MARYLAND
Health Care
Commission

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

January 25, 2023

VIA Email & U.S. MAIL

Arvin Singh
Vice President, Strategic Planning and Communications
University of Maryland Shore Regional Health
219 South Washington Street
Easton, Maryland, 21601

Re: Matter No. 23-20-2463
Shore Health System, Inc.
Relocation of University of Maryland Shore Medical Center at Easton

Dear Mr. Singh:

The Maryland Health Care Commission (Commission) staff has reviewed the above-referenced Certificate of Need (CON) application. Please provide responses to the following questions:

General

1. While we recognize a study group will be convened to address the disposition of the existing hospital site on South Washington Street, please provide the projected time frame to complete the analysis and final decision. Please describe any potential options under consideration.

2. What is the status of the Planning Commission's revised site plan approval?

State Health Plan

COMAR 10.24.10., General Standards

Charity Care Policy

3. Please provide a copy of the application used to determine probable eligibility for charity care.

4. The charity care policy states that "within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS ***may*** provide determination of probable eligibility" The charity care standard states that a determination of probable eligibility must be made within two business days. Please amend your policy to meet the standard and provide a copy of the amended policy.

G

COMAR 10.24.10.
Acute Hospital Services

Geographic Accessibility

5. Please demonstrate that the new hospital site will be located to optimize accessibility in terms of travel time for its likely service area population. The standard indicates that such a demonstration can be shown by defining the likely service area for general medical/surgical, intensive/critical care, and pediatric services and providing a travel time analysis that shows that at least 90% of this service area population is within a 30-minute travel time of the new hospital site, under normal conditions. The defined "Service Area" should be a "contiguous area comprised of the postal zip code areas from which the first 85% of " the replacement hospital's discharged patients are likely to originate.

Identification of Bed Need and Addition of Beds

6. The application states that the MIEMSS red/yellow alert system has kept a significant number of patients out of the emergency room, leading to a decline in patient admissions. Provide more detail on the factors that triggered the MIEMSS alerts. How do the Easton hospital's hours on alert compare with the experience of other hospitals that have substantive market share in the service area of University of Maryland Shore Medical Center at Easton (Shore Easton)?

7. The application states that currently, observation patients are dispersed throughout the hospital because there is no specified observation unit. Is the use of licensed beds by observation patients included in bed occupancy rates reported in the application?

8. How has the development of dedicated observation space, that should eliminate the practice of using licensed bed capacity to accommodate observation stays, influenced Shore Easton's need assessment for bed capacity in the replacement hospital?

9. The application references staffing shortages as a cause of the increased average length of stay (ALOS) (p. 49). Please provide more specific detail on how staffing shortages have affected ALOS for MSGA beds?

10. Table L shows 9.6 FTE reserved for the pediatric service. Provide more detail on the assumptions used for this staffing plan.

11. How has the "triple-demic" (COVID-19, RSV and influenza) affected the pediatric need assessment?

Construction Cost of Hospital Space

12. Please clarify whether the differential cost factor calculation in the MVS analysis includes the square footage (SF) for corridors, elevator shafts, and any unassigned areas. If not, please provide the SF for all these areas and revise the MVS analysis to include these areas. (pp. 81-82) Note: The total square footage reported on pp. 81-82 is 307,655 SF, whereas in Table 1, p. 79 you indicate the total square footage for the hospital is 382,977 SF, a difference of over 75,000 SF. Please clarify.

13. The MVS analysis uses the base cost of $485 dollars for the CUP, while the schematics refer to the construction as only a modular plant, not of the same construction type as the general hospital. Please provide a justification for using this base cost.

14. Please provide the Excel spreadsheets with the formulas and calculations used to determine the MVS benchmark and departmental differential factors for the proposed project.

Rate Reduction Agreement

15. This standard as written is no longer applicable. However, please address the hospital's position in the work that HSCRC has done in developing its Integrated Efficiency Policy. Does this work indicate that the Shore Easton is efficient or inefficient?

Patient Safety

16. Please address safety improvements for disabled patients and severely obese patients.

Financial Feasibility

17. The financial feasibility response defines Shore Health System differently than the comprehensive project description. On page 99, Shore Health System includes Shore Easton and the freestanding medical facilities in Cambridge and Queenstown but does not include the University of Maryland Shore Medical Center at Chestertown (Shore Chestertown) in the financial discussion of Shore Health System. Please explain why Shore Chestertown is not included? What is the status of Shore Chestertown in Shore Health System?

Emergency Department Treatment Capacity and Space

18. Please label the emergency department (ED) diagram, Exhibit 2, page 5, identifying the treatment spaces, including the psychiatric exam spaces, the behavioral health holding spaces, and the observation spaces. Also provide the SF for all the ED spaces.

19. The need for 25 observation beds is based, at least in part, on the increase in observation length of stay experienced between 2019 and 2022, an unusual time for hospital operations due to the COVID-19 emergency. Additionally, it is stated that staffing shortages and

COVID-19 were the drivers of the increase in the length of observation stays. Please provide more detail about the basis of the assumption that the ALOS in the observation unit will remain high. What assumptions have been made related to staffing and staffing shortages and how has that affected the staffing plan for the new hospital?

20. Describe any current or future efforts to divert non-emergency patients from the ED to more appropriate levels of care. What is the projected impact that these diversions will have on utilization?

21. Identify and discuss the number of uninsured, underinsured, indigent and otherwise underserved patients in the primary service area and the impact of these groups on ED use.

22. Is there dedicated ED space for the treatment of children and adolescents? Please describe any plans to accommodate that population. Did the hospital consider developing a combined ED/observation/inpatient space in the ED, given the very low demand for pediatric hospitalization, rather than the plan proposed for handling pediatric patients in a conventional nursing unit? Wouldn't such a configuration provide staffing efficiencies?

23. The application references three psychiatric holding rooms outside of the ED. What services will be provided to patients in these rooms? What safety features will be incorporated into these rooms? What is the projected length of stay for patients in these rooms?

24. Will the psychiatric holding rooms be used for pediatric and adolescent patients? If so, how will these rooms be outfitted to meet the special needs of these populations?

Shell Space

25. Please confirm that the project will not include the construction of any shell space.

COMAR 10.24.11.
General Surgical Services

26. Regarding the use of Metrix statewide data and HSCRC Experience Data (Tables 51-53 on pp. 123 - 125.), please clarify the source of the utilization data reported. It it from the electronic health records for each of the surgeons who performed surgical cases at Shore Easton? Or is this data reported by the hospital to these vendors? Please clarify whether this data includes only surgery at Shore Easton or includes other surgical facilities in the Shore system.

27. Given the improvements in the surgical suite design, the increased storage space for equipment and supplies, clean and soiled storage, etc., for the surgical services department, please explain the rationale for assuming a constant 45-minute turnaround time (TAT)

through FY 2032, as used in Table 53 on p. 125. Please discuss why the applicant did not use the 25-minute TAT assumption specified in the SHP.

28. Regarding Table 53 on p. 125. Please provide the Excel spreadsheet, assumptions and background methodology used to demonstrate the need for seven operating rooms (ORs). Please also include a more detailed discussion on block time and the impact of clock time on utilization and OR scheduling.

29. The applicant indicates that three Shore ambulatory surgical centers operate in Easton, Queenstown, and Cambridge. However Table 1 on page 9 lists outpatient centers throughout the five counties. Please provide more detail on the types of surgical services provided by these facilities and their case volumes and OR minutes. Please identify all centers in the system that perform outpatient surgery. Explain why these ambulatory surgical centers cannot be used to handle the outpatient surgical cases projected for performance at Shore Easton.

30. Please identify the surgeons, by specialty who performed surgical cases in the six ORs at Shore Easton in FY 2022. How many surgeons, by specialty, are assumed to be performing surgery at the hospital following project completion.

31. Please respond to Standard .05B(6)(a) & .05B(6)(b) on Patient Safety. Address the way in which the design of the surgical facilities and services will enhance and improve patient safety.

32. Please provide a response to Standard .05B(8)(a)(i)-(iv) with respect to Financial Feasibility that documents the information submitted and supports the financial feasibility for the project.

COMAR 10.24.12.
Inpatient Obstetric Services

33. On page 132 of the application, you discuss "a model commonly used in facilities with 900 or more births per year." Please identify the source of the referenced model and provide specifics on who or what organization developed this model and how it is used as an industry standard.

34. Are the two antepartum rooms intended to function as licensed beds for overnight hospitalization? If so, please elaborate on how they will be used and if it is intended that they be categorized as obstetric beds within the four planner-defined inpatient service categories used in licensing acute care hospital beds.

35. The application uses two different standards to calculate bed need ("Health Design Metrics" and SHP Acute Care Standard at 70% and later 80% to account for peak). Explain how MHCC should evaluate the use of these two different bed need methodologies.

36. On page 132, the application discusses "health design benchmarks." What are the benchmarks and who established these benchmarks?

37. Please provide the data for fiscal years 2019-2021 for Table 60 on page 137.

38. Please provide data for fiscal year 2019 for Table 65 on page 140.

39. Table 66 on page 141 is titled "UM SMC at Easton's Average and Peak Daily Census FY 2022." Please clarify the beds included in this table; does it account for both antepartum and postpartum beds, or postpartum only?

40. On page 149, the application states that "Some, but not all of these laborists have offices in the primary service area." Please identify how many laborists participate in the Shore Easton program. How many have offices within the primary service area of the hospital?

41. Please provide more detail on outreach programs that address low birth weight and infant mortality.

COMAR 10.24.09
Acute Inpatient Rehabilitation Services

42. The hospital is an existing provider establishing a new hospital in a new location. 10.24.09.04A(2)(b) states *"An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location… shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON."* Please respond to this standard.

43. Will the proposed acute rehabilitation unit comply with FGI Guidelines? How did design of the unit incorporate patient safety features?

COMAR 10.24.21
Acute Psychiatric Services

44. Please provide separate written quality assurance programs, evaluations, and treatment protocols for geriatric patients as the standard requests.

<u>Other Criteria</u>

Viability

45. Project funding includes $50 million in philanthropy. How much of the $50 million fundraising goal has been collected? What are the contingency plans if the applicant does not meet its fundraising goal?

46. Project funding includes $100 million of proposed funding from state government. It does not appear that this funding is included in the current administration's proposed budget. Please discuss any implications of this absence. Specifically, what is the impact of having to borrow an additional $100 million to fund the project?

Impact

47. Please provide a map of the Shore Easton service area that identifies the following:
    - The current location of the hospital;
    - The proposed location for the replacement facility;
    - The jurisdictional lines in the service area;
    - The major highways and roads in the service area; and
    - The existing or future public transportation routes in the service area.

Tables

48. Provide alternative versions of Tables F, G, and H that do not include revenues or expenses for the FMF operations in Queenstown or Cambridge, i.e, alternative tables that are limited to revenues obtained and expenses incurred at the existing Shore Easton hospital and the proposed replacement hospital.

49. Budget Table E - Please explain the methodology used or the basis for the $19.5 million in estimated Contingency Allowance and the $28.7 million in estimated Inflation Allowance.

50. With respect to the Workforce Table L, please discuss the projected FTE staffing reductions: MedSurg/Acute Direct Care (4.4); Med/Surg/Acute (11.6); Obstetrics (3.7); OR (9.1); ER (8.6); Lab (5.2); Pharmacy (2.1); Radiology (4.8); and Other Ancillary (14.2). Explain the extent to which these reductions in work force are attributable to the design of the new hospital or other factors.

51. Will any equipment currently in operation be moved to the replacement facility? Please explain the use of the term "in building" in Exhibit 1, Table E-Project Budget for Fixed Equipment?

Please submit four copies of the responses to the above questions and the requests for additional information within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov). If additional time is needed to prepare a response, please let me know at your earliest convenience.

As with the request itself, all information supplementing the request must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury

that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

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

Sincerely,
Wynee Hawk
Chief Certificate of Need

cc:

Andrew Solberg
Thomas Dame, Esquire
Mallory Regenbogen, Esquire
Alison B. Lutich, Esquire
Ruby Potter, MHCC
Paul Parker, MHCC
Caitlin Tepe, AAG, MHCC
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Maria A. Maguire, M.D., Health Officer, Talbot County