average Annual Change
	2012	2013	2014	2015	2016	2017	2018	2019	2012-2019	
Children (Non-Newborns Aged 0-12)										
Anne Arundel	1.84	1.60	1.71	1.82	1.62	1.76	2.07	2.05	0.21	1.6%
Baltimore City	5.71	4.75	4.37	3.97	3.58	4.20	4.27	3.44	(2.27)	-7.0%
Baltimore Co.	3.23	3.11	2.78	2.85	2.72	2.79	2.95	3.03	(0.19)	-0.9%
Carroll	1.66	1.66	2.04	1.35	1.04	1.49	1.63	2.21	0.55	4.1%
Harford	1.69	1.82	1.76	1.77	2.23	2.16	2.02	1.56	(0.13)	-1.1%
Howard	0.88	1.58	1.38	1.16	1.26	2.03	1.55	1.78	0.90	10.6%
Total Service Area	2.97	2.77	2.61	2.49	2.36	2.65	2.70	2.56	(0.41)	-2.1%
Total Maryland	2.17	2.01	1.92	1.97	1.98	2.06	2.04	1.97	(0.20)	-1.4%
Adolescents (13-17)										
Anne Arundel	13.72	16.28	15.80	16.14	16.42	15.33	15.40	11.79	(1.93)	-2.1%
Baltimore City	18.84	19.35	17.54	19.40	17.27	16.48	15.17	13.76	(5.08)	-4.4%
Baltimore County	19.58	18.94	18.18	19.06	18.46	18.66	15.75	15.44	(4.14)	-3.3%
Carroll	13.38	12.55	11.15	11.07	11.49	14.00	13.24	14.40	1.02	1.1%
Harford	10.90	12.01	11.30	13.16	11.84	13.68	12.03	10.49	(0.41)	-0.6%
Howard	14.29	13.02	13.49	13.58	13.26	13.89	13.43	12.06	(2.23)	-2.4%
Total Service Area	16.18	16.51	15.73	16.63	15.94	16.07	14.75	13.38	(2.81)	-2.7%
Total Maryland	12.99	13.38	13.37	13.86	13.33	13.42	12.97	11.58	(1.41)	-1.6%

Source Notes:
1. HSCRC and D.C. Hospital Association discharge data files (general and special psychiatric hospitals).
2. Population data retrieved from Maryland Department of Planning, State Data Center, December 2020. (Prepared from Population Division, U.S. Census Bureau, release date June 25, 2020 (for 2010 to 2019 estimates).
3. Average annual change calculated as compound annual growth rate.

IV. REVIEW AND ANALYSIS

Commission regulations at COMAR 10.24.01.08G(3)(a) through (f) identify six criteria for use in the review of proposed projects seeking CON approval.

A. The State Health Plan

COMAR 10.24.01.08G(3)(a) State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan (SHP) chapter to be considered in the review of this project is the former COMAR 10.24.07, State Health Plan for Facilities and Services: Overview, Psychiatric Services, and Emergency Medical Services. At the time of the application submission and its docketing, this chapter of regulation was in effect. The acute psychiatric hospital component of this SHP chapter of regulation was repealed and replaced effective August 9, 2021.

Some standards of the former COMAR 10.24.07 pertaining to acute psychiatric hospital services become obsolete over time because of changes in psychiatric hospital bed use and the role

and scope of state psychiatric hospital facilities since the regulations were previously updated. Other standards were simply inapplicable to this project.[7]

This section reviews the following standards that were still relevant and applicable at the point in time when this application was filed.

AP3a: Array of services
AP3b: Multidisciplinary treatment team
AP4a: Separate Certificate of Need
AP4b: Physical separations and clinical/programmatic distinctions
AP5: Availability of services
AP6: Quality assurance programs, program evaluations, and treatment protocols
AP7: Patient's legal status
AP8: Uncompensated care
AP11: Average total cost for an admission
AP12a: Supervision by a psychiatrist
AP12b: Staffing requirement
AP12c: Staffing requirements for child and adolescent services
AP13: Discharge planning
AP14: Letters of acknowledgement

Standard AP 3a

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include chemotherapy[8], individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

The applicant states that it will provide an array of services using a multi-disciplinary approach. (DI #4, p.21). The program will administer chemotherapy and provide social services. Social workers, psychiatrists, and psychologists will provide individualized psychotherapy, group therapy and family therapy services and occupational therapists will provide adjunct therapies. (DI #4, p.21). I find that the applicant states an intention to meet the requirements of the standard.

Standard AP 3b

In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

The applicant states that it will use a multi-disciplinary team that will address daily living skills, psychoeducational development, vocational development, and interpersonal skill

[7] Standards AP 1a through AP 1d and AP 10 are outdated and no longer applicable. Standards AP 2a through AP 2c, as well as AP 3c are not applicable to projects such as that reviewed in this Recommended Decision that are not part of an acute care general hospital. AP 9 is not applicable as other facilities offer child acute psychiatric hospital services within a 45-minute drive time of the proposed hospital.

[8] The term "chemotherapy" in this standard refers to the use of psychotropic drugs in the treatment of mental disorders rather than the more frequent common use of this term to describe pharmaceutical treatment of cancer.

development. Services will also include restoration of family functioning, and any specialized patient or family needs. As an existing outpatient behavioral health service provider, Hope Health states that it is uniquely positioned to bridge services between inpatient and outpatient care settings. (DI #4, p.21).

In addition, the applicant states that it will provide services to children and adolescents based on individualized treatment plans that are consistent with the needs of each age group. Services will be provided to each age group in separate units with separate nursing stations. (DI #4, p.22). I find that Hope Health's representations comply with this standard.

Standard AP 4a

A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

The applicant is seeking a CON to establish a 16-bed psychiatric hospital that will have four beds for children and twelve beds for adolescents. There is no proposed adult acute psychiatric programming in this project. (DI #4, p.22). I find that Hope Health complies with this standard.

Standard AP 4b

Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

The applicant has designed the hospital to have two physically separate units with separately staffed nurse's stations. Programmatic distinctions will be made through individualized treatment plans. (DI #4, p. 22). Hope Health states that although dining, social, and therapy spaces will be used by all age groups, the scheduling will be implemented using different time slots for each age cohort to ensure clinically appropriate separation between children and adolescents. (DI #13, p.10). I find that the applicant has a stated intention to meet the requirements of the standard.

Standard AP 5

Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

- **(i) intake screening and admission;**
- **(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or**
- **(iii) necessary evaluation to define the patient's psychiatric problem and/or**
- **(iv) emergency treatment.**

The applicant states that services that will be available to all patients include intake screening/admission, transfer arrangements to a more appropriate facility if clinically indicated, a full psychiatric evaluation to diagnose the patient, and emergency treatment if medically indicated. (DI #4, p.23). The applicant has initiated outreach for transfer agreements and states that, with CON approval, it will pursue transfer agreements throughout the central Maryland health planning region with any provider in good standing. (DI #13, p.11). I find that the applicant states an

intention to comply with this standard.

Standard AP 6

All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations, including children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

The applicant plans to have separate quality assurance programs and evaluation protocols for child and adolescent patients, as well as separate protocols for special populations including any patient with a secondary diagnosis of substance abuse. (DI #4, p.23). The applicant has provided drafts of these policies in Exhibit 11. (DI #13, p.12). I find that Hope Health's representations comply with this standard.

Standard AP 7

An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

The applicant states that it will not deny any admission based on legal status rather than clinical criteria. (DI #4, p. 23). I find that the applicant has stated an intention to meet the requirements of the standard.

Standard AP 8

All acute general and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12-month period.

The applicant provided the HSCRC data in Table IV-1 for the most recent twelve months (at the time of application submission) that shows the average uncompensated care percentage of 3.96 percent in the health service area. (DI #4, p. 24). Hope Health states that it will provide a level of uncompensated care that meets or exceeds this average. (DI #4, p. 24). I conclude that Hope Health has stated an intention to comply with this standard.

Table IV-1: Uncompensated Care (UCC) as a Percentage of Total Revenue
Central Maryland Hospitals – FY 2020

Hospital	Jurisdiction	UCC Percentage 2020
Anne Arundel	Anne Arundel	3.14%
Carroll	Carroll	2.56%
Grace	Baltimore City	3.12%
Greater Baltimore	Baltimore County	2.85%
Howard County General	Howard	3.91%
Johns Hopkins	Baltimore City	2.80%
Johns Hopkins Bayview	Baltimore City	4.84%
MedStar Franklin Square	Baltimore County	3.88%
MedStar Good Samaritan	Baltimore City	4.27%
MedStar Harbor	Baltimore City	4.29%
MedStar Union Memorial	Baltimore City	3.69%
Mercy	Baltimore City	4.19%
Northwest	Baltimore County	4.65%
Saint Agnes	Baltimore City	5.21%
Sinai of Baltimore	Baltimore City	3.67%
UM Baltimore Washington	Anne Arundel	5.09%
UM Harford Memorial	Harford	5.72%
UM St Joseph	Baltimore County	3.90%
UM Upper Chesapeake	Harford	3.22%
UMMC Midtown Campus	Baltimore City	4.62%
University of Maryland	Baltimore City	3.53%
AVERAGE		**3.96%**

Source: DI #4, p. 24.

Standard AP 11

Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

The applicant analyzed HSCRC data[9] that included the general acute care hospitals within the central health planning region with established psychiatric inpatient units. The average charge per case was $16,483.99 for children and $16,719.50 for adolescents. Hope Health projects an average total charge per case of $14,588.72 for both patient populations as shown in the following table. I find that Hope Health has provided documentation concerning its projection of its charges and, to the extent possible at this time, has produced projected charges that comply with the requirements of this standard.[10] (DI #27, p. 3). I find the record with respect to whether the projected charges are accurate to be unclear, as will be addressed in section C. Availability of More

[9] The HSCRC data is for acute care hospitals only, and excludes those with under ten psychiatric admissions, and excludes special psychiatric hospitals. The data reports charge information, often used as a proxy to represent costs. Costs are not reported in the data.

[10] Applicant has met the standard; however, Standard AP-11 is not included in the revised psychiatric services chapter of the State Health Plan.

Cost-Effective Alternatives in this recommended decision (see pages 27-31).

Table IV-2: Average Projected Charge for Acute Child and Adolescent Psychiatric Hospital Stays Central Maryland Hospitals

Children					
Hospital	Discharges	Charge Per Discharge FY 2019	Projected Charge per Discharge FY 2020*	Projected Charge per Discharge FY 2021*	Projected Charge per Discharge FY 2022*
University of Maryland	440	$16,524.25	$16,960.49	$17,430.30	$17,778.90
Johns Hopkins	160	$12,999.40	$13,342.58	$13,712.17	$13,986.42
MedStar Franklin Square	43	$11,643.04	$11,950.42	$12,281.44	$12,527.07
	Projected Charge per Discharge				$16,483.99
	Projected Charge per Discharge – Hope Health				$14,588.72
Adolescents					
Hospital	Discharges	Charge Per Discharge FY 2019	Projected Charge per Discharge FY 2020*	Projected Charge per Discharge FY 2021*	Projected Charge per Discharge FY 2022*
University of Maryland	11	$18,171.52	$18,651.25	$19,167.89	$19,551.25
Johns Hopkins	457	$17,063.87	$17,514.36	$17,999.50	$18,359.49
MedStar Franklin Square	297	$11,926.32	$12,241.17	$12,580.26	$12,831.86
Carroll	75	$20,174.42	$20,707.02	$21,280.61	$21,706.22
	Projected Charge per Discharge				$16,719.50
	Projected Charge per Discharge – Hope Health				$14,588.72

Source: DI #28, p. 25. These projected charges are based on the updated per diem charge of $1,585.73 and an ALOS (average length of stay) of 9.2 days. (DI #28, p. 25) The FY 2020 projection assumes an average increase of 2.64%; FY 2021-22 projections assume an average increase of 2.77%. DI #28, p. 25.

Standard AP 12a

Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

The applicant states that it currently has four board-certified psychiatrists specializing in child and adolescent psychiatry on staff in its outpatient program and plans to expand its medical staff to meet inpatient needs. Hope Health states that the psychiatrists will provide clinical supervision of all acute inpatient psychiatric services provided at the proposed hospital. (DI #4, p. 26).

The applicant responded further that it would not develop any formal "shared" positions, and that the licensed and certified hospital staff will not "float" between inpatient and outpatient settings. Further, any employees that would potentially work in both inpatient and outpatient settings "would be required to clock in and out when starting/ending a hospital shift." (DI #40, p.11). I find that the applicant's statements with respect to medical direction are consistent with the requirements of the standard.

Standard AP 12b

Staffing of acute inpatient psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

The applicant states that it will provide aftercare coordinators to facilitate transitions for further treatment, as necessary. The applicant also will have social workers, psychiatrists, and psychologists on staff to provide therapy services to patients. Exhibit 1, Table L of the CON application provided projected staffing numbers that the applicant states support a seven-day per week treatment program. (DI #4, p. 26; DI #1). I find that the applicant intends to comply with this standard.

Standard AP 12c

Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

The applicant states that it will employ staff who are experienced and trained in child and adolescent acute psychiatric care and notes that the existing outpatient staff are already specialized in this type of care. Additional training will be provided with the implementation of inpatient care. (DI #4, p. 26). The applicant stated it will develop and implement specific training and competency evaluations for the inpatient environment for new employees and for ongoing training and that a computer software database will be used to develop materials. The materials will be based on information from the Joint Commission, Lippincott Solutions, the Centers for Disease Control, and HealthStream. (DI #13, p. 13). I find that the applicant intends to meet the requirements of the standard.

Standard AP 13

Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

The applicant has provided a draft of its discharge planning policy that will be made available to licensing and certifying bodies to review in Exhibit 4 of its application. (DI #4, p. 28). The applicant stated that its referral network will include area hospitals, local health departments and community providers in good standing and that patient choice will be honored in selecting a provider. Hope Health identified the programs with which they currently have agreements to receive and treat patients, which includes Agape Health Systems, Optimum Health System, Leading by Example Behavioral Health, Prince George's County Health Department, Baltimore City Health Department, and the Baltimore County Health Department. In addition, it plans to continue to work with Kennedy Krieger, Johns Hopkins, and the school systems in both Baltimore County and Baltimore City. (DI #13, p. 14). I find that Hope Health has stated its intention to comply with this standard.

Standard AP 14

Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);
(ii) the local community mental health center(s);
(iii) the Department of Health and Mental Hygiene; and
(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

The applicant provided the required acknowledgement letters and the following letters of support (DI #4, p. 28):

- Aliya Jones, M.D., Deputy Secretary Behavioral Health, Maryland Department of Health
- Mary Beth Haller, Deputy Commissioner of Health, Baltimore City Health Department
- Antionette McLeod, Executive Director for Operations, Maryland Department of Juvenile Services
- Gregory Wm. Branch, M.D., Health Officer, Department of Health, Baltimore County
- Charles E. Sydnor III, Senate of Maryland, Legislative District 44
- Andrea Brown, Executive Director, Black Mental Health Alliance,
- Ronald Means, M.D., Chief Medical Officer, Catholic Charities of Baltimore
- Jonathan Shepherd, M.D., President, Board of Directors, Black Mental Health Alliance
- James Omotosho, Program Director, Optimum Health Systems, Inc.
- Subramonianpillai Teal, Clinical Director/Co-Founder, Leading by Example Behavioral Health
- Deborah Okonofua, D.N.P., Agape Health Systems
- Tiffany Carroll, Executive Director, Empowering Minds Resource Center, LLP
- Stacey Bass, Executive Director, Healthy Minds Resource Center
- Nick Mosby, President of the Baltimore City Council (Mosby was a State Delegate when his letter of support was submitted to the applicant)
- Annelle Primm, M.D., Former Deputy Director, American Psychiatric Association
- Akin Akintola, M.D., Board Certified Child, Adolescent, and Adult Psychiatrist
- Ernest L. Carter, M.D., Health Officer, Prince George's County
- Kimberly Gordon-Achebe, M.D., Medical Director of Intensive Services, Hope Health Systems

I find that the applicant has shown community acknowledgement and support for the proposed project and meets the requirements of this standard.

While, as a proposed new provider of psychiatric hospital services, the applicant is primarily limited to stating its intention to comply with the applicable standards of the SHP, I find that, with respect to these standards, there is no basis for concluding that the clearly stated intentions of the applicant are insincere or lack credibility. Therefore, my evaluation of the application leads me to find that it is in accord with all relevant State Health Plan standards, policies, and criteria.

B. Need

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

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

Hope Health presented data supporting the lack of sufficient programs providing child and adolescent psychiatric services, stating that "just five…hospitals handle over 95 percent of [child psychiatric] admissions," while "just seven hospitals…handle 95 percent of [adolescent psychiatric] admissions." Hope Health points out that follow-up care after discharge is an issue, citing Maryland Health Care Commission (Commission or MHCC) research indicating that the readmission rate[11] in Maryland for children rose from 7.2 to 10.0 per 100 discharges between 2014 and 2017, and the rate for adolescents rose from 4.6 to 8.1 per 100 discharges over the same period.[12] (DI #4, p. 6).

Noting that there is no applicable quantitative standard of need that is provided in the SHP that can be used on a contemporary basis, Hope Health relied on information published by the Maryland Hospital Association (MHA), HSCRC data, the Commission's recent work group review of psychiatric services standards, and other sources of data to construct its needs assessment.[13] (DI #4, p. 41). The Hope Health needs assessment is based on an assumed six-jurisdiction PSA for its proposed hospital, a Central Maryland region which has been historically used by MHCC and other health planning agencies for need projection and presentation of data. (It was used for decades in psychiatric hospital planning and regulation by MHCC, including in the SHP regulations in place until 2021.) It uses historical discharge analysis for the service area to develop a bed need forecast. Hope Health also reviews information on recent bed occupancy, long emergency department stays, and the limited number of psychiatric hospital providers to support its forecast model's capacity projections and the need for more capacity it describes.

The applicant defines the PSA for the project as Anne Arundel, Carroll, Harford, Howard, and Baltimore Counties, and Baltimore City. (See Appendix 6). Based on the limited number of facilities serving children and adolescents, Hope Health states that it expects to draw patients from other regions. (DI #4, p. 42). The applicant also states that the "central location" of the proposed facility will render it accessible to surrounding regions. (DI #4, p. 42).

The applicant provided population projections using the Maryland Department of Planning data for both children and adolescents statewide and in the defined PSA, as shown in the following

[11]The readmission rate is a measure of the hospitalization of patients who, within 30-days of discharge, are admitted to a stay of psychiatric hospitalization.

[12] Maryland Health Care Commission: *White Paper: Maryland Acute Psychiatric Hospital Services*. April 2019.

[13] As previously noted, MHCC adopted an update to its SHP regulations for psychiatric hospital services in August 2021. This update, unlike the former regulations germane to review of this project, does have applicable need assessment standards.

tables.[14] (DI #4, p. 43).

Table IV-3:
State of Maryland
Child and Adolescent Population Projections, 2021 to 2027

Age Group	2021	2022	2023	2024	2025	2026	2027	Change
0-12	962,003	967,073	972,142	977,212	982,281	987,351	992,420	**3.2%**
13-17	390,660	390,812	390,963	391,115	391,267	391,419	391,571	**0.2%**

Source: DI #4, p. 43.

Table IV-4: Primary Service Area
Child and Adolescent Population Projections, 2021 and 2027

Jurisdiction	Age 0-12			Age 13-17		
	2021	2027	Change	2021	2027	Change
Anne Arundel	91,506	92,766	1.4%	35,225	35,508	1.0%
Baltimore County	130,709	129,067	-1.3%	54,103	54,591	1.0%
Carroll	23,351	24,374	4.4%	10,584	9,537	-10.0%
Harford	39,336	41,501	5.5%	16,320	15,579	-5.0%
Howard	56,407	59,164	4.9%	22,657	23,343	3.0%
Baltimore City	92,613	92,257	-0.4%	36,339	36,104	-1.0%
PSA Total	**433,922**	**439,129**	**1.2%**	**175,228**	**174,662**	**-0.3%**

Source: (DI #4, p.44).

Hope Health used data on overall bed to population ratios from the Treatment Advocacy Center to calculate how many beds are required to treat a given population, estimating that 40-60 beds per 100,000 in population is the normative range, with a consensus of approximately 50 beds per 100,000 needed for inpatient psychiatric care. (DI #4, p. 44). The applicant stated that room counts rather than bed counts were used to estimate bed supply, stating that semi-private rooms (two beds) usually function as private rooms in a psychiatric environment. Citing Commission figures on bed supply, it estimates Maryland's child and adolescent psychiatric bed supply in 2019 to be 11.7 beds per 100,000 (100K) population. The applicant states that this comparison demonstrates a need for additional beds. (DI #4, p. 45).

Table IV-5: Maryland Bed Supply
Psychiatric Hospital Beds for Children and Adolescents

2021 Population Aged 0-17	Staffed Bed Count	Beds Per 100,000 Population	Staffed Bed Count of Single-Occupancy Rooms	Beds Per 100,000 Population
1,352,663	221	16.34	158	11.7

Source: DI #13, p.17.

[14] The age ranges for children and adolescents had to be altered slightly because the applicant's age category breakdown is not a perfect match with the age breakdown used in the Maryland Department of Planning population projections.

HHS utilized the discharge trends (through 2017) published by MHCC's *White Paper: Maryland Acute Psychiatric Hospital Services*. (DI #13, p. 17); moderate growth for the child use rate and significant growth in the adolescent use rate. Using HSCRC data files, the applicant identified a discharge rate of 188 per 100K for children and 1,133 for adolescents in 2019. (DI #13, p. 17). Citing 2019 HSCRC public use data[15] the applicant outlined a net bed need of four to 12 beds for children and between 48 and 103 beds for adolescents in Maryland. (See the following table. (DI # 4, p. 46).

Table IV-6: Hope Health State Bed Need Analysis
Psychiatric Beds for Children and Adolescents

	Children (0-12)	Adolescents (13-17)
Population in 2022 [1]	967,072	390,811
Projected Discharges based on assumed discharge rate: Children (188 per 100K) [2] Adolescents (1,133 per 100K) [2]	1,818.1	4,427.9
Projected Patient Days based on assumed ALOS: Children (10.5 days) [3] Adolescents (11.4 days) [3]	19,090	50,479
Bed Demand at 100% Occupancy	52.3	138.3
Bed Demand at 85% Occupancy	61.5	162.7
Bed Demand at 70% Occupancy	74.7	197.6
Staffed Beds per MHCC [4]	71	150
Bed Need	**3.72**	**47.57**
Staffed Beds per MHCC [5] (single occupancy assumption)	63	95
Bed Need	**11.72**	**102.57**

Sources: DI #4, p. 46.
[1] Maryland Department of Planning.
[2] Based on 2019 discharge counts by age in HSCRC data.
[3] Average length of stay (ALOS)) based on CY 2019 ALOS observed in HSCRC data.
[4] The most recent review of existing and approved beds by MHCC staff yields 75 beds for children and 199 beds for adolescents. Both counts are "estimates" using an "effective" count or allocation for units designed to flex between children and adolescents based on fluctuation in census.
[5] Conversion of the bed count to a room count based on the assumption that bed need forecast should not count semi-private rooms as rooms with two beds of service capacity.

Hope Health states that historic occupancy rates for child and adolescent psychiatric hospital beds can be correlated with admission delays and denials. (DI #13, p.17). The applicant states that it utilized volume and financial data produced by HSCRC to determine the bed occupancy rates of special psychiatric hospitals (Appendix 5). The occupancy rates varied from 85 to over 100 percent. (DI #13, p. 18). The applicant states occupancy rates above 100 percent

[15] https://hscrc.maryland.gov/Pages/hsp_Data2.aspx.

occur when hospitals report rooms not typically reported as staffed beds in capacity numbers. (DI # 13, p. 18).

HSCRC data states that Brook Lane and Sheppard Pratt have calculated average annual bed occupancy rates ranging from 87 percent to 128 percent in children's beds over the last three years.[16] The applicant states that occupancy rates above 90 percent can be an indication of insufficient bed capacity, resulting in an inability to admit patients on a timely basis. (DI #4, p.47). The applicant concludes there is insufficient capacity for recent patient demand and argues that the strain on the system could lead to poor outcomes. (DI # 4, p .48).

Hope Health also pointed to information on the negative consequences of children and adolescents boarding in emergency departments because transfer to a hospital bed is delayed. (DI #13, p. 19). The applicant cites a 2018 Maryland Hospital Association publication that reported 27.5 percent of children and adolescents visiting emergency departments in Maryland experienced delayed admission to an appropriate care setting because they were waiting for a bed. (DI #13, p.19). The CON application contained the following table and identified MHCC as the source of this information.

Table IV-7: Maryland Hospital Emergency Department Visits for Children and Adolescents with Diagnosed Mental Illness or Disorder by Estimated Time in Emergency Department (ED) CY 2010 - 2018

Time in ED	2010	2011	2012	2013	2014	2015	2016	2017	2018
Less than 24 hours	9,728	10,331	11,179	11,385	11,786	11,920	10,773	10,931	11,141
24 to 48 hours	173	241	248	275	345	427	433	526	568
2 to 3 days	33	51	51	65	91	110	145	208	263
4 - 8 days	20	43	46	69	69	127	178	269	282
9-20 days	5	3	6	14	3	5	20	41	45
20+ days	1	0	3	2	2	2	0	8	5
Total	9,960	10,669	11,533	11,810	12,296	12,591	11,549	11,983	12,304

Source: DI #4, p. 51.

The applicant states that delays in placement disproportionately impact the Medicaid population. noting that 43.2 percent of the Baltimore City population are eligible for Medicaid, compared to 23.3 percent overall for the State.[17] Referring to the above table, Hope Health notes that 1,163, or 9.5 percent, of the total psychiatric-related ED visits in 2018 involved an ED boarding stay of one day or longer. (DI # 4 pp. 49-52 and DI #18, p .2).

The applicant also states that there is a trend of increasing re-admission rates in Maryland

[16] Sheppard Pratt has told MHCC staff, in separate planning work outside the scope of this review, that its 20 beds identified as dedicated to children are not the only beds used by children. These other beds are in units that can serve a mixture of patients within the discharge age range used in reporting use statistics for children and what MHCC would classify as older, adolescent patients. Thus, it stated that this is the reason calculated occupancy rates for its hospital in Towson can be calculated as exceeding 100% average annual occupancy, i.e., a lower than actual effective bed inventory, rather than a staffed bed inventory, being used as a denominator.

[17] Annual Report of the Behavioral Health System of Baltimore, 2019.

hospitals for child and adolescent psychiatric hospital patients. Hope Health states that this trend indicates a need for better linkages between inpatient and outpatient care providers to prevent re-admissions, which the applicant identifies as a source of stress on patients and families. It also notes that readmissions increased the cost of hospital care. (DI #13, p. 20).

The applicant provided information on officially identified shortages of mental health professionals. It states that the proposed hospital is located in a designated Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration (HRSA) and a Child and Adolescent Psychiatrist (CAP) shortage area. (DI # 13, p. 20). The applicant states that adding a new inpatient facility will increase the number of providers in the service area for children and adolescents. (DI # 13, p. 20). The applicant cites 2012 data from the American Academy of Child and Adolescent Psychiatry (AACAP) to further demonstrate the provider shortage in Maryland. AACAP estimated that only 15 to 25 percent of children with psychiatric disorders received specialty care, with most patients being seen by their pediatric primary care physician for mental health concerns. (DI #4, p. 54). HRSA maintains records on designated HPSAs and scores HPSAs on a scale of 0-25 for mental health, with higher scores indicating greater need. Portions of the proposed facility's service area show a score of 20-25 which is the highest degree of need. (See Appendix 6.) Hope Health states that although HPSA designations are not age-specific, they demonstrate an acute need for mental health resources in the Baltimore region for the low-income/Medicaid population. Hope Health states that it has designed the project to meet this need. The applicant believes that having a diverse workforce and providers will increase the cultural competence of care and patients will be more likely to seek and receive treatment. Hope Health states it is a Minority Business Enterprise (MBE) and is committed to providing cultural diversity as part of its mission.

Lastly, the applicant describes a more general view of the current health care delivery system that it believes support a finding of an unmet need that will be addressed by this project. The applicant describes a general consensus on the existence of a systemic set of unmet needs for mental health care. Factors that adversely affect the availability, accessibility, and adequacy of services for children and adolescents include poverty and social and racial inequities. It points to increases in the suicide rate of juveniles and notes the impact of increased anxiety related to the disruptive consequences of the COVID-19 pandemic. The applicant states that psychiatric hospitals represent only part of a care continuum but they are a critical resource for individuals in crisis. (DI #4, p. 58).

Interested Party Comments

Sheppard Pratt states that the applicant has ill-defined and misstated data throughout its need analysis. It cites the population estimates, which Sheppard Pratt states it is unable to follow. It also states that the utilization projections are not based on historical discharge numbers. The interested party also states that the applicant should be using either the central planning region or the whole State in its need analysis, but not both. (DI #22, pp. 11-13).

Sheppard Pratt refutes the Hope Health claim that Sheppard Pratt turns away patients based on its high bed occupancy, stating that any denials are for a small 14-bed specialty unit which is irrelevant to this application because Hope Health would be unable to assist with those higher

acuity patients. (DI #22, p. 15). Sheppard Pratt also questions Hope Health's claims about emergency department discharge delays and states that Hope Health based the assertion on a "narrowly based" MHA study and paper entitled "Behavioral Health Patient Delays in the Emergency Department." Sheppard Pratt describes the study as narrow because it only focused on a 45-day rather than a one-year time frame, stating that discharges are not static across the year and experience ebbs and flows based on school attendance and other demands. (DI #22, p. 16).

On the issue of single occupancy rooms, Sheppard Pratt disagrees with the applicant's adjustment of bed counts based on beds per rooms capacity. It states, in its experience, that using a private or a double room is an admission decision based on patient needs. Therefore, not all double rooms are used as single occupancy. Sheppard Pratt also disagrees with the analysis that the applicant used to show that Sheppard Pratt and Brook Lane have experienced bed occupancy in excess of 100 percent. Sheppard Pratt states that the assumption cannot be true, explaining that use of psychiatric hospital beds cannot exceed the available patient days associated with licensed bed capacity. (DI #22, p. 14).

Regarding market share, Sheppard Pratt takes issue with the applicant's market share calculation. It states that the applicant has not considered the opening of the psychiatric unit at UMMC or the opening of the interested party's new facility in Elkridge in its market share calculations, both of which will serve similar populations. (DI # 22, p. 16).

On the topic of readmissions, Sheppard Pratt questioned the applicant's suggested link between bed need and readmissions and its presumption that because it is an outpatient provider it will be able to reduce current readmission rates more effectively than existing providers. (DI #22, p. 18). In addition, the interested party disagrees with Hope Health's average length of stay projections of 10.5 days for children and 11.4 days for adolescents, stating that this is contrary to the current Maryland length of hospital stay trends. (DI #22, p.19).

With respect to access barriers, the interested party agrees that there are access issues in Baltimore City. However, Sheppard Pratt contends that the applicant has not proposed a solution to the problem or shown a reason why it is better equipped to serve residents in Baltimore City than existing providers. Sheppard Pratt also questions the geographic location of the proposed hospital in the county if the applicant has an objective of working more with the Baltimore City population. (DI #22, p. 19).

On October 4, 2021, Sheppard Pratt made further comments. It reiterated its position that Hope Health failed to document a need for the proposed project, questioning Hope Health's ability to draw patients from more distant areas of the State. It also continued to question the applicant's projected market share, claiming that achieving such a market share would have a negative impact on existing providers. It also claimed an overreliance by the applicant on its outpatient service volume in formulating assumptions (DI #47, p. 15).

Applicant Response to Interested Party Comments

In response to the population estimate comments, the applicant states that it provided documentation showing the methodology used for the population projections and the sources of

the data. The applicant agrees that utilization numbers can be fluid, but states that it chose to use static occupancy rates to show consistency in its analysis. The applicant justifies the use of statewide data in conjunction with data for the central Maryland region as reasonable, stating that 40 percent of children and 45 percent of adolescents requiring inpatient psychiatric stays in this central region originate from outside the region. (DI #27, p. 7).

The applicant provided greater detail in its response on August 19, 2021 (DI #40) regarding the market area population and the estimated share it would achieve from the service area.

Table IV-8: Hope Health Estimated Market Share for Children and Adolescents

Service Area	0-12 Market Share (2022)	13-17 Market Share (2022)
Primary	9.98%	14.74%
Secondary	6.65%	7.47%

Source: DI #40, p. 7.

On the high occupancy rate reported for Sheppard Pratt and Brook Lane, the applicant states that the HSCRC data files show an occupancy range of 85 percent to over 100 percent, as it reported. (DI #4, p. 47). Hope Health states that the additional beds in the proposed project would provide greater capacity resulting in better patient access and shorter emergency room wait times. With respect to private rooms, the applicant states that the MHCC Work Group noted that most rooms were used as single occupancy. (DI #27, p. 8). Lastly in response to Sheppard Pratt's comments on the projected average length of stay, Hope Health disagrees with the assertion that the average length of stay projection is unreasonable and states even if it were higher the same number of patients would need care. (DI #27, p. 12).

In rebuttal to Sheppard Pratt's continued assertion that it lacks a statewide presence, the applicant responded with an example of existing contractual relationships with the Department of Juvenile Services (DJS) in Prince George's and Montgomery Counties and Centurion Managed Care, a provider of services for prison inmates throughout the State of Maryland. (DI #50, p. 14). The applicant also pointed to the opening of a new outpatient/partial hospitalization program in Laurel (Prince George's County). (DI #50, p. 15). In response to the interested party's concern that 84 percent of the applicant's projected admissions will represent a shift from other providers, the applicant noted that in a recent past review (Anne Arundel Medical Mental Health Hospital, Docket #16-02-2375), the applicant was able to claim that 100 percent of admissions will come from existing providers, without apparent issue. To refute the interested party claims that the applicant has not demonstrated support in the community, the applicant highlights the letter from Dr. Ernest Carter, the Prince George's County Health Officer. Dr. Carter states that the proposed facility will provide a "vital lifeline" in Prince George's County and emphasized the importance of a minority owned business with minority medical leaders, such as the one proposed by Hope Health, as being crucial to the provision of "culturally sensitive care." (DI #50, p. 16).

Lastly, the applicant opposes what it describes as the "false" or incorrect claims made about some of its building features, specifically that it will not have an ambulance bay, commercial kitchen, recreational gym, or sufficient safety features. HHS states there will be an ambulance bay located next to the gym along the backside of the building, a commercial kitchen in the larger

building for meal service, and a gym for patient use. Applicant states that although its proposed facility will be more "modest" than others, it will satisfy all requirements required by licensure and accreditation standards. (DI #50, p. 17).[18]

Reviewer's Analysis and Findings

My review of the relevant information bearing on population need for additional child and adolescent psychiatric hospital bed capacity convinces me that a project of this scope, a 16-bed special hospital, warrants a finding of need. It aligns with the information on use rate trends for young patients over the last ten years. Evidence in the record allows for a creditable interpretation that these trends are positive, especially for adolescents. A finding of need for the proposed project also aligns with the evidence that children and adolescents comprise a disproportionate number of patients that experience extended wait times for an available and appropriate bed.

I am cognizant that the observed problems of availability and accessibility to child and adolescent psychiatric hospital services are not amenable to a simple solution. Recent work by MHCC in updating the SHP's psychiatric hospital services standards has found that gaps in an effective continuum of care for behavioral health, reimbursement for psychiatric hospitalization, failures in consistently coordinating care for patients that present challenges to effective case management, and a lack of programming, both inpatient and outpatient, for certain types of specialized patient need, all contribute to the widely-voiced dissatisfaction with the delivery of mental health services in Maryland and throughout the country. However, a finding that the proposed project will not yield comprehensive improvement in system dysfunction is not a basis for finding that no need exists for additional child and adolescent bed capacity at the level proposed. The proposed project will increase psychiatric hospital beds for children (4 beds) in the Baltimore Upper Shore region by 9.7% and in the State by 5.3%. It will increase such beds for adolescents in the region by 9.0% and in Maryland by 6.0%.

Because of the relatively low volume of service, child hospital facilities cannot be feasibly distributed in Maryland to achieve comparable levels of travel time across the state. This Baltimore County project will not have a substantive impact on geographic availability. But this is not a basis for finding that the project does not meet a need for additional beds. While beds for adolescents can be more equitably distributed, the poorer travel time access for this age group seen in areas of Maryland outside of the Baltimore area, likewise, are not a basis for finding that the proposed project is not needed. The project should marginally improve the availability and accessibility of beds for adolescents, providing the potential for reducing the number of emergency department (ED) boarders and the length of time that adolescents spend boarding in hospital EDs.

My review of the interested party's comments does not demonstrate that Hope Health has not provided an acceptable basis for a finding of project need. I respect the comments provided

[18] The applicant only provided a "Demolition Floor Plan" showing the current configuration of the building space that will be renovated to create the 16-bed unit and a "Proposed Floor Plan Layout-Revised" that shows the proposed single-loaded corridor of patient rooms with nursing station and other unit support and ancillary space across the hall from the patient rooms. A plot plan of the campus or other drawings identifying the ambulance bay or the commercial kitchen were not provided.

by Sheppard Pratt and accept the force and logic of some of the arguments it makes with respect to the validity of assumptions made by the applicant and the accuracy of some data presented by Hope Health. However, in considering these comments, I do not find that they overcome the weight of evidence that I believe demonstrate that Marylanders can be better served by having additional psychiatric hospital resources. I do not believe that a review of market trends in the last decade indicate a need for large increases in the psychiatric hospital bed inventory for youth. This project would not represent a large increase. I recommend that the Commission find that the need for the proposed project has been demonstrated.

C. Availability of More Cost-Effective Alternatives

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

Hope Health states that there is not a viable option to manage the care of children and adolescents in need of hospitalization that can be achieved through outpatient service expansion or enhancement of population health measures. Hope Health states that becoming a provider of inpatient psychiatric services will improve its ability to directly control and address access-related challenges for the children and adolescents for which it currently provides outpatient diagnosis and treatment. It states that it can better manage this population by providing a more complete continuum of care and argues that this addition of hospital services will make Hope Health a more cost-effective provider of services when compared to its current position as a provider limited to delivering outpatient care only.

Hope Health states that its plan to use available space at an existing building where it currently provides outpatient services will allow it to provide these needed inpatient services, from the perspective of capital cost, in the most cost-effective manner possible.

Interested Party Comments

Sheppard Pratt states that the applicant has failed to show that its proposed project is cost-effective, as evidenced by its projected charges, that it states are 25 percent and 32 percent higher than those of Sheppard Pratt and Brook Lane (the two special psychiatric hospitals in Maryland providing services to children and adolescents). (DI #22, p. 8). Sheppard Pratt also refers to Standard AP11 as evidence that the applicant's proposed project will not be cost-effective. The interested party also states that Hope Health's projected charges for discharges less than 30 days are shown to be higher than the charges of the four other general hospital-based acute care psychiatric programs (that serve children and/or adolescents) in the central health planning region (UMMC, Johns Hopkins, Medstar Franklin Square and Carroll County). (DI #22, p.8) (Reviewer's Note: I think it is necessary, as this point in the Recommended Decision, to note that the applicant modified its CON application and lowered its rates after these comments were filed by Shepperd Pratt, claiming that the previous rates included ancillary charges, while Sheppard Pratt does not include the ancillary charges, making its rates "appear" lower).

Sheppard Pratt maintains that the applicant's calculations remain flawed, stating the applicant was only projecting annual inflation of one percent, making its financial position appear stronger. They also note that the applicant does not include benefit cost in the expenses. (DI #30, p. 8).

Sheppard Pratt highlights that the applicant did not examine the use of population health initiatives as a cost-effective alternative to the proposed hospital (DI #22, p. 9), and that the applicant proposes an unrealistic average length of stay of 9.2 days. The interested party maintains that Hope Health has placed too much reliance on its status as an established outpatient service provider to make its case that it will achieve cost savings without adequately identifying the specific resources that will be engaged to achieve cost savings. Similarly, Sheppard Pratt states that Hope Health did not adequately explain its projection of a lower average length of stay on which some of its claims for cost savings rely. (DI #30, pp. 10-11).

On October 4, 2021 Sheppard Pratt submitted further interested party comments about cost-effectiveness. The first comment concerned the applicant's plan to take 84 percent of admissions by its fifth year in operation from existing providers that Sheppard Pratt maintains have lower rates. Sheppard Pratt claims that this projection by the applicant is inconsistent with a finding that the project will improve the cost-effectiveness of care. (DI #47, p.12). Second, Sheppard Pratt reiterated its comment that the applicant is using an unrealistic average length of stay assumption. The interested party states that the applicant did not adequately explain how its program is uniquely positioned to achieve that proposed result in hospital use. (DI #47, p.12). Lastly, with respect to AP 11, Sheppard Pratt reiterates the applicant's failure to show compliance with this standard and, thus, will not be a cost-effective change in health care delivery. Sheppard Pratt states the applicant's projected charges for discharges less than 30 days are still higher than those of the four other hospital-based acute care psychiatric programs in the region, after the modifications in the projections made by the applicant. (DI #47, pp. 11-12).

Sheppard Pratt made comments under the criteria of viability, the availability of more cost-effective alternatives, need, and impact. It added a section of comments which it implies fall under the heading of "appropriate planning" for" patient safety and other quality issues." The interested party questions the project design, noting the omission of outdoor space, a commercial kitchen, and adequate space for dining, security, seclusion, and entry and admissions space. It also criticized the poor location and design of nursing units and questioned the ability to appropriately separate patient populations by age. (DI #22, pp. 22-24).

Applicant Response to Interested Party Comments

The applicant stated that Sheppard Pratt inaccurately left out discharges greater than 30 days when calculating and comparing hospital program costs. Hope Health maintains that the 30-day definition includes the acute status at the time of admission rather than excluding all psychiatric stays longer than 30 days. (DI #35, p. 4).

The applicant adds that the MHCC Work Group on psychiatric hospital services proposed the removal of the AP 11 Standard as "too prescriptive." (DI #28, p. 4). Nonetheless, in the March

15, 2021 modification of its application, the applicant included new tables for Standard AP 11 that showed a reduction of $1,895 in the average charge for children and $2,131 in the average projected charge for adolescent discharges when compared to the other hospital based acute psychiatric programs in the region. (DI #28, p. 25).

In response to the most recent comments from Sheppard Pratt, the applicant addresses the ongoing concern about the definition of charges per discharge for discharges of less than 30 days. Hope Health reiterates that standard AP 11 will soon be obsolete, and less than 30 days only modifies the word acute, with reference to the applicant's projected total average cost per admission. (DI #50, p. 12). The applicant states that these discharges should be included, and not excluded as Sheppard Pratt asserts.

Regarding its average length of stay projections, the applicant made reference to another CON application that was approved (Anne Arundel Medical Center Mental Health Hospital, Docket No.16-02-2375)[19] that relied on claims of improved early discharge planning and increased use of outpatient programs to project reductions in average length of stay. (DI #50, p. 13).

Reviewers Analysis and Findings

There are no competitive applications in this review.

I believe that systemic improvements beyond the development of more hospitals and expansion of hospital bed capacity have significant potential for reducing historic levels of demand for hospitalization and, as such, could have the effect of improving hospitals' ability to better manage the process of admitting, treating, and discharging young patients. However, there is evidence that the problems currently experienced in this regard are, at least to some extent, related to a mismatch between the demand for hospital resources and the supply of such resources. For this reason, I approach the issue of "cost-effectiveness" from the perspective that expanding the inventory of child and adolescent psychiatric hospital beds, to the extent proposed by Hope Health, is needed, as I have already considered in the previous section of this Recommend Decision. My approach to considerations of cost and effective is also, of course, based on the actual regulation articulated in COMAR 10.24.01.08.

The applicant is projecting an ability to put 16 additional beds into service at a capital cost that is comparable to the approved CONs issued to UMMC and TidalHealth in 2019. These general hospitals were approved to establish child and adolescent units of similar size (16 and 15

[19] The new Anne Arundel mental health facility, the J. Kent McNew Family Medical Center in Annapolis, is a special psychiatric hospital for adults (aged 18 and older). It opened in the second quarter of 2020. Its average length of stay (ALOS) was 7.1 days during its first 18 months of operation (through October 31, 2021). This operational experience indicates that the hospital has not been able to achieve the 6.1day ALOS projected in its CON application. However, it is a lower ALOS than that experienced for all adult psychiatric patients in Maryland over the same period, which was 8.7 days in 2020 and 8.8 days in 2021. It should be noted that this data is limited to stays experienced in Maryland general acute care and specialty psychiatric hospitals. It does not account for the LOS of Maryland residents discharged from D.C. or other non-Maryland hospitals.

beds, respectively) by renovating existing general hospital space. With respect to size, I find that the Hope Health project can also be viewed as falling within a reasonable range of the space programming used by these recent applicants, but can be fairly characterized as minimal, especially given that these newest general hospital units for children and adolescents are being developed in hospitals with long-established psychiatric programs (serving adults and children at UMMC and only adults at TidalHealth). These general hospitals have more existing ancillary and support space for inpatients and families of inpatients than Hope Health has identified and would probably be hard-pressed to feasibly develop. This reinforces my view that the proposed hospital, as described and as located, will be minimal in size. For this reason, I am concerned that, with respect to physical facilities for the proposed new hospital, the low-cost alternative put forth in this review may have a negative impact on the effectiveness of patient care, on the ability to have comprehensive programming addressing a broad range of patient needs, on the feasibility of serving patients with specialized needs, and on patient and family satisfaction.

I find that the applicant's choice with respect to achieving the objective of establishing the hospital on its existing outpatient campus in Baltimore County, through renovation of existing space, is an obvious lower cost choice among possible alternatives. My chief concern is effectiveness, as noted above, but I do not believe I have a definitive analysis in the record that would allow me to make a confident recommendation on this criterion.

It is notable that the applicant modified its original application, after interested party comments, generating a new revenue and expense statement and lowering projected charges to be in line with two other freestanding acute psychiatric hospitals in Maryland that serve children and adolescents. Interested party comments also led to revisions in the applicant's response to Standard AP 11, which requires a showing by an applicant of lower costs than that observed by existing providers of psychiatric hospital services. Sheppard Pratt also made substantive criticism with respect to some of applicant's choices in forecasting average length of stay, revenues, and expenses, as well as comments on Hope Health's assumptions in preparing elements of its application that touch on questions of project costs and effectiveness. An iterative process of this kind does not give me confidence in the quality of the business planning performed by Hope Health for this project.

In conclusion, I believe that when I compare Hope Health to alternative existing facilities, I find that the proposed project is a marginally "cost-effective" alternative for providing the needed psychiatric hospital service capacity in Maryland, and this is something which I believe is needed. However, based on substantive comments made by the interested party on important and still open questions throughout the review about the definition of how to define and measure cost effectiveness, I question whether this project is the best option. I still have concerns that this project in its totality only provides a minimal plan for establishing a new special hospital which may have a negative impact on its ability to compete in the market and to provide effective patient care.

D. Viability of the Proposal

COMAR 10.24.01.08G(3)(d): Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set

forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

This criterion requires consideration of three questions: availability of resources to implement the proposed project; the availability of resources to sustain the proposed project; and community support for the proposed project.

Availability of Resources Necessary to Implement the Project

A timeline of key submissions in this review is included as Appendix 8 and is helpful in the analysis of financial viability of the proposed project.

In the original CON application, Hope Health estimated the total cost of the project to be $4,500,000, funded by a loan in the amount of $4.5 million. (DI #4, Exh. 1, Table E; DI #4, Exh. 9). Hope Health simply stated that, based on its need projections, anticipated volume of visits, and projected net revenue, that the project would be viable. (DI #4, p. 69).

Several email exchanges, phone calls, and a phone conference occurred in early February 2021 among Commission staff, HSCRC staff, and Hope Health in efforts to obtain more detail on the CON application's financial statements and projections, its underlying assumptions, volume projections, and other aspects of the application. The need for audited financial statements, clarification on the various legal entities involved, and licensing issues were also discussed.

Sheppard Pratt and the University of Maryland Medical Center filed for interested party status on March 1, 2021. Only Sheppard Pratt provided comments on Hope Health's application. Hope Health responded to the Sheppard Pratt comments on March 10, 2021.

On March 15, 2021, Hope Health submitted a modification to its CON application. The project budget estimate was unchanged. However, its projection of operating expenses was revised upward and its projection of hospital revenue declined, yielding lower net income.

On March 31, 2021, Sheppard Pratt provided additional comments regarding the updated information submitted by Hope Health. It reiterated many of the same previously filed comments. The focus of these comments was on projected expenses, commenting that the projected expenses were too low to support the projected level of staffing and other resource inputs.

In the response to MHCC staff completeness questions for the modified CON and the interested party comments, on April 26, 2021, Hope Health provided new information and again revised the financial information in the application. The following table summarizes the modifications in the project budget estimate and in projected revenue, operating expenses, and income between October 21, 2020 and April 26, 2021.

Table IV-9: Summary of Selected Modifications in the Hope Health CON Application

	Original CON Application October 21, 2020	Modification March 15, 2021	Modification April 26, 2021
Total Budget	$4,500,000	$4,500,000	$1,500,000
Net Patient Revenue	$6,112,302	$5,844,590	$5,844,590
Total Expenses	$5,336,098	$5,787,042	$6,011,217
Net Income (Loss)	$776,205	$57,548	-$166,627

Source: Tables E and J from DI #4, DI # 28, and DI # 35.

In the April 2021 modification, Hope Health Properties, is cast as refinancing the terms of the existing loan on the building and, as the landlord, paying for approximately $3,000,000 in improvements. Hope Health's audited consolidated financial statements for 2018 and 2019 show $579,652 in cash and cash equivalents as of the end of calendar year 2019.

The complete project budget estimate, as originally submitted and subsequently revised, is provided in a side-by-side comparison in Appendix 4. Hope Health, as the parent organization, is responsible for the full financing of the project.

Availability of Resources Necessary to Sustain the Project

This project will renovate an existing outpatient child and adolescent psychiatric services program building to create a new psychiatric hospital that combines Hope Health's outpatient services with new inpatient child and adolescent psychiatric facilities. The following table provides the initial (October 2020 CON application) key projections for the new inpatient child and adolescent hospital during the first three years of operation.

Table IV-10: Key Operating Projections
Proposed Hope Health Psychiatric Hospital

	FY2022	FY2023	FY2024
Discharges	508	540	550
Patient-Days	4,672	4,964	4,964
Net Patient Revenue	$6,112,302	$6,494,322	$6,494,322
Total Operating Expenses	$5,336,098	$5,681,130	$5,681,130
Net Income	$776,205	$813,192	$813,192

Source: DI #4, Tables I and J.

The initial revenue and expense projections changed substantially during the review of the application, as did the supporting information for these changes.[20] The following table tracks these changes, in summary.

[20] These modifications were clearly triggered by agency questions and interested party comments.

Table IV-11: Hope Health Services Revenue, Expense, and Net Income Projections

	Year 1 of Operation			Year 5 of Operation			Change 10/20 - 4/21
	CON Application 10/21/2020	Modification 3/15/21	Modification 4/26/21	CON Application 10/21/20	Modification 3/15/21	Modification 4/26/21	
Net Patient Revenue	$6,112,302	$5,844,590	$5,844,590	$6,494,322	$6,209,877	$6,209,877	(4.4%)
Total Expenses	$5,336,098	$5,787,042	$6,011,217	$5,681,130	$6,161,135	$6,209,877	12.7%
Net Income (Loss)	$776,205	$57,548	($166,627)	$813,192	$48,742	$1,252	(121.5%)

Source: Table J updates from DI #4, DI #28, and DI #35.

Community Support

Hope Health submitted several letters supporting this proposed project from members of its medical staff leadership, community physicians, local mental health agencies, and several State legislators. In addition, support letters were received from Mary Haller, Deputy Commissioner of Health for Baltimore City, Gregory Wm. Branch, M.D., Baltimore County Health Officer; Ernest Carter, M.D., Prince George's County Health Officer, Antoinette McLeod, Executive Director of the Maryland Department of Juvenile Services; and Aliya Jones, Deputy Secretary for Behavioral Health of the Maryland Department of Health. (DI #4).

Interested Party Comments

Sheppard Pratt, states that the applicant has not shown that it will generate and sustain excess revenues over expenses within the first five years of operation. In addition, it states that the applicant has overstated revenue and understated expenses in its projections, especially with respect to staffing expenses. Sheppard Pratt commented, with respect to the initial application, that Hope Health projected a per patient day average charge of $1,658 and stated that this is 25 percent higher than Sheppard Pratt's average per diem charge ($1,259) and 32 percent higher than that of Brook Lane ($1,137). (DI #22, pp. 3-4). In addition, the interested party commented on Hope Health's projections of 2.77 percent annual cost increases, stating that a more reasonable projection would be in the 1.7 percent to 2.3 percent range. (DI #22, p. 5). Finally, the interested party commented that Hope Health's financial health in general was poor, with net income from the financial statements that was only $444,727 and $567,091 in 2018 and 2019 respectively, levels of income generation likely to be insufficient to cover the losses likely to occur in its proposed hospital operations. (DI #22, p. 5).

The interested party also commented on the $600,000 the applicant budgeted for contractual services, with no clear use of this expenditure identified. Sheppard Pratt commented that the applicant has omitted numerous essential departments necessary for a psychiatric hospital to operate, including non-psychiatric medical care, pharmacy, infection control, medical records, patient services/accounts, purchasing, information technology, human resources, maintenance, dietary and environmental services. (DI #22, p. 6). The interested party also states that Hope Health understates salary expenses for certain positions, focusing on the psychiatrist as an example. Hope Health only budgeted employment costs for a psychiatrist averaging $195,260 and Sheppard Pratt states that, in its experience, the actual cost is approximately $230,000. (DI #22, pp. 6-7).

In later comments, the interested party states that while the applicant's modification added

staffing costs of $429,920, the changes failed to add in the related benefit costs. Sheppard Pratt states that it calculated a needed annual benefit expense of approximately $908,006, resulting in a net loss of $1.15 million in its first year of operation. In addition, the interest party states that the applicant has assumed annual inflation of only one percent in both revenue and employment costs. (DI #30, p. 8).

The interested party states that even with the application modifications made by Hope Health, its charges will still be higher than those of Sheppard Pratt, which it claims will handle higher acuity patients than the proposed hospital. Regarding long term sustainability, the interested party states that Hope Health is showing only $580,000 in assets at the end of 2019 and only $146,244 in cash, putting it only one unforeseen event away from being forced to close. (DI #30, p. 9).

In the final comments submitted in October 2021, Sheppard Pratt reiterated its view that the proposed project is not viable, again citing the applicant's underestimation of operating expenses, primarily created by unrealistic projections of staffing and employee benefit costs. It stated that the applicant had no cost allowance for utilization of contractual employees, no moveable equipment depreciation allowance, or accounting for laboratory fees and supplies. The interested party also states that the applicant understates the rent and real estate tax expenses that will be required (DI #47, p. 4) and claims that the applicant realized the benefit expense and then changed key personnel to contractors, receiving no benefits, as a means of producing a positive bottom line in its projections. The interested party asserts that the applicant will not be able to successfully recruit staff without providing benefits. (DI #47, p .5). Sheppard Pratt also commented on the principals' lack of experience in owning or operating a psychiatric hospital for children and adolescents and the architect's lack of experience in designing hospital facilities. (DI #47, p. 2).

The interested party states that the applicant has both incorrect and overstated revenue projections and has not submitted a rate application to HSCRC, resulting in HSCRC's inability to comment on the viability of the proposed project. (See the later section of this Recommended Decision that reviews HSCRC comments). The interested party recommends that the Commission should conclude that the applicant does not have the necessary resources to sustain the proposed facility, pointing to the applicant's 2019 financial statement which showed margins equivalent of only 3.84 days of cash on hand with a daily payroll of $20,090.

Sheppard Pratt states that the applicant's revised project funding plan shifts $3.5 million in construction costs to its affiliate, HHP, to make the project appear profitable. It also states that the affiliate is projected to charge Hope Health a rental rate that is below the rental cost of comparable space in the surrounding market. (DI #10, p. 10).

Applicant Response to Interested Party Comments

Hope Health states that the original projections were based on publicly available information, which was limited to information for general hospitals with psychiatric units. The two freestanding psychiatric hospitals in the region serving the proposed demographic (Sheppard Pratt and Brook Lane) did not have publicly available data. When the interested party provided the data in a response, the applicant modified its application to reflect this new information. The

applicant believes that its projections are reliable, yielding enough net income by 2027 to cover the annual debt of the proposed project and all other obligations. (DI # 27, p. 2; DI #28, p. 5).

Regarding expenses, Hope Health states that its hospital will have "lean staffing and small margins" and that many staff positions will carry-out multiple roles. (DI #27, p. 3). In addition, the applicant states that it plans to use contractual staff for laundry, housekeeping, dietary, supplies and pharmacy expenses and has budgeted $600,000 accordingly for this expense. In projections, the applicant used Sheppard Pratt's most recent cost report and increased the numbers by 20 percent to accommodate for a reduced efficiency of scale. (DI #27, p. 3). In response to the interested party comments on the psychiatrist's salary, the applicant states that it plans to use several psychiatrists to cover its four allotted full time-equivalent positions and will use them in both outpatient and inpatient roles, creating further efficiency. (DI #27, p. 4). The applicant states that Sheppard Pratt's comparison to Hope Health's proposed smaller hospital are inapt because they are comparisons of two significantly different operations.

In responding to later comments, Hope Health states that Sheppard Pratt has left ancillary charges out of its rate comparison, accounting for the lower rate used as a basis for comparison by Sheppard Pratt. In addition, Hope Health states that it anticipates a charity care reduction of 4.11 percent, a bad debt reduction of 11 percent, and a contractual allowance reduction of 6 percent which bring its projected rate down to $1,250.98. (DI #35, p. 5). The applicant's response discloses that the expense projections in the tables were adjusted based on the cost reports received from Sheppard Pratt. Hope Health assumed that its costs will be 25 percent higher than Sheppard Pratt because of the small scale of operation and discounting opportunities available for Sheppard Pratt. The applicant also points to the revised workforce table to enumerate benefit costs. (DI # 35, p.7).

In response to the interested party's comments about inexperience as a hospital provider, the applicant cited the 20 years of experience of its medical director, Senior Staff Psychiatrist, and the Executive Director. Hope Health also provided an exhibit demonstrating the architect's experience working on hospital projects. (DI #50, pp. 2-4).

On the issue of benefits, the applicant states that it is common in the psychiatric care field to allow high level positions such as psychiatrists to work as independent contractors because it allows them to make a higher salary and gives them more flexibility. (DI #50, p. 6).[21] Applicant supports this contention by stating that its current staff includes nine psychiatrists specializing in children and adolescents who are independent contractors and are not paid benefits. (DI #50, p. 5). In addition, the applicant has assumed that benefits are equivalent to 21 percent of base salary and has assumed that wage inflation will be 1.9 percent per annum, which Hope Health claims to reflect the current labor market experience. It also states that these assumptions are consistent with assumptions made by other recent CON applicants proposing projects that were ultimately approved by the Commission.

[21] A review of recent behavioral health CON applications found that no other applications included contractual psychiatrists, or many contractual employees. The CONs reviewed and total contractual employees in their applications: University of Maryland Psychiatric, Docket 18-24-2429, 0.0; PRMC Child and Adolescent Psychiatric Unit, Docket 18-22-2417, 0.4; Upper Chesapeake Campus at Aberdeen, Docket 18-12-2436, 0.0; AAMC Mental Health Hospital, Docket 16-02-2375, 0.5; Sheppard Pratt at Elkridge, Docket 15-13-2367, 0.0.

Hope Health addressed the interested party comments on its failure to allow for medical examination and education assessment costs by stating that these expenses are included in the miscellaneous expenses line item reported in Tables J and K. It states that laboratory service expenses are included in the supply expense category in Tables J and K. (DI #50, p. 8).

Referencing Sheppard Pratt's critique that Hope Health failed to include the real property tax pass-through, and the depreciation expense related to major movable equipment in its Table J profit and loss statement, Hope Health states that it was denied an opportunity to update Tables J and K, given that this "deficiency" was not identified until the release of HSCRC's August 9, 2021 memorandum. (DI #50, page 9, October 14, 2021). Hope Health notes that the amount in question, $97,475, is in the record and correcting this deficiency, with no other changes, would only change the project's operating income in Year 5, inflated, to show a near breakeven level of performance.

The applicant notes that HSCRC also stated, in its August 9, 2021 memorandum (DI #39, page 3) that the profit and loss statement "should properly reflect the interest component of the amortization, and the depreciation of the acquired assets, but should not present the repayment of principal loan proceeds; such repayment is an element of a cash flow statement, not a P&L." Hope Health states that removing the principal repayment from the amortization expense "would show profitability." (DI #50, page 9) It continues that, "if actual bad debt turns out to be below HHS's extremely conservative assumption of 11% . . . it would also counteract the additional $97,475" in equipment depreciation and property tax expenses. It notes that the depreciation component of this expense is the largest component, $87,500. Since this is not a "cash item," the applicant notes that it will not "affect HHS's ability to pay its bills and payroll."

In response to the statement that the rental expense is too low, the applicant states that the proposed hospital will not be the only tenant in the building. It states that the rent per square foot is actually lower in the outpatient clinic and notes that related entities are free to charge less than market rate if they choose. (DI #50, p.11).

In terms of revenue, the applicant states that it is unable to file a rate application before CON approval. It states that its projected rates do not include bad debt, charity care or contractual adjustments and it is unclear if the interested party includes these items in its rate accounting. (DI #50, p.10).

HSCRC Memoranda

The Commission requested that the Health Services Cost Review Commission (HSCRC) staff review the financial projections provided in the CON application and subsequent filings and advise the commission on whether the project is financially feasible and viable.

On August 9, 2021, HSCRC staff responded to the Commission's request for a financial feasibility and viability analysis of the proposed project. (See Appendix 9). Because of its importance and to provide better continuity for the reader in my Recommended Decision, I have summarized HSCRC's input as follows:

HSCRC found that it was uncertain what party was represented in various tables

and the affiliated parties and roles in the project were not clear. The confusion was compounded by the changing relationships throughout the review. HSCRC concludes that HHP may be affiliated with Hope Health by mutual ownership but that HHP may not be directly owned by Hope Health. HHP leases four outpatient psychiatric clinics as divisions of Hope Health. The hospital will also operate as a division of Hope Health System.

The applicant states, "The HHP properties are held as collateral on HHP mortgage debt incurred for acquisition and renovation of HHP Properties. HHS, as the primary tenant in the HHP properties, is a guarantor of the HHP mortgage debt. HHP intends to refinance the balance owed on its existing mortgage and consolidate that balance with additional funds borrowed to pay for the improvements to the Whitehead Road property that are required to facilitate the development and operation of the HHS psychiatric hospital (HHH). HHP anticipates more favorable interest rate and other terms than applicable to its existing mortgage debt." In addition, the applicant's original lease, submitted with the CON application, was amended to correctly reflect the affiliated parties and the terms of the lease.

The loan terms are shown in the table below:

Table IV-12: The Original and Modified Loan and Loan Terms
Proposed Hope Health Psychiatric Hospital

	Original Loan Terms	Modified Loan Terms
Loan Amount	$ 2,750,000	$5,677,866
Amortization/months	300	300
Interest Rate	5.370%	4.000%
Monthly Payment	$16,803	$30,153
Annual Payment	$201,632	$361,837
Total Principal	$3,721,156	$6,759,947

Source: DI #35, p. 3

Noting that the project budget changed from $4.5 million in the original application to $1.5 million in the April 26, 2021 response to completeness questions, HSCRC staff state that this implies that HHP, as the landlord responsible for building improvements, will use a loan to make improvements. Hope Health Hospital's financial responsibility, as tenant, is reduced. As a result, the use of funds by Hope Health is limited to moveable equipment, professional fees, and a working capital allowance. The source of funds in the project budget is listed as cash.

HSCRC staff note that use statistics presented by the applicant have remained unchanged, projecting a discharge growth rate of two percent, average length of stay declining at two percent per year, and a patient day volume of 4,964 days and an average annual occupancy rate of 80 percent in the first year, increasing to 85 percent occupancy in the five-year projection. HSCRC states that these may be optimistic projections, given the presence of three other nearby psychiatric hospital service providers for children and adolescents. (Sheppard Pratt, Johns Hopkins, and University of Maryland)

The biggest changes HSCRC found have occurred in Table J, the profit and loss (P&L) statements. The latest Table J (P&L uninflated) is the fourth revision of the P&L table by the applicant. In the application the original projections showed $8.2 million in revenue and an $813K profit. The current Table shows $7.9 million in revenue and profits of approximately $1K, which is, essentially, break even. When adjustments are made for moveable equipment, depreciation, and real estate property pass-thru, then added back in, HSCRC staff believes the adjusted statement would show a loss of $96K. Expense line items have changed with each updated submission without adequate explanation. This raises concerns about the applicant's research and preparation, and the refinanced loan terms are not consistently reflected when the P&L statement and the completeness responses are compared.

Table K (P&L inflated) statements present the same concerns as seen in Table J. Revenue is estimated to grow at 2.2 percent annually, higher than what is projected in expenses (1.9 percent annually) yielding improvement in the profit margin over time. Given the payor mix projection that 86 percent of the hospital patients will be Medicaid patients, HSCRC staff questioned the rate assumption and whether a government payer can be reasonably expected to increase reimbursement rates every year.

The workforce changes to Table L also raised concerns. The original application reflected 59.7 regular FTE staff compared to the current Table L with 65.1 FTEs, 16 of which are contract staff. Several of the contractual positions include the key roles of Clinical Director, Psychologist, and Psychiatrist, which raises questions about how his staffing plan would affect staff turnover and the quality of care.

The financial statements provided by Hope Health do not indicate a strong financial position. The 2018 audited financial statements show the building as an asset of Hope Health, contradicting HHP ownership stated by the applicant in subsequent revisions. Cash balances, current ratios, and equity ratios from 2017 and 2018 financial statements do not present a robust financial operation and, as of the date of the HSCRC memo (August 9, 2021), no information from 2019 or 2020 has been provided.

HHP proposes to borrow $5.7M to refinance the current debt and to afford financing for the larger $4.5M project. Hope Health is guaranteeing the entire $5.7M loan, not just the $1.5M for the hospital.

HSCRC states it cannot provide an opinion on Hope Health's financial health or the financial feasibility or viability of the project, based on the information received, the information that was not updated or received, and revisions made during the review of the application.

(DI #39, pp.1-4).

I note that, in a March 24, 2021 communication with the applicant, HSCRC staff requested additional information on the CON application Tables F, G and H (Statistics), Profit and Loss

statements inflated/uninflated for the entire facility or service, and balance sheets for Hope Health (inclusive of the hospital). However, no complete response was received. I also note that, on April 1, 2021, Commission staff again requested this information (DI # 31). The applicant noted that its April 26, 2021 completeness response was intended to address all issues raised by MHCC, the Sheppard Pratt comments, and HSCRC, collectively. (DI #37).

In a second memorandum on September 9, 2021, HSCRC staff reviewed the additional information submitted by Hope Health on August 19, 2021 and stated *"… staff was not satisfied that its requests had been fulfilled by the applicant. Additionally, reference to the audited financials led to more concerns regarding apparent related party transactions as well as other transactions surrounding building and debt that were not fully disclosed in the footnotes. Staff is currently not able to judge the reasonableness of projected volume assumptions, and staff is not able to judge the projected financial health of HHS through 2028*." (DI #42, pg.1).

Reviewer's Analysis and Findings

I find that the utilization projections provided by Hope Health have not changed substantially over the course of this review and I find that these volume projections are not unreasonable. In addition, Hope Health has provided impressive letters of support for its project by persons who are familiar with behavioral health services in central Maryland.

However, the project funding plan and the financial revenue and expense projections for this project have undergone substantial change in the course of the application review. The ongoing revisions, combined with unanswered questions and questions without complete responses, raise serious concerns about the financial feasibility of the project, as well as the long-term viability of the proposed hospital operation.

More specifically, the continued reduction in estimated net income from increased and more realistic expense estimates included with each revision submitted raise concerns regarding the viability of the project, as shown in Table IV-9. While the applicant states that the facility will still be profitable, the margin predicted in year five of operation, over the course of this review, have shrunk to just over one thousand dollars.

I find it would take only marginal changes in the expenses and/or revenue anticipated by Hope Health to result in an unprofitable operation. To recommend establishment of a new hospital, I find it important to be fully confident in the applicant's financial projections and the ability of the applicant to adequately and appropriately staff the hospital and support the hospital with a strong organizational asset base, if the future presents unforeseen challenges. In this case, HSCRC, the agency responsible for regulating hospital revenue in Maryland has been unable to endorse the feasibility of the project or the long-term viability of the proposed hospital operation and highlighted the reasons presented in the record for viewing this project's likelihood of success with a low level of confidence.

Hope Health had several opportunities to provide additional information, during this review, to directly respond to the problems that HSCRC staff noted, including, for example, the accounting for real property tax expenses, the equipment depreciation expense, and principal

repayment in the amortization expense. (DI #50, pg. 9). I also note that revisions were made after the applicant stated its responses to HSCRC were complete in an earlier communication (DI #37). The review process is one that can be characterized as an iterative process, in which the applicant revised its application in a manner clearly indicating that the revisions were being made in response to discussions with MHCC and HSCRC staff and interested party comments. Ultimately, the applicant failed to provide an effective rebuttal to the full range of questions brought forward by the interested party comments and HSCRC staff. My review of the latest financial statement from 2020 does not alter the finding.

I conclude, based on the record provided in the application and supplemental filings by Hope Health, the review by HSCRC staff, and the interested party comments, that Hope Health has not demonstrated that the project is viable. Specifically, I find that Hope Health has not demonstrated the availability of resources necessary to sustain the project.

E. Compliance with Conditions of Previous Certificates of Need

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

Hope Health is a first time Certificate of Need applicant in Maryland. (DI #4, p.70), with no history of a previous CON to consider. Therefore, this criterion is not applicable in this review.

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

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

Applicant Response

Impact on Other Providers in the Service Area

The applicant provided two tables (see Appendix 5) illustrating its anticipated impact on existing hospitals serving children and adolescents. (DI #4, pp. 71-72). The data in the tables is sourced from HSCRC discharge data files for 2019 and the projections rely on population projections sourced from the State Data Center of the Maryland Department of Planning. For children, two hospitals are projected to experience the greatest level of impact: Medstar Franklin Square and Sheppard Pratt. Both are projected to experience an impact level of "10%," described by Hope Health as a percentage "reduction in current volume." Nominally, the Year 5 "shift" of patients, which appears to be a number of patients that Sheppard Pratt would admit in Year 5 of the Hope Health Hospital operation, is 73 patients; the same figure projected for MedStar Franklin

Square is five patients. Nominally, University of Maryland Medical Center (UMMC) is projected to see a "shift" of 21 patients in Year 5; Johns Hopkins and AHC Shady Grove are projected to see a "shift" of 10 patients in Year 5.

For adolescents, Sheppard Pratt Health System is projected to experience a "12%" level of impact as a result of the establishment of the Hope Health Hospital (a reduction of 216 admissions in Year 5) while UMMC (-25 admissions in Year 5) and MedStar Franklin Square (-27 admissions in Year 5) are projected to have an impact level of nine percent. Nominally, Johns Hopkins is projected to experience a shift of 35 admissions and AHC Shady Grove a shift of 34 patients in Year 5, translating to an impact level of 7 percent and 5 percent, respectively. Sheppard Pratt Health System is projected to experience a 12 percent reduction in current volume. The applicant states that the shift in volume is intended to relieve the pressure currently experienced by existing hospitals and concludes that the proposed project would not have a negative impact on the viability of any existing hospital program. (DI #4, p.71).

Impact on geographic and demographic access to services

The applicant states that the primary objective of this project is "to address the identified shortage of inpatient access for children and adolescents in need of inpatient mental health services in the State." (DI #4, p. 33). It also states that the proposed project would improve patient access to services and expand bed availability generally. (DI #4, p. 71).

Impact on costs to the health care delivery system

The applicant states that its project will have a positive impact on the cost of boarding patients at hospital emergency departments (i.e., reduced costs), helping to alleviate current bottlenecks and reducing costs for patients and their payors. It argues that mitigating these bottlenecks will have a positive impact on the health care delivery system, allowing for improved quality of care by reducing emergency department boarding. (DI #4, p. 72).

Interested Party Comments

The interested party states that the proposed project will threaten existing providers to the extent that there will be a negative impact on access to care. (DI #22, p. 2). It criticizes the applicant's forecast of "shifting" patients from existing hospitals without considering the cost of this volume loss for those hospitals. Sheppard Pratt states that it experiences higher costs in treating certain segments of the young psychiatric patient population (e.g., children and adolescents with neuropsychiatric or autism disorders) and states that this causes Sheppard Pratt to operate at a loss. It states that the applicant's proposed impact (a "10 percent" impact) would equate to a revenue loss of $4.1 million dollars for Sheppard Pratt in the first year of the new hospital's operation. It describes how it will suffer additional losses because the applicant does not plan to treat these higher acuity (and higher cost) patients, leading to an even greater negative impact. (DI #22, p.21).

The interested party added that there will be a broader negative impact on the health care system because the applicant is proposing an average charge of $1,658 per patient day, charge that

Sheppard Pratt identifies as higher than the average charge of two existing special psychiatric hospitals serving children and adolescents (Sheppard Pratt and Brook Lane). It states that the applicant's high charge hospital will have a negative impact on Maryland's total cost of care. (DI #22, p.22).

Applicant Response to Interested Party Comments

The applicant responded to the interested party comments by reiterating that its program will reduce costs to the health care delivery system by reducing emergency department boarding, clearly implying that additional bed capacity is a primary factor in emergency department boarding.

In comparing charges, the applicant states that the interested party has understated its average length of stay and omitted ancillary charges from its reported charges. (As previously noted, the applicant modified the CON application on March 15, 2021, projecting lower per diem charges.) (DI #27, p. 13).

Reviewer's Analysis and Findings

My review of the record leads me to conclude that the proposed hospital is likely to have an impact on the limited number of existing hospitals that provide psychiatric hospital services to the young patient population in the Baltimore area. However, the size of the hospital, the actual expansion of bed capacity proposed (regionally, for both age groups, an increase in the bed inventory of just under ten percent), and the delays that have been reported in moving younger patients from hospital emergency departments to beds, lead me to find that the impact of this project on other hospitals is not existential. The potential benefits that I believe are likely through development of more beds at a new special hospital outweigh the negative impact that existing hospitals are likely to experience.

As previously noted, I believe the record is unclear with respect to the impact that this project may have on cost to the health care delivery system. The scale of operation at the other special hospitals that serve children and adolescents, which, unlike the proposed Hope Health hospital, also serve a larger adult population base, indicate to me that Hope Health will have difficulty in achieving unit costs similar to those hospitals. I do not think that the State Health Plan standard requiring such a favorable comparison, AP 11, is sound and support the changes made in the new State Health Plan chapter of regulation that came into effect after review of this application began. I am more concerned about whether the scale of operation will allow for a viable hospital operation.

I do not believe this project, if implemented, is likely, to have a significant impact on the costs and charges of other providers of psychiatric hospital services. I cannot find that the interested party clearly demonstrated such an impact.

Consistent with my findings with respect to need for the project, I find that this project will have a moderate positive impact on access to child and adolescent psychiatric services by

creating a new hospital and additional beds for an age group experiencing delays in hospital admission. It will not have a significant impact on geographic access.

V. SUMMARY AND RECOMMENDATION

Based on my review of the applicable criteria and standards, I recommend that the Maryland Health Care Commission deny this Certificate of Need application, primarily on the basis that the project has not been demonstrated to be viable.

State Health Plan

With respect to the applicable State Health Plan standards, with one exception, compliance with these standards has been demonstrated. Thus, the applicant has indicated that it will provide the services required of a psychiatric hospital, using a multi-disciplinary team approach, and that it will implement quality assurance programs evaluating performance and treatment protocols for special populations. Hope Health pledges to provide appropriate physical separation and clinical/programmatic distinction between its adolescent and child patient populations and pledges that it will not deny admission solely based on a patient's legal status. It has made an adequate commitment to the provision of uncompensated care and has proposed staffing the hospital with physicians, therapists, and aftercare coordinators with experience in child and adolescent acute psychiatric care. It documented an appropriate discharge planning policy and identified other providers with which it will coordinate care for patients that need referral for specialized treatment and post-discharge services. Hope Health also documented support for its project from the Maryland Department of Health, local health departments, other providers, and elected officials.

Standard AP 11, the exception referenced above, requires private psychiatric hospitals to document that its age-adjusted average total cost for acute admissions is no more than the age-adjusted average total cost per admission in acute general psychiatric units in the local health planning area. In reviewing this standard, I have interpreted "cost," as used in this standard, to be a reference to "charges." Facially, the applicant produced, a projection of revenue implying compliance with this standard. However, the interested party filed credible comments which called into question the assumptions made by Hope Health in creating these projections and, thus, cast doubt on the applicant's demonstration of compliance. I am accepting the applicant's facial compliance with Standard AP 11 but I do not believe that Hope Health provided a strong rebuttal to all of the questions raised by the interested party with respect to its assumptions.

In addressing the SHP standards as a proposed new provider of psychiatric hospital services, Hope Health's task was, primarily, one of effectively demonstrating its intention to comply with the applicable standards. I find that this demonstration was credible and clear. Therefore, I find that the application is in accord with the relevant and applicable State Health Plan standards, policies, and criteria.

Need

I find that a project of this scope, a 16-bed special hospital for children and adolescents,

warrants a finding of need because it aligns with use rate trends for young patients and is supported by information on the problems faced by children and adolescents in accessing hospital care on a timely basis. The proposed project will increase psychiatric hospital beds for children in the Baltimore Upper Shore region by less than 10 percent and, statewide, the project will represent an increase of just over five percent. The corresponding increases for adolescents are nine percent, in the region, and six percent, statewide.

The interested party commented that Hope Health did not establish a need for the project. However, I do not find that these comments overcome the weight of evidence that I believe demonstrate that Maryland youth can be better served by having additional psychiatric hospital resources. While large increases in the psychiatric hospital bed inventory for youth do not appear to be warranted or feasible, this project would not represent a large increase. On this basis, I recommend that the Commission find that the need for the proposed project has been demonstrated.

Costs and Effectiveness

There are no competitive applications in this review.

The applicant projects the ability to put 16 additional beds into service at a capital cost that is comparable to the approved CONs issued to UMMC and TidalHealth in 2019 for a similar number of child and adolescent psychiatric hospital bed capacity. The Hope Health project falls within a reasonable range of the direct patient care space programming used by these recent applicants, but is minimal, given that relevant support and ancillary space is more readily available at these general hospitals, which have provided psychiatric hospital services for adults and, in the case of UMMC, adolescents as well, for many years. I am concerned that, with respect to physical facilities for the proposed new hospital, the low-cost alternative put forth in this review may have a negative impact on the effectiveness of patient care, on the ability to have comprehensive programming addressing a broad range of patient needs, on the feasibility of serving patients with specialized needs, on patient and family satisfaction, and on competitiveness of the facility.

The applicant's choice to establish the proposed hospital on an existing outpatient service campus, through renovation of existing built space is an obvious lower cost choice among possible alternatives. My chief concern is effectiveness. Thus, in conclusion, I find that the proposed project is a marginally "cost-effective" alternative for providing additional psychiatric hospital service capacity for Maryland youth, but I have concerns that the project only provides a minimal plan for establishing a new special hospital and that this may have a negative impact on its "effectiveness" and its ability to compete in the market.

Viability

I find that the utilization projections provided by Hope Health are not unreasonable and that Hope Health has documented community support for its project by persons with knowledge of the behavioral health care system in central Maryland.

During this review, the project funding plan and the financial revenue and expense

projections for this project underwent substantial changes, with consequent reductions in estimated net income resulting from more realistic expense estimates. The margin predicted in year five of operation shrank to just over one thousand dollars. Thus, only marginal changes in the expenses and/or revenue anticipated by Hope Health will result in an unprofitable operation. This has not provided me with confidence in the applicant's financial projections or its ability to operate the hospital if unforeseen challenges arise. HSCRC is unable to endorse the feasibility of the project or the long-term viability of the proposed hospital.

The review process was an iterative process in which the applicant revised its application in response to discussions with MHCC and HSCRC staff and interested party comments. Ultimately, the applicant failed to provide an effective rebuttal to the full range of questions brought forward by the interested party comments and HSCRC staff. Therefore, I have concluded that Hope Health has not demonstrated that the project is viable. Specifically, I find that Hope Health has not demonstrated the availability of resources necessary to sustain the project.

Impact

While I find that the proposed hospital is likely to have an impact on hospitals that serve the young in the Baltimore area, this impact is not existential and the potential benefits that I believe the marginal improvement in availability and access to services that can be achieved through development of more beds at a new special hospital outweigh the negative impact that existing hospitals are likely to experience.

The relatively small scale of operation of the proposed hospital may not allow for unit costs and charges that will not translate into marginally higher the system-wide cost of hospitalizing children and adolescents. However, I am more concerned about the impact of this scale on the viable operation of the hospital rather than its impact on health care expenses. I do not believe this project is likely to have a significant impact on the costs and charges of other providers of psychiatric hospital services for youth.

I find that this project will have a moderate positive impact on access to child and adolescent psychiatric hospital services. More bed capacity should mitigate, to some extent, delays in hospital admissions, which are substantive for this age group.

Recommendation

Based on these findings, I must recommend that the Maryland Health Care Commission deny this Certificate of Need application, primarily on the basis that the project has not been demonstrated to be viable.

Because I would like to see more resources dedicated to the provision of hospital services for children and adolescents, I hope that Hope Health can constructively reconsider the issues raised in this Recommended Decision and, if possible, develop a stronger and more demonstrably viable project plan, on its own or in combination with other organizations. Because of its experience as a service provider for the young, the support that its project received, and its service record as a provider of services to low income and minority patients, I would be comfortable

endorsing a project from Hope Health if a future project plan can be brought forward with a more solid demonstration that it can be developed and operated on a viable basis.

IN THE MATTER OF	*	**BEFORE THE**
	*	
HOPE HEALTH	*	**MARYLAND**
	*	
SYSTEMS, INC.	*	**HEALTH CARE**
	*	
Docket No. 20-03-2444	*	**COMMISSION**
	*	

*** ***

CORRECTED FINAL ORDER

Based on the Reviewer's analysis and Recommended Decision, on April 21, 2022, by the Maryland Health Care Commission, **ORDERED**:

That the application of Hope Health Systems, Inc. for a Certificate of Need to establish a special psychiatric hospital for children and adolescents is hereby **DENIED**.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1

HOPE HEALTH SYSTEM PROFILE

Hope Health Systems Programs at a Glance

Hope Health Systems offers over twenty years of relevant experience and in depth knowledge in delivering mental health, early intervention, training, consultation, and treatment services.

Hope Health Systems Programs

OMHC

Our services at the OMHC level are designed to promote mental health and improve functioning in children, youth, adults, and families. In addition, our services are tools used to effectively decrease the prevalence and incidence of mental illness, emotional disturbance, and social dysfunction. The responsibility for diagnostic and treatment services is vested in a multi-disciplinary team comprised of psychiatrists, licensed social workers, licensed professional counselors, marriage and family licensed therapists, public health educators, and other mental health professionals.

Behavioral Health Care Coordination

The Behavioral Health Care Coordination program assists minors with psychiatric illnesses while providing their family with support and access to resources within the community. HHS utilizes a team approach by identifying all supports in the family's lives and ensuring that all services are family centered. Families are assigned a care coordinator who helps assess, prioritize, and advocate for the needs of the family while developing a supportive team of people. Family needs are addressed through referral to appropriate services and coordination of services with multiple providers and unpaid supporters,

Expanded School-based Mental Health (ESMH)

Our School-Based Mental Health (ESMH) program augments existing services provided by the school and helps to ensure that a comprehensive range of services (assessments, preventions, case management, and treatment) are available on site at the school. Parents and students may receive additional supportive services through our main center located in Woodlawn. We currently serve sixty (60) Public Schools in Baltimore County, Baltimore City and Charles County.

Mobile Treatment Services Unit (MTS)

Mobile Treatment Services are designed specifically for adults and children with major mental illness who are unable to participate in OMHC settings. A team of nurses, therapists, a case manager, and psychiatrists provide medication management, supportive individual and group psychotherapy,

and case management services. Mobile treatment services are delivered in the patient's home or in appropriate community settings when necessary. HHS has also partnered with more than 5 homeless shelters in the Baltimore area to provide MTS within. Substance Abuse Treatment Services -HHS Provides preventative and treatment services for the illicit use of a substance as a drug, including the non-medical use of prescription drugs. HHS provides outpatient treatment and Early Intervention (DWI-Education) services in the OMI-ICE

Health Homes

Our Health Homes program provides health

promotion and education services in coordination with the PRP and MTS programs, HHS staff facilitates collaboration between primary care, specialists, behavioral health providers, community-based organizations and school-based providers (for minors). Health Homes integrates somatic and behavioral healthcare services to promote holistic well-being.

Psychiatric Rehabilitation Program (PRP)

Our Psychiatric Rehabilitation Program provides services to children, adolescents and adults. Each client is assigned a Family Services Coordinator (FSC) based upon the needs

of the client as well as personality matches. The FSC provides oneon-one assistance via mobile treatment in the home, community, and/or HHS office. The client and FSC build a strong, supportive relationship to improve areas such as social skills, coping skills, self-sufficiency, academic/vocational success, anger management, family relationships and community integration. Visits will focus on addressing these areas of development while engaging in recreational activities.

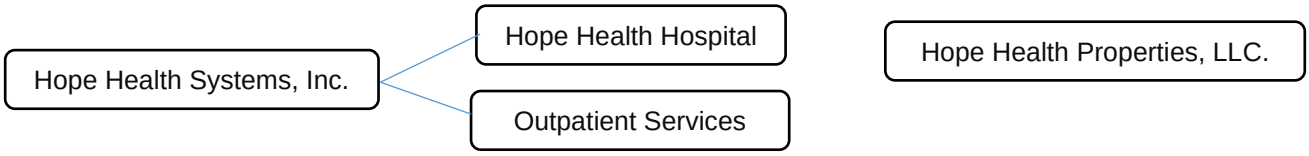
Correctional and Aftercare Mental Health Services

The Correctional and Aftercare Mental Health Services program is offered at the Baltimore City Juvenile Justice Center (BCJJC (DJS)). This program provides mental health services to youth in the juvenile center. Partnering with Centurion Managed Care, HHS provides community re-entry programs for released inmates and serves as a direct link to community resources. HHS' goal is to provide more integrative services in addition to medication management, to have a continuum of services available to released inmates, to provide reciprocal training and education opportunities and to ensure continuity of care for transferring inmates on the mental health caseload.

Adult Services

Family League and Family Recovery Program (FRP) - A division of Family League of Baltimore, FRP is a family-support initiative administered through the Maryland Juvenile Court. This nationally recognized program provides parents with the substance abuse treatment they need, along with a full range of supportive services, including: mental health care, transportation, housing assistance, and case management support. This program has worked in partnership with Hope Health Systems, Inc. and the Juvenile Court to serve the Baltimore community. HHS provides mental health assessments to determine appropriate referrals as needed and provides direct mental health services through individual, couple and family therapy as well as support groups at FRP.

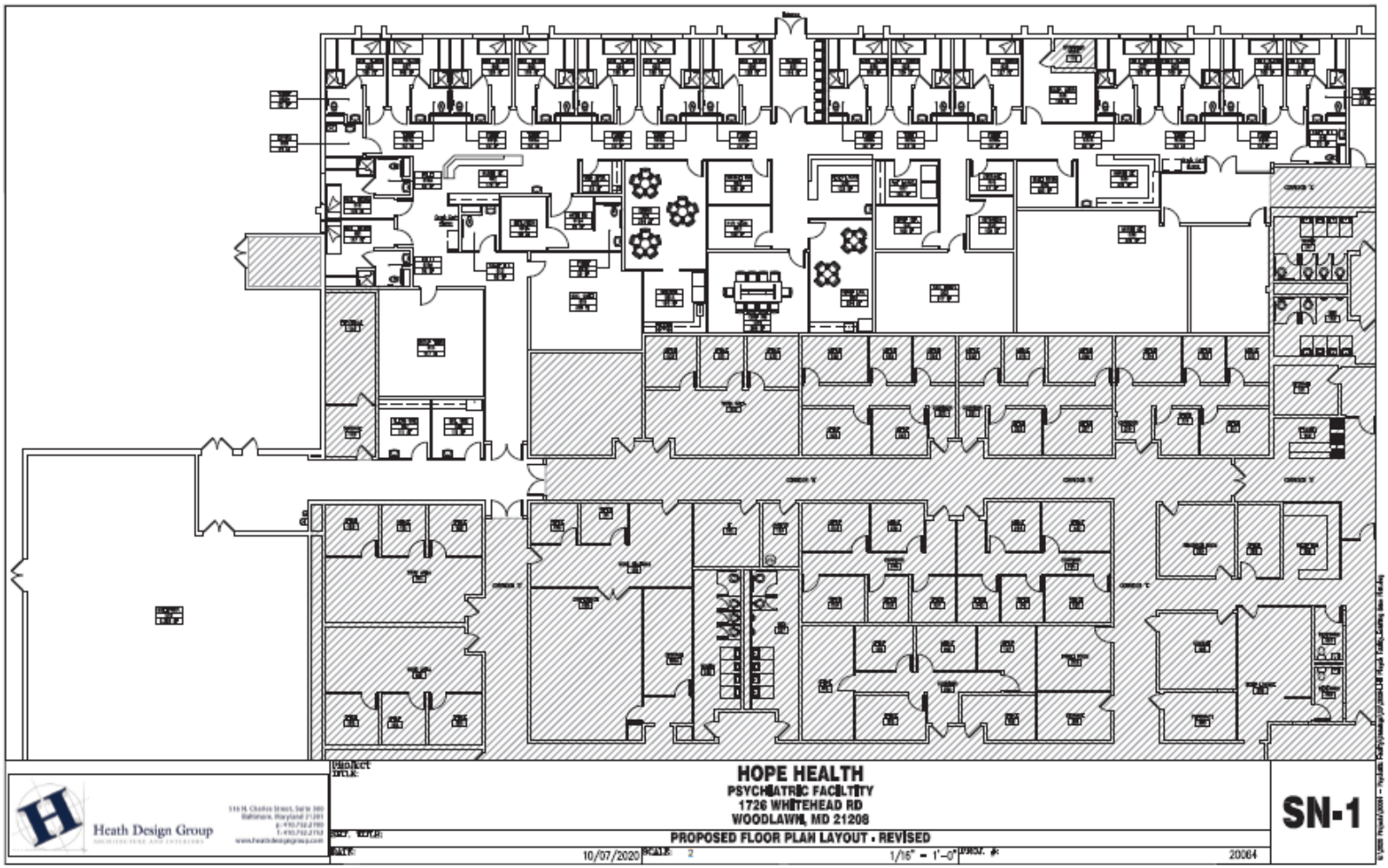
Proposed Organization Structure



Entity	Role	Applicant states	HSCRC concludes
Hope Health Systems, Inc. (HHS)	Operator	- Leases space from HHP - Not a member of HHP	- Primary tenet of HHP - Guarantor of HHP mortgage debt
Hope Health Outpatient Services Division (3 locations*)	Current subsidiary of HHS	- Currently provides services to state and local agencies	
Hope Health Hospital (HHH)	Proposed subsidiary of HHS	- New proposed division of HHS	- New tenant operation
Hope Health Properties, LLC (HHP)	Owner of real estate	- Separate/no hierarchical relationship to other entities	- May be affiliated with HHS by mutual ownership - May not be directly owned by HHS - HHP properties are held in collateral on HHP mortgage debt incurred for the acquisition/ renovation

(DI #35, p.2 and DI #39, p.1).
*Woodlawn, Greenspring and Eldersburg (Delaware location now closed)

APPENDIX 2
PROJECT DRAWINGS


Heath Design Group
HOPE HEALTH
PSYCHIATRIC FACILITY
1726 WHITEHEAD RD
WOODLAWN, MD 21208
PROPOSED FLOOR PLAN LAYOUT - REVISED
10/07/2020
1/16" = 1'-0"
20084
SN-1

SD-1
HOPE HEALTH
PSYCHIATRIC FACILITY
1726 WHITEHEAD RD
WOODLAWN, MD 21206
DEMOLITION FLOOR PLAN
1/16" = 1'-0"
20064
04/29/2020
Heath Design Group

APPENDIX 3

RECORD OF THE REVIEW

APPENDIX 3
RECORD OF THE REVIEW
Hope Health Systems
Docket No. 20-03-3444

Docket Item #	Description	Date
1	Letter of Intent for Psychiatric Care Hospital submitted by Hope Health System, Inc.	4/6/20
2	Notice to Maryland Register soliciting additional letters of intent	4/27/20
3	Summary of Pre-Application Conference	6/30/20
4	Certificate of Need Application	10/21/20
5	MHCC staff to applicant – Acknowledge receipt of application for completeness review	10/27/20
6	Commission requested publication of notification of receipt of the Hope Health System proposal in the Baltimore Sun	10/27/28
7	Commission requested publication of notification of receipt of the Hope Health System proposal in the Maryland Register	10/27/20
8	The Baltimore Sun provided the notice of publication of application	10/28/20
9	MHCC staff sends request for additional information to applicant	11/22/20
10	Applicant sends staff copy of company profile	11/30/20
11	Applicant requested and Commission approved an extension to file first completeness questions until 12/16/20	12/8/20
12	Applicant requested definition of ownership from MHCC staff	12/15/20
13	Commission received responses to the request for additional information	12/16/20
14	MHCC Staff to applicant – Formal start of Review of Application will be 1/29/21 and request for additional information	1/13/21
15	MHCC Staff to Baltimore Sun – Request to publish notice of formal start of review. Application docketed.	1/13/21
16	Maryland Register – Request to publish notice of formal start of review	1/13/21
17	Request Local Health Planning Comments Form sent by MHCC staff	1/14/21
18	Applicant response to questions in review approval letter of 1/13/21	1/29/21
19	MHCC staff requests HSCRC opinion of application	2/3/21
20	Staff requests for additional information in emails on 2/8/21, 2/11/21 and 2/12/21	Various
21	Applicant responds to questions from e-mails of 2/8, 2/11 and 2/12	2/26/21
22	Sheppard Pratt files for interested party status and comments	3/1/21
23	University of Maryland Medical Center files for interested party status	3/1/21
24	Applicant submits email to MHCC staff with questions	3/1/21
25	MHCC response to applicant's questions in 3/1/21 e-mail	3/4/21
26	E-mail from MHCC staff to applicant – follow up to 3/4/letter	3/9/21
27	Applicant responds to Sheppard Pratt comments	3/10/21
28	Applicant files modification to application	03/15/21
29	MHCC posts modification to its website for comment period	3/17/21
30	Commission received Interested Party Comments from Sheppard Pratt on the Modified Application from Hope Health Systems	3/31/21
31	E-mail correspondence Wideman/Buck/Neihaus – – review of terms HHS (the Division Parent and/or the Consolidated Systems), HHP (the	4/1/21

	landlord) and HHH (the Proposed IP Psych Hospital)	
32	E-mail correspondence Wideman/Buck/Neihaus MHCC review of the application of Hope Health System	4/5/21
33	MHCC staff sends completeness questions to applicant on modification	4/12/21
34	E-mail correspondence Buck/Neihaus/Wideman -additional discussion on procedures regarding MHCC review of the application	4/13/21
35	Applicant submits response to MHCC, HSCRC and interested party comments	4/26/21
36	Emails between Wideman and applicant regarding clarification of response; response includes the final response to each group	4/26/21
37	Email from Wideman announcing Boyle appointed reviewer	4/29/21
38	Email correspondence Boyle to Fadiora – request for additional information on 4/26/21 submission	8/5/21
39	HSCRC responds with comments in a memo to the 2/3/21 request – In Email correspondence Wunderlich/Schmith/Gallion to Hawk/Baker	8/9/21
40	Hope Health System response to 8/5/21 questions	8/19/21
41	Email correspondence Boyle to Wunderlich – request HSCRC comments on additional information submitted	9/7/21
41a	Email Harting to Wideman announcement as new counsel	9/8/21
42	HSCRC responds with comment in a memo to the 9/7/21 request – Email correspondence Wunderlich/Schmith/Gallion to Boyle/Hawk/Baker	9/9/21
43	Email correspondence Harting to Boyle – applicant request to be allowed to response to HSCRC comments	9/13/21
44	Email correspondence Boyle to Harting/Buck/Farrakhan – Documents posted to website for comment by IP and denial of Hope Health request to respond to HSCRC comments	9/24/21
45	Email correspondence Harting to Boyle – request Reviewer reconsider decision to deny Hope Health to respond to HSCRC comments	9/28/21
46	Email correspondence Harting/Wideman – status of ruling on request to be allowed to respond to HSCRC comments	10/1/21
47	Sheppard Pratt Health System's Interested Comments to Hope Health Systems 4/26/21 and 8/19/21 submissions	10/4/21
48	Email correspondence Buck to Boyle – Sheppard Pratt objects to Hope Health replying to HSCRC Comments	10/5/21
49	Boyle to Harting/Buck/Farrakhan – Deny Hope Health Request for reconsideration of 9/24/21 ruling	10/5/21
50	HHS response to Sheppard Pratt Health System's Interested Comments 10/4/21	10/14/21
51	Harting to Boyle – Request to Submit 2020 Audited Financial Statements	12/29/21
52	Boyle to Harting – Boyle Ruling on 2020 Financial Statement	3/4/22
53	Harting to Commission – Submission of 2020 Financial Statement	3/7/22

APPENDIX 4
PROJECT BUDGET

Project Budget Side by Side Comparison of Original vs. Revised CON Submissions

Uses of Funds	ORIGINAL BUDGET	REVISED BUDGET
Capital Costs		
New Construction		
Building and Fixed Equipment	$0	$0
Site and Infrastructure	$50,000	$0
Architect Fees	$9,400	$0
Subtotal-New Construction	$59,400	$0
Renovations		
Building	$2,287,498	$0
Fixed Equipment (not included in construction)	$131,250	$0
Architect/Engineering Fees	$128,500	$0
Permits (Building, Utilities, Etc.)	$2,500	$0
Subtotal – Renovation	$2,549,748	$0
Other Capital Costs		
Contingency Allowance	$318,718	$0
Movable Equipment	$875,000	$875,000
Gross Interest During Construction	$0	$0
Other	$0	$0
Subtotal - Other Capital	$1,193,718	$875,000
Total Current Capital Costs	$3,802,866	$875,000
Inflation Allowance	$0	$0
Total Capital Costs	$3,802,866	875,000
Financing Cost and Other Cash Requirements		
CON Application Assistance		
Legal Fees	$60,000	$60,000
Other Consulting Fees	$637,134	$565,000
Subtotal- Financing/Other Cash	$697,134	$625,000
Total Uses of Funds	$4,500,000	$1,500,000
Sources of Funds		
Cash	$4,500,000	$1,500,000
Total Sources of Funds	$4,500,000	$1,500,000

APPENDIX 5
PROJECTED IMPACT OF HOPE HEALTH HOSPITAL
EXISTING MARYLAND HOSPITALS WITH PSYCHIATRIC HOSPITAL SERVICES FOR CHILDREN AND ADOLESCENTS

Children

Hospital [1]	Market Share 2019	Population Increase 2022 [3]	Total Discharges 2022 (Before Project)	Impact					
				Year 1 Shift	Year 2 Shift	Year 3 Shift	Year 4 Shift	Year 5 Shift	% Impact
OOS [2]				7	7	7	7	7	
University of Maryland	24.32%	4	444	18	19	20	20	21	4%
Johns Hopkins	8.84%	1	161	9	10	10	10	10	6%
Sinai Hospital*	0.06%	0	1	0	0	0	0	0	0%
MedStar Franklin Square*	2.38%	0	43	4	4	4	5	5	10%
Johns Hopkins Bayview*	0.06%	0	1	0	0	0	0	0	0%
Carroll*	0.06%	0	1	0	0	0	0	0	0%
UM Shore at Easton*	0.06%	0	1	0	0	0	0	0	0%
AHC Shady Grove	8.40%	1	153	9	10	10	10	10	6%
MedStar Southern Maryland*	0.06%	0	1	0	0	0	0	0	0%
Mt. Washington Pediatric*	1.88%	0	34	0	0	0	0	0	0%
Sheppard Pratt Health System	37.65%	6	687	64	69	70	72	73	10%
Brook Lane	16.25%	3	297	6	6	7	7	7	2%
Unmet Need [4]				10	10	10	10	10	
State Total [5]	1			127	135	138	141	143	

Adolescents

Hospital [1]	Market Share (2019)	Pop. 2022 [3]	UMMS CON (2018)	Total Discharges 2022 (Before Project)	Impact					
					Year 1 Shift	Year 2 Shift	Year 3 Shift	Year 4 Shift	Year 5 Shift	% Impact
OOS [2]					20	21	22	23	24	
University of Maryland	0.26%	0	260	271	22	24	24	25	25	9%
Johns Hopkins	10.75%	19	-1	475	31	33	34	35	35	7%
Sinai**	0.05%			2		0	0	0	0	0%
MedStar Franklin Square	6.98%	12	-35	274	24	26	26	27	27	9%
MedStar Montgomery General	4.47%	8	-5	193	5	5	6	6	6	3%
Suburban	1.06%	2	-5	42	1	1	1	1	1	2%
MedStar Saint Mary's**	0.61%	1		27		0	0	0	0	0%
Carroll	1.76%	3	-5	73	3	3	3	3	3	4%
UM Medical Center Midtown**	0.02%			1		0	0	0	0	0%
CalvertHealth	3.64%	6	-5	156		0	0	0	0	0%
UM Baltimore Washington**	0.02%			1		0	0	0	0	0%
AHC Shady Grove	13.43%	23		594	30	32	33	34	34	5%
UM Saint Joseph**	0.02%			1		0	0	0	0	0%
Sheppard Pratt Health System	41.41%	72	-83	1750	190	203	208	213	216	12%
Brook Lane	15.52%	27		687	15	17	17	17	17	2%
Unmet Need 4]					40	40	40	40	40	
State Total				4547	381	405	414	423	428	

Source： DI #4, pp.71-72, Hope Health CON Application

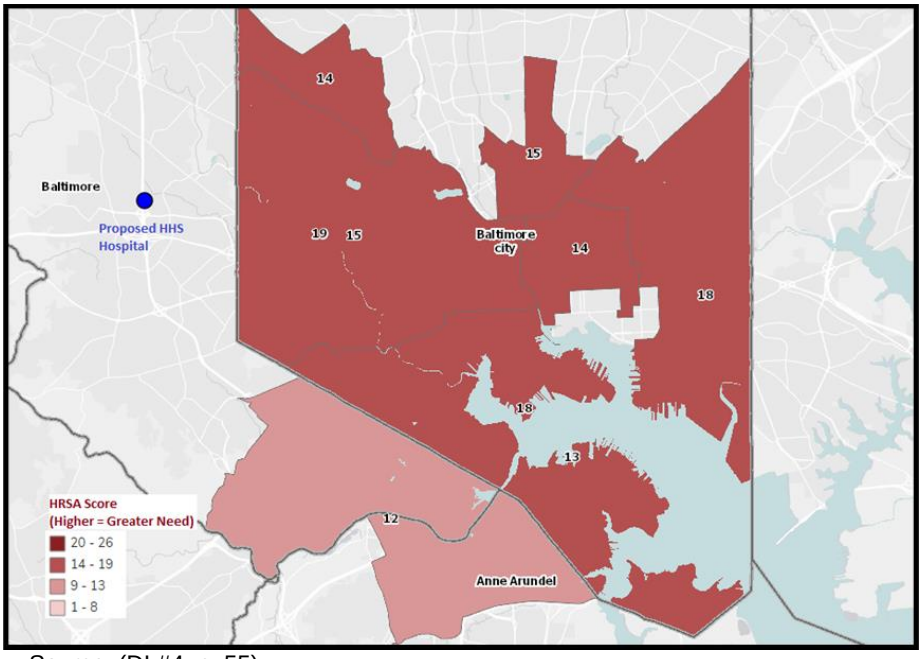
*This hospital is not considered to be a provider of hospital services to children by MHCC.
**This hospital is not considered to be a provider or approved provider of hospital services for adolescents by MHCC.
Notes by MHCC staff:
[1] Some hospital names in the applicant's table were updated to reflect the correct current name.
[2] "OOS" is a designation for projected discharges at Hope Health originating from out of state, or outside of the Hope Health designated service area.
[3] "Population Increase 2022" and "Pop. 2022" are the change in patients due to population change, utilization and market share from 2019.
[4] "Unmet" need is intended to represent discharges projected at Hope Health that are new in origin and not derived by assumptions concerning "shifts" in service volume historically experienced or which, in the future, would otherwise be experienced by existing hospitals if the proposed new hospital is not established.
[5] The totals in this row for Year 1 through Year 5 were corrected by MHCC staff.
[6] The "Market Share 2019" column is from 2019 HSCRC discharge abstract for APRDRGs 740-776 for each age category.

APPENDIX 6:
SERVICE AREA DRIVE TIME MAP AND HPSA DESIGNATION SCORE

Map of 30-Minute and 60 Minute Drive Time from Proposed Hospital

Source: (DI #4, p. 42).

Map of HPSA Designations in Baltimore Area



Source: (DI #4, p. 55).

APPENDIX 7: Hope Health Need Assessment and Utilization Forecast

Children	2021	2022	2023	2024	2025
ED Boarding / High Occupancy*	117	125	128	131	133
Unmet Need**	10	10	10	10	10
Total Projected Admissions	127	135	138	141	143

Adolescents	2021	2022	2023	2024	2025
ED Boarding / High Occupancy*	341	365	374	383	388
Unmet Need**	40	40	40	40	40
Total Admissions	381	405	414	423	428

Source: (DI # 4, pp. 58-59).
*As seen in Section on Emergency Department (ED) Boarding above, an estimate of need for additional beds was shown for 508 children (127 plus 381 equals 508).
**Unmet need includes rises in mental illness rates, increasing awareness/diagnoses, and patients lost due to access.

Hope Health Volume Assumptions – Children and Adolescent Beds

Children	2022	2023	2024	2025	2026
Beds	4	4	4	4	4
Occupancy Rate	80%	85%	85%	85%	85%
Total Bed Days	1,168	1,241	1,241	1,241	1,241
ALOS	9.2	9.2	9	8.8	8.7
Total Discharges	127	135	138	141	143

Adolescents	2022	2023	2024	2025	2026
Number of Beds	12	12	12	12	12
Occupancy Rate	80%	85%	85%	85%	85%
Total Bed Days	3,504	3,723	3,723	3,723	3,723
ALOS	9.2	9.2	9	8.8	8.7
Total Discharges	381	405	414	423	428

Source: (DI # 4, pp. 58-59).

APPENDIX 8
TIMELINE ON KEY EVENTS REGARDING THE PROPOSED HOPE HEALTH SYSTEM HOSPITAL

Year	Month	Hope Health System (HHS) CON Application Timeline
2020	Oct	**10/21/20: CON Application Filed by HHS (DI #4)**
	Nov	11/22/20: Completeness Questions Sent
	Dec	12/16/20 First Completeness Response Received
2021	Jan	1/13/21 Second Completeness Questions Sent 1/29/21 Second Completeness Response Received
	Feb	2/3/21: MHCC requests HSCRC Opinion Multiple emails between applicant and staff 2/16/21 Meeting with staff, HSCRC and applicant . 2/26/21 HHS Responds to additional questions from staff and HSCRC received
	Mar	3/1/21 Interested Parties (IP) SP/UM join review. SP submits comments 3/10/21 HHS responds to IP **3/15/21 HHS submits Modification, (DI #28)** 3/24/21 HSCRC emails HHS with list of questions in follow-up to 2/16/21 meeting 3/31/21 IP responds to Modification
	Apr	4/1/21 MHCC emails applicant with previous questions from HSCRC included. (DI#31) 4/12/21 HHS responds to IP **4/26/21 HHS submits completeness reply to modification that includes responses to: IP, HSCRC and Commission (DI #35, confirmed in D I#36)** 4/29/21 Commissioner Boyle is named as Reviewer
	May	
	Jun	
	Jul	
	Aug	8/5/21 Boyle requests additional information 8/9/21 HSCRC submits memo stating no determination on viability reached up through information as of 4/26/2021 (DI #39) **8/19/21 HHS responds to Boyle's questions. (DI #40).**

Items in bold are major submissions by HHS.

Year	Month	Hope Health System (HHS) CON Application Timeline
2021 Continued	Sep	9/7/21 Boyle asks HSCRC to review additional information from 8/5/2021 letter for viability 9/8/21 Harting enters appearance as counsel for HHS 9/9/21 HSCRC updated viability memo w/additional information and still no decision reached due to unanswered questions, lack of documentation and inconsistent data 9/13/21 HHS requests to respond to HSCRC comments 9/24/21 Boyle issues letter with timeline on allowed responses
	Oct	10/4/21 IP submits comments on April Modification Completeness and Boyle's August letter (DI #47) 10/5/21 Boyle issues letter explaining denial of HHS request to respond to HSCRC comments **10/14/21 HHS responds to IP (DI #50)**
	Nov	
	Dec	12/29/21 HHS submitted request to submit FY2020 Audited Financial Statements that are now available
2022	Jan	
	Feb	
	Mar	3/4/22 Boyle approves submission of 2020 Financial Statement 3/7/22 HHS submits 2020 Audited Financial Statement
	Apr	
	May	
	Jun	
	Jul	

Items in bold are major submissions by HHS.

APPENDIX 9
MEMORANDA BY HSCRC STAFF ON THE PROPOSED HOPE HEALTH SYSTEM HOSPITAL
AUGUST 9, 2021
SEPTEMBER 9, 2021

maryland
health services
cost review commission

MEMORANDUM

TO: Wynee Hawk, Chief, CON, MHCC
Eric Baker, Program Manager, CON, MHCC

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

DATE: August 9, 2021

RE: Hope Health Systems, Inc. (HHS)
Special Psychiatric Hospital – 16-bed Child & Adolescent Facility
Docket No. 20-03-2444

****

This memo is in response to your request dated February 3, 2021. Hope Health Systems, Inc. (HHS) has submitted a Certificate of Need (CON) application dated October 21, 2020, proposing a capital expenditure of approximately $4.5 million to construct a 16-bed special inpatient psychiatric hospital for children and adolescents in a building owned by Hope Health Properties, LLC (HHP). The proposed facility is to house 16 single patient rooms (4 for children and 12 for adolescents). The inpatient facility would be established by renovating part of a building in which HHS currently operates an outpatient psychiatric clinic, located in the Woodlawn community of Baltimore County, Maryland. Programming at HHS currently includes partial hospitalization, outpatient mental health, expanded school mental health, Department of Justice (DOJ) service, rehabilitation programs, substance abuse, and mobile treatment. HHS states that it believes its range of outpatient services positions it well to provide its discharged inpatients with continued follow up care.

You have requested that the staff of HSCRC review the financial projections provided in the CON application and subsequent filings, (and separately you have requested that HSCRC staff advise MHCC as to any questions we would like answered before offering our opinion), and then also to advise MHCC of our opinion on the general financial feasibility of the proposed project. Additionally, you have requested that HSCRC staff comment on any other aspects of this CON application that may be pertinent. MHCC staff has not commented on the utilization projections presented in the CON application as to reasonableness and has not asked HSCRC staff to assume that HHS will achieve the projected utilization volumes.

BACKGROUND

As you have described it, the project will consist of approximately 10,134 SF of renovation, which, upon completion, will be separate and distinct from the existing outpatient services offered within the building, with a separate entrance for patients and visitors.

THE PROJECT

As you have described it, the total cost of the project is approximately $4.5 million, and the applicant plans to fund the project with a loan from Taylor Capital Consultants, who has pre-qualified the full amount for the loan. (Exhibit 9 of application). The project cost consists of approximately $2.4 million in demolition, building renovation, and infrastructure improvements; $1 million in fixed and movable equipment; $640,000 for IT systems; $140,000 in architect fees and permits and $320,000 for contingency.

HSCRC REVIEW, DISCUSSION, and OPINION

HSCRC staff has reviewed the following: 1) the CON application dated October 22, 2020, and the CON Modification dated March 15, 2021; 2) the subsequent Completeness Responses dated January 7, 2021, January 29, 2021, and April 26, 2021; and 3) the Interested Party Comments Responses dated March 15, 2021. Consistent with your request, we compiled and shared with you our review questions, which were forwarded to the applicant on March 24, 2021, and for which partial responses were included in the Completeness Responses received April 26, 2021. We understand that the April 26, 2021 Completeness Responses constitute a response to our questions dated March 24, 2021 as well as questions from MHCC and interested parties, and we, therefore, do not anticipate further responses from HHS to those questions not addressed, or not addressed fully in the April 26, 2021 communication.

Upon review of the materials submitted by HHS, it became evident that the applicant may have confused the presentation of the affiliated parties, as well as their respective roles in the proposed project. The applicant was uncertain as to which of the related parties was being represented by the statistical and financial Tables in the CON and subsequent submissions. To further compound the confusion, the descriptions of the relationships between the parties as documented in the submissions changed as time passed and more questions followed.

It is currently believed that HHP may be affiliated with HHS by mutual ownership, but that HHP may not be directly owned by HHS. Additionally, it is believed that HHS currently operates four (4) outpatient psychiatric clinics at the following locations: Woodlawn, Greenspring, Eldersburg, and Middletown, and that these service locations operate as a division(s) of HHS. It is believed that the proposed inpatient psychiatric hospital "Hope Health Hospital" (HHH) is also to operate as a division of HHS. Therefore, the identity of the smallest and most immediate corporate entity responsible for the proposed new service offering is HHS. This understanding is confirmed on page 2 of the Completeness Responses dated April 26, 2021. Additionally, it is important to note that on this same page of this same document it states: "The HHP Properties are held as collateral on HHP mortgage debt incurred for acquisition and renovation of the HHP Properties. HHS, as the primary tenant in the HHP Properties, is a guarantor of the HHP mortgage debt. HHP intends to refinance the balance owed on its existing mortgage and consolidate that balance with additional funds borrowed to pay for the improvements to the Whitehead Road property that are required to facilitate the development and operation of the HHS psychiatric hospital (HHH). HHP anticipates more favorable interest rate and other terms than applicable to its existing mortgage debt. HHP and HHS have negotiated amendments to the HHS lease that reflect the above refinancing."

The Table E - Project Budget has changed from the initial presentation of a $4.5M project to the current presentation of a $1.5M project. The initial presentation may have been a blended one, part HHP and part HHS. The current presentation is believed to describe the cost to HHS for its division HHH as a proposed new tenant operation. The uses are limited to moveable equipment, professional fees, and a working capital allowance. Sources are limited to "cash," but they may well be proceeds from the proposed HHP financing to be advanced to HHS via mutual ownership.

The Table I – Statistics, New Facility or Service has remained constant and unchanged since the initial October submission. It is of interest to note, however, that the applicant has submitted 4 different P&Ls since October, with 2 different top line revenue measures, and with 3 different total operating expense measures. Total discharges are projected to grow at an average annual rate of 2%, while average length of patient stay is projected to decline at an average annual rate of 2%. Total patient days is projected to remain unchanged at 4,964 patient days per year from 2023 through 2028. As per page 71 and 72 of the CON, the existing state resources will be the source of shifting volumes to HHH, and the greatest of such resources are Sheppard Pratt, Johns Hopkins, & University. Staff requested information from the applicant regarding its proposed systems and resources designed to achieve 80% occupancy in the very first year of operations (2022) given the well-established networking systems by incumbent service providers. Such assumed volume assumptions appear optimistic on their face, especially given that all future periods are projected at 85% occupancy. The applicant did not provide a response to this request. Staff is currently not in a position to judge the reasonableness of this projected volume assumption.

The Table J – P&L Uninflated, New Facility or Service has changed from its initial presentation of a $8.2M top line revenues with a $813K (12.5%) positive operating margin projected for 2028 (two years after completion and occupancy) to the current presentation of $7.9M top line revenues with a $1K (0.0%) breakeven operating margin for that same projected year. However, upon further review of the current presentation, it appears that the depreciation on the moveable equipment included on Table E --approx. $87,500/ year-- and the real property tax pass through to tenant rent as per the lease (approx. $9,975/year) have been omitted from the presentation. If such were to be added back to operating expenses, then the resulting profit margin may be a negative $96K (-1.5%) in 2028. Also of note is

that some of the line-item components of operating expenses are changing from submission to submission without narrative explanation, leading staff to question the applicant's research in preparing the expense values presented. And the recent changes in the salaries, wages and benefits buildup beg the question - has the applicant departed from its original vision of a consistent, competent, quality patient service offering? Additionally, it was noted that the value of Project Amortization approximates that of the debt service requirement of a $1.5M loan over 30 years at a 6.5% interest rate. There is inconsistency with the refinancing described in the Completeness Responses dated April 26, 2021, which noted the rate at 4%. The P&L should properly reflect the interest component of the amortization, and the depreciation of the acquired assets, but should not present the repayment of principal loan proceeds; such repayment is an element of a cash flow statement, not a P&L.

The Table K – P&L, Inflated, New Facility or Service has, as may be expected, also changed with each resubmission of Table J. In addition to all the comments already noted in reviewing Table J, all of which also apply to Table K, there are additional observations. Revenues are projected to grow at an annual average rate (2.2%) slightly higher than that projected for Total Operating Expenses (1.9%), which slightly pushes improvement in the projected operating margin year over year. Given the assumption that patient mix and patient days are nearly 86% attributable to Medicaid, staff questions the likelihood that this governmental payer will agree to reimburse at ever higher rates of service year after year. The projected 2028 operating margin of $92K may be closer to breakeven after accounting for the omitted depreciation and real property tax expenses.

The Table L – Workforce Information has changed in a material respect as resubmitted. The original Table L reflected 59.7 FTEs, all of which were regular employees, and $3.8M in compensation without disclosing the value of benefits if any. The current Table L reflects 65.1 FTEs, 49 of which are regular employees, 16.1 are contracted employees, and $4.7M in compensation with $545K of that in benefits that are restricted to just the regular employees. Staff took particular interest in the job categories selected for reclassification of FTEs from regular with benefits to contracted employees without benefits. The positions of Clinical Director, Psychologist, and Psychiatrist were included among those job categories reclassified as contracted without benefits. Staff is concerned that this reclassification may introduce new challenges to the project that may impact the timing of readiness to begin service, and the quality of service. Staff understands that the marketplace for medical and clinical professionals is very competitive and is concerned with the turnover of professional personnel.

Financial Statements for HHS have been included with the submitted materials. Review of these statements has raised questions and concerns. Building is included in the assets of the 2018 audited statements, which may contradict the representations that the building is owned by HHP, not HHS. The cash balances, current ratios, and equity ratios reflected in the 2017 and 2018 audited statements are less than what one may expect for a financially healthy business operation. The disclosures in such audited statements were less than adequately helpful in explaining the relatively material transactions regarding acquisition of building and debt. As of the date of this memo, staff has yet to receive audited statements for 2019 and 2020.

In the March 24, 2021 communication to the applicant, staff requested that the applicant provide several materials to aid in reaching an opinion regarding the feasibility of the project. Such requested materials included CON Tables F, G & H, which pertain to Statistics, P&L Uninflated and P&L Inflated, respectively, for the "Entire Facility or Service," implying application to HHS (inclusive of the HHH division). Please recall that HHS is represented to be guarantor of the debt of HHP. Such requested materials also include projected balance sheets for HHS (inclusive of HHH division). The applicant did not provide a response to this request. Staff is currently not in a position to judge the projected financial health of HHS through 2028 (two years after planned completion and occupancy). It should be noted that as per the Completeness Responses dated April 26, 2021, HHP is proposing to borrow $5.7M to refinance its current debt and to afford financing for the larger $4.5M project. HHS is obliged to guarantee the entire $5.7M loan, not just the $1.5M for HHH.

You have requested that staff opine on the financial feasibility of the special psychiatric hospital project proposed by HHS. Generally speaking, staff needs to gain comfort that the applicant has sufficient working capital to maintain the operation from its inception throughout at least two years after the completion and full occupancy of the project. Staff needs to be satisfied that such use of its working capital does not put at risk the financial position of the applicant (as measured by its debt covenants, its balance sheet liquidity, its leverage and equity ratios). In addition, staff needs to be comfortable that the applicant can assemble the financial resources necessary to get the project off the ground and can then subsequently service any such financing sources without putting its financial position at a level of unhealthy risk. These required levels of comfort go beyond the question of whether the project can achieve a positive operating

margin at least two years (or longer as required) after project completion and full occupancy. The HSCRC staff typically bases its opinion on sufficient competent evidence as submitted by the applicant, recognizing that there are times when the evidence needed to review is beyond that which was included in the initial CON application. At this time, based upon review of all the submitted materials, and with no expectation of further response from the applicant, staff is not in a position to reach an opinion of the financial feasibility of this project.

maryland
health services
cost review commission

MEMORANDUM

TO: Marcia L. Boyle, Commissioner/Reviewer, MHCC
Wynee Hawk, Chief, CON, MHCC
Eric Baker, Program Manager, CON, MHCC

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

DATE: September 9, 2021

RE: Hope Health Systems, Inc. (HHS)
Special Psychiatric Hospital – 16-bed Child & Adolescent Facility
Docket No. 20-03-2444

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This memo is in response to your request dated September 7, 2021, regarding our review of additional materials submitted by the applicant on August 19, 2021 (and following the materials previously submitted and reviewed as documented in our response to you dated August 9, 2021), and any impact such subsequent review has had on our opinion on the financial feasibility of the project.

BACKGROUND

Consistent with your initial request dated February 3, 2021, HSCRC staff (staff) compiled and shared with you our review questions and observations, which were forwarded to the applicant on March 24, 2021. Included in that communication, staff specifically requested projected P&Ls and balance sheets for HHS through at least 2 years following project completion and full occupancy or longer as required to reflect a positive operating margin. Note the applicant has been submitting materials through 2028, the 7th year of planned operations. Additionally, staff specifically requested proposed systems and resources designed to achieve 80% occupancy in 2022, the 1st year of planned operations. Note also the applicant has represented that all subsequent periods would maintain 85% occupancy. Finally, staff requested audited financials with full footnote disclosures. In addition to these requests, the reasons for such requests were clearly delineated to the applicant, so that staff may have such materials to reference as aid in reaching an opinion.

HSCRC STAFF REVIEW, DISCUSSION, and OPINION

Staff has reviewed the subsequent Completeness Response dated August 19, 2021 and its attached exhibits. Upon review of these materials, staff was not satisfied that its requests had been fulfilled by the applicant. Additionally, reference to the audited financials led to more concerns regarding apparent related party transactions as well as other transactions surrounding building and debt that were not fully disclosed in the footnotes. Staff is currently not able to judge the reasonableness of projected volume assumptions, and staff is not able to judge the projected financial health of HHS through 2028 (or later as a positive operating margin has yet to be projected). At this time, based upon a review of all the submitted materials, and with no expectation of further response from the applicant, we are not in a position to reach an opinion on the financial feasibility of the project. Our conclusion, therefore, remains unchanged.