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

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Response to Comments from Sheppard Pratt

Hope Health Systems, Inc. ("HHS") through its undersigned counsel submits the following responses to the comments submitted by Sheppard Pratt Health System, Inc. ("Sheppard Pratt") to the HHS application for a Certificate of Need to open and operate a specialty sixteen bed psychiatric hospital.

A. General Principles

Health care facilities, including one intending to provide the services described by HHS in its application, are required to obtain a certificate of need. Md. Code, Health-Gen. § 19-120. The requirement for certificates of need is one of the **tools** used by the Maryland Health Care Commission ("Commission") in the fulfillment of its obligation to "promote the development of a health regulatory system that provides, for all Marylanders, financial and geographic access to quality health care services at a reasonable cost……." Md. Code, Health-Gen. § 19-103. [1] If a person seeking interested party status is opposing an application, the comments shall state with particularity the State Health Plan standards or the review criteria in §G of this regulation that the person seeking interested party status believes have not been met by the applicant and the reasons

[1] On the opinion page of the January 15, 2020 issue of The Detroit News a senior research fellow at George Mason University stated that (20) years of health economists overwhelmingly suggested that CON laws limit access to higher- quality, lower cost and that African Americans are less likely to obtain certain kinds of care in CON states than African Americans in non-CON states. The senior research fellow went on to opine that CON laws persist not because they protect patients but because they protect large, well-heeled providers from new competition.

why the applicant does not meet those standards or criteria. Md. Code Regs. 10.24.01.08. As shown below, the "reasons" put forth by Sheppard Pratt in support of its belief that HHS has failed to satisfy the requirement for issuance of the requested CON are little more than a series of unsupported and in some instances, offensive, bald conclusions or opinions.

B. Sheppard Pratt's Contentions and HHS Responses

(I). HHS's Revenue and Expense Projections are Unreasonable

HHS made its projections of revenue and expenses based on the information publicly available to a new inpatient psychiatric hospital provider. HSCRC, authorized to establish hospital rates to promote cost containment, access to care, equity, financial stability and hospital accountability, has broad responsibility regarding the public disclosure of hospital data and operating performance. The rates used by HHS are in keeping with the existing providers daily rates and were established to ensure they were less than then per diem rate offered by general acute care hospitals. In its modification, the expected reimbursement rate was reduced to reflect only Sheppard Pratt and Brook Lane's rates.

Sheppard Pratt assertions regarding HHS revenue and expenses projections are highly subjective conclusions derived from "Sheppard's Pratt's" experience. HSCRC establishes hospital- specific and service-specific rates for all inpatient, hospital-based services. Sheppard Pratt has not disclosed the details regarding any of the information it provided to HSCRC in seeking rate approval for its services or of the factors relied by HSCRC in establishing the rates applicable to either of Sheppard's Pratt's facilities. Without these particulars, there is no basis to find that the HHS projections are so unreasonable as to lead to the conclusion that the HHS hospital will not be financially viable within (5) years from commencement of operations, if not immediately so.[2]

[2] In Sheppard Pratt's arguments, they indicate that the daily rate for inpatient child and adolescent psychiatric services is $1,259 for its location and $1,137 for Brook Lane. However, they fail to account for the ancillary services associated with the hospital service line. As seen in the 2021 approved Rate Sheet, both Brook Lane and Sheppard Pratt have several additional service lines that they may offer, such as lab, individual and group therapy, and drugs. These charges were included in HHS's per diem rate. Sheppard Pratt conveniently removed these customary charges

Sheppard Pratt's argument regarding HHS expense projections fails to consider drastically different operational models that are poised to account for distinction in workforce and staffing between its current operations and the proposed hospital. This small hospital model is designed to account for lean staffing and small margins. HHSHHS intends for certain individuals to provide several roles within the operations; indeed, the regulations allow for a single individual to cover multiple requirements. The State Operations Manual for Medicare Certification for a psychiatric hospital states throughout, only that the hospital employ an adequate number of staff to cover the respective requirement. As a Joint Commission accredited facility, the proposed hospital will meet or exceed the CMS standards.

For those service lines in which employed staff will not cover, HHS intends to utilize contracted labor. The costs were obtained from the most recently filed cost report by Sheppard Pratt and increased 20% to account for reduction in efficiencies of scale. The contractual amount accounted for various cost centers, including: Laundry and Linen, Housekeeping, Dietary, Supplies, and Pharmacy Supplies. HHS took the rates for each cost department, divided it by the number of reported patient days by Sheppard Pratt and applied that number times 120% to the projected number of patient days for the proposed facility. This benchmarking method was used as a conservative estimate, and HHS allocated more than $600,000 in costs on annual basis for these additional services.

Sheppard Pratt also anticipates that the applicant has understated employment costs for psychiatrist and assume we are using only four psychiatrists. However, in keeping with our small hospital model and our current arrangement with psychiatrist associated with our outpatient care service line, HHS intends to use several psychiatrists to cover the four total FTEs. This is one of many examples that explain the distinction between Sheppard Pratt's service model and the

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to meet its argument. Further Sheppard Pratt claims the assumption that rates would increase 2.77% is unrealistic and offer a 2.3% rate increase as more reasonable. HHS utilized the 2021 rate increase on a year over year basis.[2] As the increase is determined by HSCRC on an annual basis, and they have used 2.77% in the most recent year, this is a reasonable assumption.

proposed model. The applicant is not seeking to provide duplicative care, but rather seeking to provide transformational healthcare in the service area. Similar to the Anne Arundel Medical Center application in 2016, HHS is projecting to operate as low-cost provider. AAMC demonstrated that it is possible to operate at significantly lower costs compared to providers, including 43% lower costs compared to Sheppard Pratt. [3]AAMC similarly noted that there will be efficiencies related to inpatient and outpatient services at the same sight, as will be the case with the proposed provider. HHS projects these efficiencies will reduce the ALOS and create efficiencies with post-discharge placement planning. [4]

(II) HHS DOES NOT DEMONSTRATE THAT ITS PROPOSED PROGRAM IS COST EFFECTIVE, COMAR § 10.24. 01.08G(3)(f).

HHS's application demonstrates the project is cost effective. Standard AP 11 of the State Health Plan, COMAR § 10.24.07, requires that:

> **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 cost per case per HSCRC data for 2019 and adjusted by interim rate increases clearly shows the projected costs per case in HHS original filing meets this State Standard. Sheppard Pratt removes cost for cases that are treated as acute care admission despite their longer length of stay in excess of (30) days. The State standard is meant to excludes categorically different admissions for long-term care – not every psychiatric acute care admission that exceeds 30 days.

[3] See Page 8
https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/filed_2016/aamc_mental_health/con_aamc_response%20to%20hscrc%20comments_20180202.pdf

[4] HHS has considered the potential impact to the application in the event HHS is provided a lower rate and if costs are increased above initial estimates. To demonstrate financial viability while considering the comments from MHCC, HHS has made several modifications to the Tables J, K, and L. The changes demonstrate that HHS may utilize additional staff, reduce its revenue and remain viable.

Figure 2.1 - Average Total Cost of Acute Psychiatric Admission – Central Planning Area Children					
Hospital	Inpatient Discharges	Total Cost Per Discharge (2019)	FY 2020 Rate Increase (2.64%)	FY2021 Rate Increase (2.77%)	FY 2022 Rate Increase (2.00%)
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
			Total Cost Per Discharge		$16,483.99
			HHS Cost Per Case[5]		$14,588.72

Figure 2.2 - Average Total Cost of Acute Psychiatric Admission – Central Planning Area Adolescents					
Hospital	Inpatient Discharges	Total Cost Per Discharge (2019)	FY 2020 Rate Increase (2.64%)	FY2021 Rate Increase (2.77%)	FY 2022 Rate Increase (2.00%)
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 Hospital Center	75	$20,174.42	$20,707.02	$21,280.61	$21,706.22
			Total Cost Per Discharge		$16,719.50
			HHS Cost Per Case[6]		$14,588.72

Further, the MHCC psychiatric services work group has proposed removing this standard. During Acute Psychiatric Services Workgroup Meeting on August 19, 2019, Ms. Fleck read Standard 11, and then asked for feedback on the standard. Mr. Phelps commented that the standard is too prescriptive. HSCRC evaluates the financial feasibility of CON projects and sets rates. Ms. Wilkerson, Ms. Wray, and other work group members agreed. Ms. Fleck noted that the consensus is to eliminate this standard.[7] The standard does not appear in the drafted version of the new State

[5] Updated with new rate of $1,585.73 at 9.2 ALOS.
[6] Id.
[7] https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/FINAL_SHPPSYCH_Rpt_LTRandAttch.pdf (pg 33)

Health Plan. Ultimately, the cost per day for HHS's proposed hospital is much lower than a general acute care provider, resulting in cost savings for the State.

(III) HHS DOES NOT DEMONSTRATE THAT ITS PROPOSED PROGRAM COMPLIES WITH THE NEED STANDARD, COMAR § 10.24.01.08G(3)(b)

Sheppard Pratt contends that the requirement that HHS establish the need for its hospital is particularly important because, as Sheppard Pratt sees it, HHS "seeks to establish its program by taking 85% of its market share from existing providers…." Sheppard Pratt first maintains that it currently serves the supposed target population at an annual loss. (Shepperd Opp., pg. 21). However, in the very next breath Sheppard Pratt contends, would cause it to lose $4.1 million in gross revenue and $770,000, profit. HHS proposes to siphon off. Nowhere in the Md. Code or COMAR is there a standard that requires consideration, let alone protection, of existing providers' market share, gross revenue or net profit. Common sense suggests that Sheppard Pratt is not so vigorously opposing HHS' application so that it can maintain its annual losses.

HHS has demonstrated a need for services. As of the time of the filing, the State had not set a defined formula for demonstrating need. HHS was required to use the information available to the general public to demonstrate the drastic need for mental health services for adolescents and children. Despite the lack of available information, HHS was able to articulate various metrics that demonstrated an overall need for services, based on the totality of the circumstances discussed.

Population Estimates: HHS provided an adequate summary of its population estimate analysis. In an effort to provide more transparency, we have included a copy of the excel spreadsheet used to make our estimates.

Utilization Rates: HHS identifies in its report two sources of data used to identify the utilization rate, including the MHCC white paper which shows rates from 2010-2017 and the

custom data set purchased by HHS.[8] HHS has provided the data set utilized with the parameters for the State's review. The total cost of the data was $3,800.

Using the two data sources HHS identified a static range utilization rate, although the rate demonstrated a decline between 2017-2019 in the custom data set, there was in a steady increase in state's data set between 2015-2017, and in general the utilization rates ebbed and flowed. HHS was not privy to the data set used by MHCC in the White Paper but used a generally accepted range of services in the request from HSCRC. HHS utilized a static rate to ensure consistency throughout its analysis. The projections used by HHS were reasonable. As demonstrated throughout the analysis, there is a general need for services.

Further, it was reasonable for the applicant to factor in the statewide need analysis, as central region providers treat neatly 40% of the child population and 45% of the adolescent population originating from outside of the central region.[9] Accordingly, it would have been unreasonable to assume that only patients in the central region would utilize the hospital. Indeed, HHS provided an analysis to MHCC on February 25th wherein HHS estimated that at least 18% and 27% of our patient population, respectively, would originate from outside the central region. The intent is to focus on the Central region as the primary service area, but it would be irresponsible to not consider patients from outside the planning region.

Based upon the analysis, HHS demonstrated a need for psychiatric services.

Bed Estimates Occupancy: HHS assumed a 70% occupancy rate for all applicants as the MHCC work group noted that the current 90% threshold was too high. They did not provide a recommended threshold, and therefore a reduction to 70% is a reasonable assumption and

[8] AS noted, HHS is not a current hospital provider and thus does not have access to the full set of data that current hospital providers are able access.
[9] See included HSCRC Custom Data Set

demonstrates a consistent emphasis on patient quality of care. Despite this, in Section X (Pg. 58) HHS identifies a potential utilization in the proposed hospital of 85%. HHS recognizes that under best practices a 70% occupancy rate would be used, but also realizes that there is a need beyond the 70% threshold.

HHS also used the assumption that all double occupancy rooms are used as private rooms. This was based upon the reports in the MHCC workgroup, wherein it is noted that in most circumstances the rooms were used as single occupancy. [10] Sheppard Pratt also noted the issue of double occupancy in its recent CON application, wherein they noted a history of blocked beds as a result of having semi-private status. (Docket No. 15-13-2367 AP 4a) There is generally a shift in healthcare utilization that consistently demonstrates the benefits of single occupancy space.[11] HHS leveraged best practices in its assumption that going forward all patients would be served in single occupancy rooms.

Sheppard Pratt also identifies potential inconsistences with the occupancy level cited in the application. HHS noted within the application that they were limited to publicly available data. Despite this, Sheppard Pratt confirmed they have 96 beds, but offer differing total patient days and admissions compared to what has been reported in multiple sources. HHS identified this and has already explained in its response to MHCC on January 7th that the potential occupancy rate, depending on the sources used, ranged from 85% to over 100%. This range is consistent with Table 4 provided by Sheppard Pratt in its interested party comments.

HHS used this information to provide an additional statistic demonstrating the potential need for additional mental health services as a result of patient turn away. Sheppard Pratt may have

[10] https://mhcc.maryland.gov/mhcc/pages/plr/plr/documents/FINAL_SHPPSYCH_Rpt_LTRandAttch.pdf
[11] Taylor E, Card AJ, Piatkowski M. Single-Occupancy Patient Rooms: A Systematic Review of the Literature Since 2006. HERD. 2018 Jan;11(1):85-100. doi: 10.1177/1937586718755110. Epub 2018 Feb 15. PMID: 29448834.

a different experience, but it cannot misrepresent the statistical relevance that the study provided with regard to turn away based on occupancy rates. The additional beds in the area proposed by HHS would alleviate the impact of high occupancy rates to the community.

Absent a specific need calculation approved by the state, HHS provided various measures, that viewed as a totality of circumstance, clearly demonstrated a need for additional inpatient mental health services in the area. As stated at the outset of the response in the original filing:

> "To quantify the need for this project, HHS examined the current State guidelines, MHCC's psychiatric services work group's recent review of standards, and research on determining beds need for child and adolescent inpatient psychiatric services. As the State has not defined one formula for determining need, HHS reviewed influential data metrics and observable outcomes indicative of the unmet need this project will help address."

ED Boarding: ED boarding is a well-documented issue and the applicant provided several research examples within its response (See Page 49 of the initial CON application). Sheppard Pratt's insistence that HHS System invented the issue is without merit. The study relied upon by HHS was commissioned by the Maryland Hospital Association, which gave the following primary purpose:

> "This study will serve to inform policy and practice within the mental health infrastructure in Maryland. These indicators will illustrate the opportunities for patient care outside of the emergency department system"[12]

[12] https://www.mhaonline.org/docs/default-source/resources/behavioral-health/ed-discharge-delay-study/maryland-hospital-association-protocol.pdf?sfvrsn=a3e1d40d_2

HHS thus justifiably used the report to identify the current mental health infrastructure within the state and identify additional need for inpatient services. HHS used the study to recognize that there was a direct correlation of ED Boarding and the availability of inpatient psychiatric beds.

Sheppard Pratt does correctly point out that 45% of patients were not waiting for placement within an inpatient unit. Rather, 45% were waiting for bed space within the recommended placement setting, 41% of which were for an inpatient acute psychiatric unit.

Based on the updated analysis, there would still be a need to serve 208 children[13], and 416 adolescents[14] patients. The updated calculation still demonstrates a need for additional beds. Furthermore, HHS does not project that all its patients will come from the ED boarding, but rather up to 133 for children by 2025 and 388 by 2025 for adolescents. Below the updated statistic identified above. (See figures 23 – 26 on pages 58-59 of the original filing).

Additionally, the 41% patient population cited was specifically for an inpatient acute psychiatric unit. There was another section within the report that was dedicated to patients waiting for a specialty psychiatric unit, the report identifies Sheppard Pratt individually in this section (accounted for 4% of the patients). Thus, the indication that HHS would not be able to serve the identified patient population is unfounded, as the report specifically identified those patients who Sheppard Pratt would uniquely be able to serve.

Sheppard Pratt has erroneously assumed the level and quality of care that HHS will provide the community will not reach the levels offered by Sheppard Pratt. Although HHS will not provide complex care to patients requiring specialty care, it will have the proper staffing and support available to serve a majority of the patients requiring inpatient psychiatric care.

[13] 41% of the 508 Children identified in Figure 18 of the initial CON application.
[14] 41% of the 1,015 Adolescents identified in Figure 19 of the initial CON application.

Re-admissions: Within this section of the need analysis HHS seeks to inform the MHCC on the various additional issues plaguing the mental health community and demonstrate its ability to serve the patient population and help to continue to reduce the readmission rates. Contrary to Sheppard Pratt's assertion that we are claiming to perform better than current providers, we were seeking to demonstrate that we would be able to provide care in line with the current providers. We applaud Sheppard Pratt's quality of care.

The response offered by Sheppard Pratt is seeking to unduly influence the State to deny new providers the opportunity to provide care for the singular benefit of its bottom line; rather than focusing on providing care to a patient population clearly in need of additional services.

Other Unmet need: HHS is a Minority Business Enterprise (MBE), and has received recognition as a Top 100 MBE organization. There is a need for culturally conscious providers who can provide increased access to services, such as the proposed service line HHS seeks to provide. As stated within the application, African Americans have been, and continue to be, negatively affected by prejudice and discrimination in the health care system. Conscious or unconscious bias from providers and lack of cultural competence can result in misdiagnosis, inadequate treatment and mistrust of mental health professionals.[15]

As an MBE provider, HHS is uniquely positioned to improve access, reduce mistrust, and offer quality care to a growing patient population. Its commitment to provide care to a vast majority of Medicaid patients also serves to demonstrate its commitment to the community. Again, HHS is not seeking to disparage the existing providers, but does believe it will offer a new option for high quality care to the community.

[15] https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

Cumulative Need: HHS demonstrated throughout its application that it has relied upon relevant data sources and has been transparent with the State where potential inadequacies lie. As a result of the limited data sources, HHS provided the state with a myriad of analyses, all of which demonstrated a consistent result of need for inpatient psychiatric beds for children and adolescents.

The ALOS used by HHS within the application is reasonable. Sheppard Pratt identifies that there is significant fluctuation and changes to the ALOS by provider, and that every provider has a different ALOS. Despite this, it does nothing to distract from the overall need in the community.

Even if HHS was to demonstrate a higher ALOS, the same number of patients need care, as identified within its analysis. The result of increasing its projected ALOS at the proposed hospital would only result in reduced total admissions and would further demonstrate a reduced impact to existing providers, such as Sheppard Pratt (See Section IV, below).

Sheppard Pratt stated: "[We recognize] that expanding capacity for behavior health services may be appropriate in Maryland..." HHS agrees and has provided the State with an opportunity to alleviate the need and has offered an overall assessment that demonstrates why that need exists.

(IV) HHS FAILS TO EVALUATE THE IMPACT OF ITS PROPOSED PROGRAM ON EXISTING PROVIDERS OR THE HEALTH CARE DELIVERY SYSTEM, COMAR § 10.24. 01.08G(3)(f).

HHS has provided the detailed information to meet the requirements set forth in the State Plan. The information provided is similar to what has been previously accepted by the MHCC to satisfy the requirements under COMAR § 10.24.01.08G(3)(f), See University of Maryland (Psych) - Docket No. 18-24-2429. In its response, HHS demonstrated the minor overall impact to the existing healthcare providers, including Sheppard Pratt. HHS also

provided a direct statement regarding the potential cost of care and confirmed it will decrease costs for patient. See, page 72:

> "These beds will assist in decreasing ED Boarding by alleviate bottlenecks at existing providers for these age groups. Doing so will decrease costs for patients, payors (including the State), and improve quality of care."

Furthermore, in assessing the costs associated with the proposed project in Table 5, Sheppard Pratt failed to account for the increase ALOS that it currently provides to its patient population. Sheppard Pratt noted that they used a 9.2 ALOS for all providers, despite earlier indicating they have a 13.1 ALOS for its non-neuropsych patient population. Using the actual ALOS of 13.1 for Sheppard Pratt and the average ALOS for Brook Lane between 2017-2019 from HSCRC Data, the total cost of care per patient at the proposed project is expected to demonstrate overall cost savings for the health care delivery system.

Provider	Patient Per Day Rate	HHS Projected Shift[16]	ALOS	Per Patient Charge	Total Charges at Source Hosp.	Total Charges at HHS	Impact to Healthcare System
HHS	$1,658		9.2	$15,254			
Sheppard Pratt	$1,288	136	13.1	$16,873	$2,294,701	$2,074,490	-$220,211
Brook Lane	$1,163	33	11.5	$13,375	$441,359	$503,369	$62,010
						Total Savings	$158,201

As explained in more detail above, the rate utilized by HHS also includes ancillary charges, which Sheppard Pratt also failed to include within its daily rate analysis in Table 5. These additional charges would prove to further demonstrate the cost savings the proposed location would have on the health system.

Using the reduced rate included in our modification application the impact would be more favorable to the proposed hospital:

[16] Using same numbers identified in Shepperd Pratt's Table 5 response.

Provider	Patient Per Day Rate	HHS Projected Shift[17]	ALOS	Per Patient Charge	Total Charges at Source Hosp.	Total Charges at HHS	Impact to Healthcare System
HHS (Modified Rate)	$1,586		9.2	$14,589			
Sheppard Pratt	$1,288	136	13.1	$16,873	$2,294,701	$1,984,065	$310,635
Brook Lane	$1,163	33	11.5	$13,375	$441,359	$481,428	-$40,069
						Total Savings	$270,566

Accordingly, HHS has met the standard demonstrating that we assessed the impact on the existing providers.

(V) THHS DOES NOT DEMONSTRATE IT HAS PLANNED APPROPRIATELY FOR PATIENT SAFETY AND OTHER QUALITY ISSUES.

Sheppard Pratt has "invented" a standard and then requests the Commission to accept its assessment that HHS fails to meet it. This is but another indication of Sheppard Pratt's commitment to maintain its "market share". HHS has a history of providing high quality care in its communities and shall ensure the same level of care is provided within the proposed hospital. As noted throughout the application, HHS currently offers a range of outpatient and partial hospitalization services and is accredited by CARF and The Joint Commission. HHS stated within the application under AP 3b (Pg. 22) that it has committed to obtaining TJC accreditation at the proposed hospital location and shall abide by all their standards.

The HHS hospital will be designed to meet the State and Federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted within the application, the plans are also in the schematic design phase and may be slightly updated to improve patient processes. Schematic design is defined as "the first phase of basic services for project design. At this stage in a project, the design professional describes the project three-dimensionally. A range of alternative design concepts are explored to define the character of the completed project and an optimum realization

[17] Using same numbers identified in Shepperd Pratt's Table 5 response.

of the project program".[18] As seen in Table E, HHS estimated nearly $950,000 in contingencies and other potential costs associated with the design of the building that may be used on improvements and updates to the floor plan. Illustrative safety measures are discussed below.

(a) Psychiatric Patient Safety: The floor plans provided by the applicant are clearly labeled Schematic designed, and meet the requirements identified within the State Plan. Further under COMAR 10.24.10 (12) HHS indicated: The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. HHS has also committed to adhering to the highest level of patient safety and compliance, as designated by The Joint Commission.

(b) Security: HHS will ensure that all areas are secure in keeping with federal and state regulations.

(c) Code and TJC Compliance: HHS has identified that it is committed to obtaining TJC accreditation.

(d) Separation of patient population: The floor plan demonstrates two different areas of the building each dedicated to serving a distinct patient population. Although there are shared hallways, HHS has indicated in AP 4b (Pg. 22) there is not requirement that patient population not share hallways, and other providers have successfully demonstrated that hey may do so in a safe manner, See, University of Maryland (Psych) - Docket No. 18-24-2429. HHS will ensure that patients will be separated at all times.

(e) Entrance and Admission: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the

[18] https://www.ucop.edu/construction-services/facilities-manual/volume-3/vol-3-chapter-1.html#:~:text=Schematic%20design%20is%20the%20first,realization%20of%20the%20project%20program.

plans are also in the schematic design phase and may be slightly updated to improve patient processes.

(f) Access to Unit: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the plans are also in the schematic design phase and may be slightly updated to improve patient processes.

(g) Other ingress and egress: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the plans are also in the schematic design phase and may be slightly updated to improve patient processes.

(h) Food Safety: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the plans are also in the schematic design phase and may be slightly updated to improve patient processes.

(i) Nursing Stations, Crash Carts: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the plans are also in the schematic design phase and may be slightly updated to improve patient processes.

(j) Seclusion rooms: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has

been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the plans are also in the schematic design phase and may be slightly updated to improve patient processes.

(k) Outdoor Space: The facility will be designed to meet the State and federal requirements and shall ensure high quality care and safety for its patient population. The hospital has been designed to meet the unique needs of the adolescent and child patient population and in keeping with the FGI Design Standards and Guidelines. As noted, the plans are also in the schematic design phase and may be slightly updated to improve patient processes.

B. Conclusion

As it is entitled to do as an interested party, Sheppard Pratt has put forth every conceivable argument in its opposition to the HHS application. The most telling basis for that opposition, we believe, is set forth in their comments regarding potential loss of revenue. That is not to say that HHS was correct in every aspect of its submission. Indeed, the modification submitted contemporaneously submitted with these responses confirms that HHS is eager to make corrections where warranted. Neither perfection, infallibility nor adherence to Sheppard Pratt's subjective operating practices (for the most part not disclosed with any particularity), are the tests for determining whether HHS has met its burden. HHS has demonstrated, as well as any applicant could based upon available data, both the need for the services to be provided at its hospital and that it is uniquely qualified to provide those services to all Marylanders including, in particular, those persons who as result of historical and continuing social and economic disadvantage are unserved or underserved.

Respectfully,

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EXHIBIT LIST

1. Population Estimates – Excel

2. Maryland HSCSC Custom Public Use File – four (4) Excel files

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

3/11/21
Date

Signature of Owner or Board-designated Official

CFO
Position/Title

Lanre Fadiora
Printed Name

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

3/10/21

Date

Signature of Owner or Board-designated Official

Executive Director

Position/Title

Yinka Fadiora

Printed Name

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

03/11/2021
Date

Signature of Owner or Board-designated Official

CEO
Position/Title

Oladipo Fadiora
Printed Name