LUMINIS HEALTH DOCTORS COMMUNITY MEDICAL CENTER

CERTIFICATE OF NEED APPLICATION

ESTABLISHMENT OF AN OBSTETRIC SERVICE AND FACILITY EXPANSION AND RENOVATION

APRIL 7, 2023

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Part I

For internal staff use

MARYLAND HEALTH CARE COMMISSION

____

MATTER/DOCKET NO.

____

DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Doctors Community Medical Center**

Address:

8118 Good Luck Rd	**Lanham**	**20706**	**Prince George's**
Street	City	Zip	County

Name of Owner (if differs from applicant):
Luminis Health Doctors Community Medical Center, Inc.

2. OWNER

Name of owner: Luminis Health Doctors Community Medical Center, Inc.

3. APPLICANT. *If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.*

Legal Name of Project Applicant
Luminis Health Doctors Community Medical Center, Inc.

Address:

8118 Good Luck Rd	**Lanham**	**20706**	**MD**	**Prince George's**
Street	City	Zip	State	County

Telephone: 301-552-8118

Name of Owner/Chief Executive: Deneen Richmond, President

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:

____

5. **LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).**

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation 6/27/1989
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):	______	
D.	Limited Liability Company	☐	
E.	Other (Specify):	______	
	To be formed:	☐	
	Existing:	☒	

6. **PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED**

A. Lead or primary contact:

Name and Title: Jessica Farrar, Vice President of Strategic Planning and Decision Support

Mailing Address:

Street	City	Zip	State
2001 Medical Parkway	**Annapolis**	**21401**	**MD**

Telephone: **443-481-3449**

E-mail Address (required): **jfarrar@luminishealth.org**

Fax:

B. Additional or alternate contact:

Name and Title: Marta Harting, Counsel

Mailing Address:

Street	City	Zip	State
Venable, LLP, 740 E. Pratt St, Suite 900	**Baltimore**	**21202**	**MD**

Telephone: **410-244-7542**

E-mail Address (required): **mdharting@venable.com**
Fax: **410-244-7742**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☐
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☒
(4)	A change in the type or scope of any health care service offered by a health care facility	☒
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	☒

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

(1) Brief Description of the Project

The Applicant, Luminis Health Doctors Community Medical Center, Inc. (LHDCMC) proposes to (a) establish a new obstetric program; (b) construct a new acute care pavilion adjacent to the existing hospital building, and (c) renovate hospital infrastructure and surgical services facilities to improve hospital function. LHDCMC is committed to providing access to acute care services, including obstetrics, for residents of its service area.

The new acute care pavilion will be four stories and span 167,000 square feet. The first floor will provide an expanded main lobby as well as other patient and administrative and support functions. The second floor will include renovated general purpose operating rooms. The third and fourth floors will be dedicated to the new obstetric program

(2) Rationale for the Project

The new obstetric program will improve access to care, improve maternal and infant health outcomes, and expand program options for maternity care in northern Prince George's County. Although Prince

George's County has the second highest birth rate in the State of Maryland, the total number of licensed obstetric beds in the local region has declined from over 100 obstetric beds in FY2015 to fewer than 50 today. The lack of a sufficient number of obstetric beds in Prince George's County forces over 7,000 women to leave the County each year to deliver their babies and to receive other related services, including ambulatory obstetric and women's healthcare which is frequently located close to hospital obstetric services. Prince George's County has a low OB/GYN physician-to-population ratio. The dependence on out of county obstetric units and OB/GYNs creates inequities through transportation challenges, disjointed medical management of pregnancy and lack of perinatal and postnatal continuity of care. Prince George's County has high infant mortality rates, high number of low birth weight infants, and high teen birth rates

Renovations to the existing hospital support services facilities are necessary because existing support services areas are undersized for current hospital functions, and fall far short of what is needed for anticipated care needs and new programs in the future. Support services proposed for expansion include pharmacy, imaging and radiology, sterile processing, food and nutrition as well as overall patient flow spaces throughout the buildings. Renovations to the existing hospital surgical services department are necessary in order to improve operating room size and flow to allow for more efficient care and modern surgical equipment which is often too large to fit into older, smaller operating rooms.

(3) Cost

The capital cost of the project is $285,954,229. Details regarding the capital cost are in Table E of the CON Application Tables (Exhibit 1).

(4) Master Facility Plans

In 2021, Cannon Design and Ben Dyer Associates were engaged to assist with the development of a campus development plan along with a strategic facilities master plan for the LHDCMC Campus. The campus development effort included an assessment of the existing buildings and structures, vehicular and pedestrian access, memorialization of the existing utility infrastructure, and environmental analysis. Concurrent with the analysis of the site, a detailed evaluation of the interior spaces was performed with a focus on space utilization, physical condition, and functionality.

Upon the conclusion of the data collection and analysis, several guiding principles were established which are addressed by the proposed project, including:

1. Improving and simplifying vehicular and pedestrian circulation
2. Modernization of all visitor and patient care areas

3. Right sizing and optimizing space to promote integrated and efficient operations
4. Purposeful development and expansion to improve the services offered to the community

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. <u>If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.</u>

Applicant Response:

PART 1 -- BACKGROUND

LHDCMC was founded in 1975 as a physician-led hospital. Since its acquisition by the Applicant more than 30 years ago, LHDCMC has been a nonprofit acute care hospital located in Lanham. In that time, it has been recognized by U.S. News & World Report as a high-performing hospital in specialty care areas, and it is the only hospital in Prince George's County on Forbes' list of best midsize employers. It has earned Hospital Compare's four-star quality rating – the highest in Prince George's County.

LHDCMC was the first hospital in Prince George's County to open a comprehensive breast care center with a dedicated surgeon and has the largest lymphedema program in the area. It boasts a partnership with Children's National Hospital to provide pediatric emergency services and is an in-network hospital with Kaiser Permanente. LHDCMC has received the Healthiest Maryland and Business' Wellness at Work Gold Award.

In 2019 LHDCMC became part of the Luminis Health integrated health system. Luminis Health, formed in 2019, primarily serves residents of Anne Arundel, Prince George's, and Calvert Counties, and Maryland's Eastern Shore. Comprised of LHDCMC, Luminis Health Anne Arundel Medical Center (LHAAMC), J. Kent McNew Family Medical Center, and Luminis Health Clinical Enterprise (LHCE), the health system includes 829 licensed beds, more than 6,400 employees, 1,800 medical staff, and 1,300 volunteers.

The members of Luminis Health have always shared a dedication to compassionate care, delivered when and where people need it most. Now, the newly created $1.2 billion organization is carrying that same commitment into the future as a health system that is dedicated to promoting, facilitating and enhancing the delivery of quality, efficient, and effective health care, and improving the health and wellbeing of the communities it serves. That commitment is demonstrated through project proposed in this Application.

A. The Critical Need for Additional Obstetrics Capacity in Prince George's County

The proposed obstetrics program is intended to address the lack of adequate obstetrics capacity in Prince George's County that creates negative health consequences and inequities for Prince George's County residents. Prince George's County is the second most populous county in Maryland and has the second highest birth rate in the State, yet the total number of licensed obstetric beds in the County has declined from over 100 obstetric beds in FY2015 to fewer than 50 today. In 2021, UM Capital Region Medical Center, relocated from north of Route 50/New York Avenue corridor, inside the beltway, to south of Route 50, outside the beltway and has fewer licensed beds. Concurrently, Washington Adventist Hospital, with 21 licensed obstetric beds, relocated from Takoma Park to White Oak, a move of only a few miles but a greater distance to most of the LHDCMC service area population. Prince George's County also has a low OB/GYN physician-to-population ratio. This is because ambulatory OB/GYN practices are often located close to obstetric hospitals to facilitate the providers' ability to deliver both office and hospital-based care on short-notice.

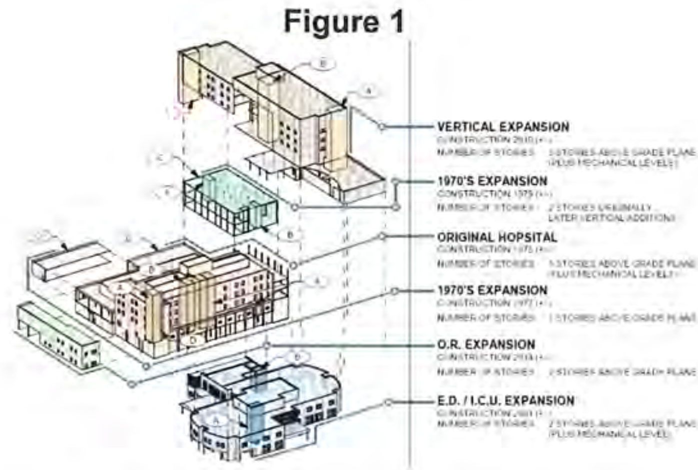
Although the LHDCMC service area reported 8,717 obstetric discharges in FY 2022, the limited options for obstetrics care in Prince George's County forced 82% of obstetrics patients (over 7,000 women) to travel outside the County for care. The dependence on obstetric units and OB/GYNs outside of the County creates inequities through transportation challenges, disjointed medical management of pregnancy and lack of perinatal and postnatal continuity of care. Compared to the rest of the State, Prince George's County has high infant mortality rates, a high rate of low-birth-weight infants, and high teen birth rates.

In addition to inpatient obstetric beds, Prince George's County needs community-based obstetrics care because easy access to OB/GYNs and local delivery sites are critical for the improvement of maternal and infant outcomes. The women of Prince George's County deserve access to obstetrical care close to home on the LHDCMC campus. As described further below, LHDCMC's proposed obstetrics program will improve access to obstetrical care and related services in Prince George's County, including outpatient ambulatory women's care from preconception health to postpartum care, gynecology, and breast health.

B. The Need to Modernize Hospital Support Services and Surgical Facilities

LHDCMC was built in several phases between 1975 and 2010 with two main floors, a four story (west) tower built as part of the original 1975 building, a six-story (east) tower built in 2010. The North Building and Annex is a 6-story medical office building constructed in 1975. There was a two-story expansion that housed a small expanded surgical suite as part of the 2nd floor that was built in several phases between 1979 and 2015. It is attached to the north side of the Main Hospital. **Figure 1** is a schematic that shows the construction of the main hospital in 1975 and the expansion and renovations in portions of the facility at LHDCMC over the years.

Figure 1



Unfortunately, in spite of many previous small expansion projects, the LHDCMC campus was not designed for efficient or substantial expansion or modernization. As evident from Figure 1, there has been a piecemeal approach to capital renovations to meet the need of the community which has resulted in an undercapitalized and undersized facility. The current hospital footprint is at its maximum capacity since the roadways for the campus are adjacent to the building on all sides. In order to expand horizontally, the entire campus roadway must be re-routed. Similarly, the foundation and structural support for the various portions of the buildings are not designed to accommodate significant upward expansion. Therefore, the hospital buildings are at their full capacity and unable to accommodate additional services, or expansion of space to modernize or renovate existing services.

Many of LHDCMC's existing support services departments, including Supply Chain/Material Management, Lab/Morgue, Environmental Services (EVS) / Linen, Lab, Food & Nutrition, and Information Technology services, do not meet space planning benchmarks for support services based on a similarly sized facilities and do not have the ability to accommodate the expanding clinical services necessitated by the new obstetrics program. The age of the facility is the reason many support services are not sized to modern standards and fail to meet industry benchmarks, operating at sizes from 10% to 85% the size of typical services in hospitals in the US. See response to COMAR 10.24.10.04B(6) below.

In addition to the inadequacies in LHDCMC's existing support service facilities, LHDCMC has outdated and inadequate surgical services facilities. LHDCMC is licensed for 12 general purpose operating rooms, but several of them are obsolete due to their size so cannot be fully utilized to meet the need for surgical services in the community served by LHDCMC. The current operating rooms are an average of 526 square feet, too small by contemporary standards. Additionally, the existing mechanical, electrical, and plumbing for the surgical suite were installed over 30 years ago and are subpar when compared to modern systems. The operating rooms also lack advanced lighting and mechanical controls which leads to less efficient systems with higher energy use. Sterile processing and other support services are not currently collocated for efficiency. Further, finishes throughout the surgical suite are dated and no longer appropriate, with wall tiles and coverings that do promote maximally clean and sterile environments.

PART II – PROPOSED PROJECT

The proposed project consists of two primary components: (1) service expansion through the establishment of an obstetrics program at LHDCMC, and (2) a capital project consisting of building a new acute care patient tower, renovating surgical suites and current infrastructure and support services by revising visitor and patient flow through the campus, and updating utilities.

A. Obstetrics Program

The obstetric program will provide a full obstetrics services to the LHDCMC market. The obstetric program integrates best practices in facility design, clinical operations for obstetric care, and security and safety for patients, infants and staff. The eighteen (18) Postpartum / Antepartum Unit patient rooms are standardized and designed for flexibility when necessary.

The obstetric program will be located on Level 3 and Level 4 of the Acute Care Pavilion. Level 3 will include the Labor & Delivery program including labor delivery recovery (LDR) rooms (6), Antepartum (3), Birthing Center (midwife) (2), with additional patient, family, and clinical support spaces. Level 4 will include the Postpartum / Antepartum Unit (18 beds), Level II Continuing Care Nursery (4 stations), Well-Baby Nursery (4 bassinettes), Respiratory Therapy and clinical support spaces.

The proposed obstetric program will meet the need in Prince George's County's for additional obstetrics services by improving access to care and maternal and infant health outcomes. The program will provide:

- Local access for patients who now travel to LHAAMC for deliveries.
- Local access for patients who now travel to Montgomery County and Washington, DC for deliveries.
- Additional OB/GYN providers who offer women's healthcare, prenatal care, pregnancy management, and postpartum care through hiring of additional clinicians by Luminis Health to provide OB/GYN care in the LHDCMC service area.
- Additional OB/GYN providers in the service area who accept Medicaid and have access to resources to help women obtain health insurance through state programs.
- Effective, integrated management of chronic medical conditions throughout pregnancy.
- Improved quality of care through expansion of existing and development of additional Luminis Health resources, including maternal safety bundles.
- Culturally responsive services and program offerings for a variety of ethnic and religious groups.

LHDCMC will deliver a comprehensive and integrated perinatal program incorporating outpatient services from preconception to menopause, and inpatient labor and delivery, postpartum, antepartum, and a special care nursery. LHDCMC will continue to work closely with LHAAMC and community providers to provide coordinated high quality pediatric and

neonatal care. A leader in women's services, LHAAMC ranks second among Maryland hospitals for the number of deliveries and has a Level III neonatal intensive care unit (NICU), providing high acuity care for premature and seriously ill newborns.

The obstetric program at LHDCMC will create opportunities for OB/GYNs to successfully provide care in this under-resourced region by offering (a) program affiliation with the well-recognized women's care programs of Luminis Health, (b) the laborist model at LHDCMC to attract clinicians seeking to leverage this program model and provide robust ambulatory clinical care in the community, and (c) a new, locally based facility with progressive design and programmatic features. The obstetrics program will also optimize health system resources locally and efficiently to support the broader health system strategy of Luminis Health.

The LHDCMC obstetric program is expected to yield the following community and population health benefits:

- **Provide access to a local delivery site and increase the number of ambulatory providers.** The establishment of this obstetrics program will empower community-based OB/GYN physicians to maintain and increase access to women's health services to address the shortage in the northern Prince George's County area. In addition, LHDCMC will hire at least four additional practice-based OB/GYN providers to add to its existing complement of four, to provide preconception, prenatal and postpartum care in Prince George's County. This will help to meet the need for additional clinicians in this undersupplied region. The introduction of this obstetrics program at LHDCMC is critical to recruiting and retaining clinicians in the area.

- **Improve maternal/child health outcomes and reduce health disparities.** Additional physician capacity will provide greater access to OB/GYN services, prenatal through postpartum, screening, prevention, and management of chronic conditions and mental health. Training and protocolized maternity care including integration with the Luminis Health Women's and Children's Committee on Quality and Safety at LHAAMC to support best practices and continuous quality improvement. Linkage and direct access to social services and case management and culturally responsive programs to increase patient satisfaction and promote patient engagement.

- **Reduce the C-Section rate through protocol development and utilization of the laborist model**. Reducing the C-Section rate will reduce average length of stay and total cost of care for obstetrics patients in the region. Hospitals across the country have demonstrated the opportunity to reduce low-risk, first birth C-section rates. LHAAMC is actively working to reduce the C-section rate and racial disparities in C-section rates. These initiatives and goals will continue across the Luminis Health system of care at LHDCMC. LHDCMC assumed a lower ALOS of 2.35 compared to the LHDCMC service area of 2.58.

- **Reduce travel time for obstetric care for patients who now rely on delivery sites in Montgomery County, Anne Arundel County, or Washington, DC.** The new

program is expected to reduce travel time for over 2,200 patients and their families, including the 800 service area patients who travel to LHAAMC.

B. Capital Expansion and Renovations

The new construction provides a new front door to the main facility, convenient access to the Acute Care Pavilion and redefines the arrival experience for the community. Constructing a new facility provides LHDCMC the opportunity to implement a flexible universal grid that accommodates all key clinical rooms to support the obstetrics program and allows for future flexibility to accommodate all patient care services.

The new construction also allows for key functional adjacencies identified by OB/GYN clinicians, such as the C-Section Suite being located directly above the expanded Surgical Suite, to achieve and create clinical efficiencies for patient care delivery and staff efficiency. The location for the new construction connects to the existing LHDCMC support services circulation spine, and defines a service zone for the entire LHDCMC existing hospital with efficient distribution patterns and support/materials flow to both the new construction and existing hospital.

1. New Acute Care Pavilion (New Obstetric Program, Support Services and Renovated Surgical Services)

The new acute care pavilion will be four stories and span 167,000 square feet. The first floor will be largely patient flow space, allowing for redesigned lobby and entry to various hospital services, as well as expanded space to enable support services expansions and renovations.

LHDCMC's surgical services are located on the second floor of the existing hospital, adjacent to the planned new pavilion. The new pavilion will be constructed to allow for the second floor to be dedicated to surgical services to allow seamless flow between the new pavilion and existing acute care pavilion. As discussed above, LHDCMC currently has 12 general purpose operating room licenses, but they cannot be fully utilized due to size constraints. Through this expansion and renovation, LHDCMC proposes to maintain 12 total operating rooms, but to convert two of the current licenses to dedicated C-section operating rooms. The second floor is designed, between the new facility and renovations, to provide space for 10 modern, general purpose operating rooms as well as collocated and resized support services such as sterile processing.

The new obstetrics program will be located on the third and fourth floors of the new pavilion. The facility is designed to integrate best practices in hospital obstetrics program design and clinical operations for obstetric care as well as safety and security for patients, infants, and staff. The obstetrics spaces will be used for all aspects of care delivery, including space dedicated to labor, delivery, recovery and postpartum. The two dedicated C-Section operating rooms will be located on the third floor of the new pavilion to provide fast access to surgical obstetrical care when needed.

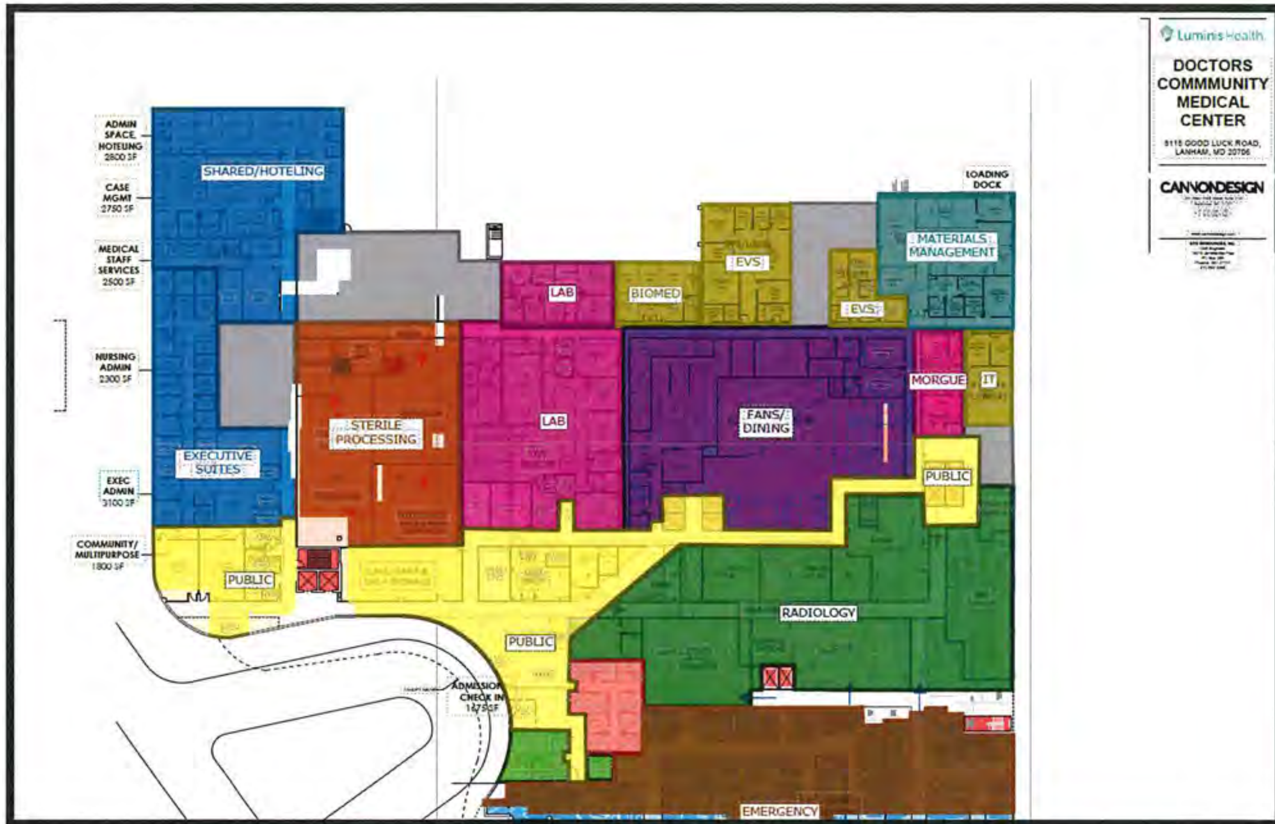
Specifically, the four floors located within the proposed pavilion will be used as follows:

Level 1

Entrance/Lobby/ Support Services

- Redesigned Lobby. The new pavilion's construction adjacent to the existing building will allow for a redesigned lobby and main entrance with areas for an information desk, admissions / check-in / and health information management. There will be centralized areas for security, a dedicated space for community / multipurpose room, public toilets, an expanded café with grab & go service, and administrative areas for executive use, medical staff services, nursing administration, case management, and shared office space.
- Sterile Processing Distribution (SPD). In its current state, the SPD function is undersized for the volume of service provided at DCMC with no area to expand and refine workflows. The new SPD will be relocated to the first floor, directly below the surgical services, which will allow for improved function and efficiency of current operations with direct vertical connectivity to the operating room suites on Level 2.
- Loading Dock. The loading dock is woefully undersized, and with the new pavilion's location adjacent to the current loading dock, the loading dock will have to move to the other side of the building where it will be adjacent to roadways. The relocation and expansion of the loading dock will allow for it to properly support the supply chain and will create efficiencies for receiving and distribution.
- Supply Chain Management. This service will be relocated adjacent to the new loading dock in increased space.
- Laboratory. The current lab space is adjacent to the new construction, which will allow for expansion into adjacent new building as well as allow for partial renovation of the existing lab. This will also allow for the morgue to be relocated closer to the new loading dock.
- Support Services Staff Lounge & Lockers. This will relocate to a vacated portion of the current Supply Chain Management Warehouse, which is most suitable for efficient access and workflows.
- Food & Nutrition. The renovation will allow for a renovated and expanded dining area with additional seating for patients, families, and staff, and a new servery that will move into vacated administrative space. We will also have a partial renovation of the existing kitchen/food prep area.
- Environmental Services (EVS). This service will undergo renovation and expansion into the vacated Information Technology (IT) space.
- Laundry Service. Clean linen and new laundry service will be provided in the vacated Pharmacy space.
- Imaging. This service will expand in place to meet planning benchmarks; Nuclear Medicine is also part of the Radiology department

The following drawing provides a general schematic of the first floor, after new construction and renovation is complete.



Level 2

Surgical Services

- Expansion of the existing size of the second floor will allow for expanded and reorganized operating room suites. The new and renovated surgical space will provide operating rooms based on current best practice technology and space requirements with an integrated sterile core and vertical connectivity to SPD, located directly below on the first floor.
- Relocating and renovating surgical space will allow for reorganization of the existing procedural space such that there will be dedicated space for procedure rooms, cath and interventional radiology services, and prep and recovery bays. This will enhance procedural efficiency as well as efficiency for the operating rooms and surgical services staff.
- Renovation of space vacated by the surgical services in the existing building will allow for space to provide a new Post-Anesthesia Care Unit, as well as spacious prep and recovery areas. This will allow for better efficiency for staff and improved experience for patients and families as well as better overall circulation through the entire second floor surgical and procedural space.
- Pharmacy – The pharmacy will relocate to the second floor, where it will have additional space to expand to better meet the needs of existing and future patients. The space that is vacated by relocations of other services, including cardiac rehab and BioMed will allow for more convenient and safer design and flow for pharmacy.

- Respiratory Therapy will relocate into a portion of space vacated by other services. This will improve access to clinical spaces.

The following drawing shows that second floor departments will be much less broken up and given space to function with high efficiency in the new design.

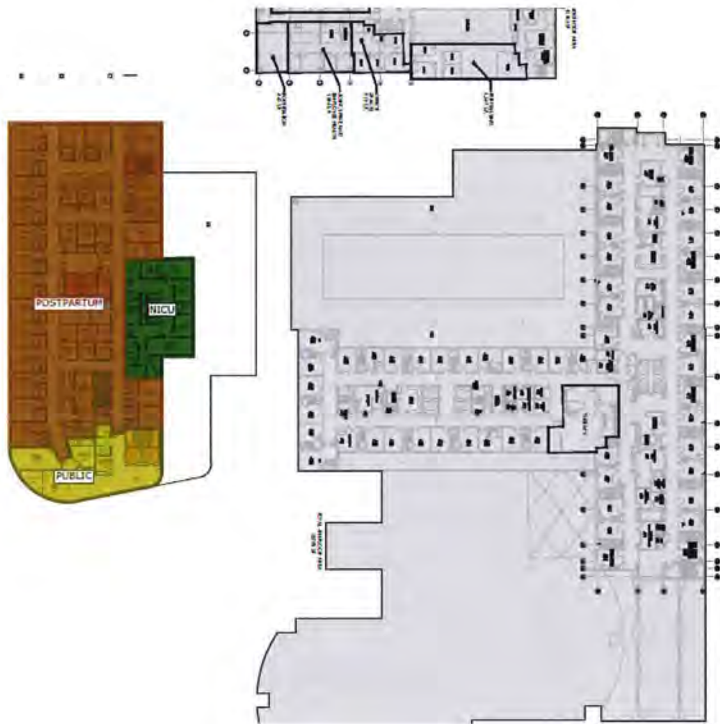
Levels 3 and 4
Obstetrics Program

- Level 3 is new construction and will include obstetric triage, six Labor Delivery Recover rooms (LDRs), two LDRs designed for a birthing center experience for patients delivering with a midwife, and three Antepartum rooms.
- Level 3 will have two dedicated C-Section operating rooms, On-Call rooms, and associated clinical support.

The following is a general schematic of the 3rd floor, after new construction.

- Level 4 will have 18 Postpartum beds and the Level II Nursery.
- The Level II Continuing Care Nursery will have 4 stations and 4 bassinettes as a part of the Well-Baby Nursery.
- Respiratory Therapy, and associated clinical support will be located on Level 4.

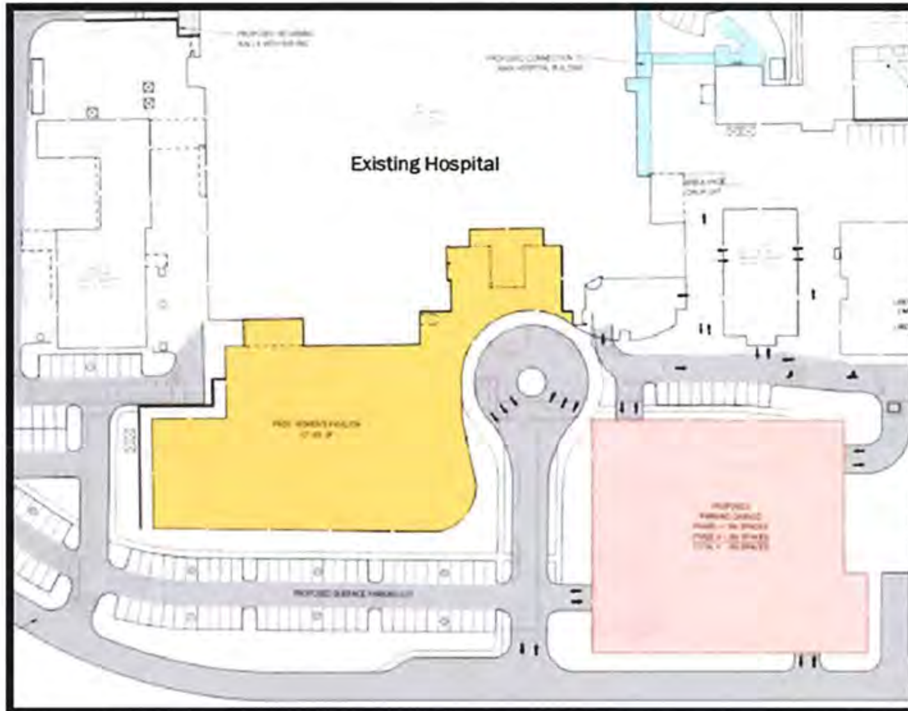
The following is a general schematic of the 4th floor, after new construction.



2. Renovation of Existing Acute Care Facilities

The new tower will also allow additional room to resize, modernize, and renovate many hospital support services, including pharmacy, imaging and radiology, sterile processing, pre- and post-operative care, food and nutrition, and patient flow (lobbies, corridors and waiting areas). As described above, surgical services will also be expanded to extend from the current space in the main hospital pavilion into the new pavilion. This expansion will improve operating room size and flow to allow for more efficient care and modern surgical equipment, which is often too large to fit into older, smaller operating rooms.

The following is a schematic showing the new pavilion construction adjacent to the existing hospital pavilion.



3. Site Development, Circulation and Utilities

With the proposed campus expansions, significant changes to the overall site are required, including the loading dock and utilities. The loading dock requires relocation and expansion so it can properly support the supply chain and efficiencies for receiving and distribution. The utility infrastructure for water, electric and wastewater systems requires and overhauling. Over the lifetime of the LHDCMC campus, the utility systems on and off campus have grown in their complexity.

C. Required Information

(1) Construction, renovation, and demolition plans

LHDCMC proposes a multi-phased capital improvement project that will require site modifications, an addition to the existing facility (the Acute Care Pavilion), and renovations to the existing hospital. The project will enhance functional efficiency, patient experience and space deficiencies. LHDCMC proposes a four level Acute Care Pavilion that will accommodate administrative and clinical support services on Level 1, Surgical Services on Level 2 and two (2) floors to provide Obstetrics Services to the community (referred to as The Maternity Center in construction documents).

The Acute Care Pavilion, obstetric program and internal department renovations will be developed based on current standards and requirements established by the 2022 Guidelines for Design and Construction of Hospitals by the Facility Guidelines Institute (FGI) and is designed with careful consideration given to patient's, infant's and staff's safety, comfort, and convenience. The projects have also been planned to achieve LEED Silver requirements.

Acute Care Pavilion

The proposed Acute Care Pavilion will include a four-story addition along with a penthouse; a two-story main entrance, and lobby space that connects directly to the existing hospital. This provides operational efficiency between new and existing functional programs.

The proposed exterior building envelope will be a modern reinterpretation of existing campus materials, paired with new complimentary materials. A palette of masonry rain screen, metal panels, and glass will create a warm and welcoming image. The penthouse massing of the addition is shifted to the south, engaging with the south facade to create prominence at the highest visible location on arrival to the campus. Level 1, Level 2, and Level 3 of the Acute Care Expansion align and connect to the existing hospital. Level 4 does not connect back to the existing hospital.

To provide a main entrance with significantly more presence on the campus and in the community, LHDCMC has chosen to locate the Acute Care Pavilion in the parking lot immediately west of the main entrance at the top of the sloped loop road upon entry to the LHDCMC campus. This will provide an arrival destination that is clearly visible and distinct as visitors arrive on campus. The Acute Care Pavilion will have an inviting form welcoming patients, staff, and visitors. Parking will be adjacent to this new main entrance, benched into the natural slope of the campus, tempering its visual mass, and maximizing convenience for patients and visitors.

A new designated service corridor will be the "back of house" support spine that unites the new Acute Care Pavilion to the existing hospital. It will allow for efficient flow of staff, materials,

linen, equipment, trash, etc. On the new designated services corridor, vertical circulation is addressed with two service elevators, one to transport patients, staff, and one to transport materials to and from the Acute Care Expansion.

The four levels of the Acute Care Pavilion are as follows:

Level 1

- Lobby Services – Main Entrance with areas for Information Desk, Admissions / Check-in / HIMS (ROI) Security, Community / Multipurpose, Public Toilets, Café / Grab & Go, Executive Administration, Medical Staff Services, Nursing Administration, Case Management, Hoteling space.
- Sterile Processing Distribution (SPD) – relocation/ expansion to improve function and efficiency of current operations with direct vertical connectivity to the OR suite on Level 2.
- Building Services – elevator and stairs.
- Loading Dock – new 5 bay loading dock including 6,000 sf new construction for EVS medical waste management, Gas Cylinder Storage, Soiled Linen and Emergency Preparedness Storage.

Renovation

- Gift Shop – relocates to vacated Lymphedema Clinic.
- Corridor connection from new Acute Care Pavilion to existing support services corridor.
- Laboratory - expansion into adjacent shell space, partial renovation of existing Lab and a new Morgue located closer to the new loading dock.
- Supply Chain Management – is relocated adjacent to the new loading dock in increased space.
- Support Services Staff Lounge & Lockers - relocates to vacated portion of the current Supply Chain Management Warehouse.
- Food & Nutrition - renovate and expand dining seating and servery into vacated administrative space; partial renovation of kitchen/food prep area.
- Environmental Services (EVS) - renovation and expansion into the vacated Information Technology (IT) space.
- Clean Linen and new Laundry service will be provided in the vacated Pharmacy space
- Circulation corridor and wayfinding improvements.
- Imaging – will expand in place to meet planning benchmarks; Nuclear Medicine is also part of the Radiology department.

Level 2

Surgical Services

- Expansion of the existing operating room suite to provide ten operating rooms based on best practice, technology and space requirements; with integrated sterile core and vertical connectivity to SPD.
- Two dedicated procedure rooms and six (6) prep and recovery bays.

Renovation

- Renovate existing Surgery suite to provide new PACU, prep and recovery areas.

- Implement new circulation corridor on Level 2 for arriving Surgical and Endoscopy outpatients.
- Cath/IR - relocate and expansion into vacated PACU. Adjacent to the Surgery Suite.
- Non-Invasive Cardiology – relocate into vacated Cardiac/Angio space adjacent to Cath/IR.
- Pharmacy – relocate to Level 2 and expansion into vacated Cardiac Rehab, BioMed, Shell Space, and support areas.
- Respiratory Therapy – relocate into a portion of vacated Nuclear Medicine.
- New GME space will be provided in a portion of vacated Nuclear Medicine.
- ICU/CCU Admin – renovate to provide new circulation corridor to Acute Care Pavilion.
- IT – relocate and expansion into vacated support areas.
- Circulation corridor and wayfinding improvements.

Level 3

Obstetric Program

- Triage, LDRs (6), Antepartum (3), Birthing Center (midwife) (2), C-Section (2), On-Call rooms, and associated clinical support.
- Building Services – elevator and stair.

Renovation

- No renovation.

Level 4

Obstetric Program

- Postpartum and Antepartum Unit (18 beds), Level II Continuing Care Nursery (4 stations), Well-Baby Nursery (4 bassinettes), Respiratory Therapy, and associated clinical support.
- Building Services – elevator and stair.

Renovation

- No renovation.

Mechanical Space / Penthouse

- Main mechanical and electrical spaces are located on Level 1 adjacent to the Support Services zone.
- Mechanical Penthouse is also proposed for mechanical equipment specifically to serve the Acute Care Pavilion.

<u>Acute Care Pavilion – Circulation</u>

The Acute Care Pavilion proposes four new elevators and is organized with a designated public circulation/transport zone that is separated from patients, staff, and materials movement.

- Two designated public elevators for surgical and obstetrics patients and visitors are provided from the Main Entrance on Level 1 to the surgical services located on Level 2 and obstetrics services located in the obstetrics program on Levels 3 and 4.
- Two patient / service transport elevators are provided in the support service zone for the movement of patients, staff, and materials.
- Obstetric patients arriving from the Emergency Department will be transported on Level 1 to the off-stage patient corridor to the patient elevators to Level 3 Staff and support service areas have designated entrances and zones separate from public entrances.
- Upon arrival, the new main entrance located on Level 1 will serve as the primary point of access and wayfinding for all patients and visitors.
- Obstetric program patients and authorized visitors will check-in on Level 1 in order to gain access to Level 3 and Level 4 obstetrics services via dedicated secured elevators and stairs.

Acute Care Pavilion - Security Features

As part of the Acute Care Pavilion, there will be specific features that address the potential of infant abduction that distinguishes the program from general health care services. The following features address safety and security as well as best practice functional design features:

- Secure Zones: Overall facility design and configuration will include secure mother-baby inpatient zones to prevent non-authorized patients, visitors, and family movement throughout the Maternity Center's inpatient care and nursery zones.
- Access points: Department / facility configuration will incorporate safety and security. Secured doors at all entries and stairs to the Obstetrics Labor and Delivery and Postpartum areas to control access.
- IT Access Control Systems: The Obstetrics zones and access points will also have dedicated security monitoring and notification systems. These security systems include electronic access control such as card readers, cameras, door prop sensors, and infant abduction sensors.
- Communications: Monitoring / alert systems will be provided to support clinical and security protocols.

Loading Dock

Existing: The existing receiving dock is immediately adjacent to the main entrance creating congestion for patients, staff and visitors. One of the key challenges for the existing LHDCMC campus is to improve campus flow and wayfinding and clearly separate service circulation from main entry circulation. The current loading dock is functionally deficient and undersized and will need to be relocated to accommodate the Acute Care Pavilion.

Proposed: A new loading dock is planned to be located in the newly defined support zone of the site, adjacent to the northeast corner of the medical center building on Level 1. This relocation will enable the loading dock to have proper access and configuration, as well as have increased space to meet contemporary space planning benchmarks.

An approach area dedicated to the loading dock will be sized in length and width to allow for maneuvering, docking, and entry/exit of service vehicles and trucks. The surface parking area that serves the loading dock will be connected directly to the new loop road for ease of access, redundancy in circulation, and separation of public and private functions.

(2) Changes in square footage of departments and units

Changes to the overall building square footage, and the square footage of departments and units are detailed in the attached **Exhibit 1**, Table B.

(3) Physical plant or location changes

Mechanical Systems:

- New water-cooled chillers (N+1) will be provided for the Acute Care Pavilion. They will be connected to (N+1) cooling towers on the roof. Base mounted pumps (N+1) with variable speed drives will be included. Chilled water distribution piping will be installed to serve the new air handling equipment.
- Dual fuel condensing type hot-water boilers (N+1) will be provided for the obstetric program. They will utilize variable speed pumping systems. Stainless steel vent and combustion air pipes will be connected to the boilers. Heating hot water distribution piping will be installed throughout the Acute Care Pavilion. A below ground fuel oil storage tank will serve the dual fuel boilers.
- A steam boiler system will serve the Sterile Processing Department (SPD) needs for equipment washing and sterilization.
- Custom type indoor air handling units will be located in the Mechanical Penthouse. The air handlers will be constructed for healthcare applications and include a return fan array, hot water coil, humidifier, chilled water coil, UV light array, supply fan array, energy recovery wheels and final filters.
- Clean steam generators will provide humidification for the air handling systems.
- Supply air and return air will be ducted to pressure independent double wall VAV and CV boxes as required for pressurization. Air devices will be installed throughout the facility. Smoke and fire dampers will be provided as required by code.
- Each air handling unit will have a dedicated general exhaust fan. Independent exhaust systems will be provided for Pharmacy Compounding Rooms, Med Gas Rooms, Sterile Processing Distribution (SPD) and Isolation Rooms.
- Ductless split systems will be provided for spaces requiring independent supplemental cooling.
- Four-pipe fan coil units will be provided for supplemental cooling and heating in limited support spaces.
- All piping and ductwork will be insulated as required by the Energy Code.
- The existing Andover BMS will be expanded to serve the Women's Pavilion and existing air handling units serving the Acute Care Pavilion.

Plumbing and Fire Protection Systems:

- Domestic cold water will be extended from the new loop road utilities to feed fixtures throughout the Acute Care Pavilion. A domestic water booster pump skid will be installed to serve the Acute Care Pavilion. Domestic hot water will be provided with semi-instantaneous gas fired domestic water heaters.
- The Acute Care Pavilion will have a sanitary waste and vent system along with a storm water drainage system
- Natural gas will be provided from a new service.
- Oxygen will be extended within the existing building served from the existing central tank and generator system.
- Nitrogen, Carbon Dioxide, and Nitrous Oxide will be extended from the new loading dock medical gas storage rooms.
- Medical air and medical vacuum pump skids will be provided for the Acute Care Pavilion.
- The Acute Care Pavilion will be fully protected by a sprinkler system. The majority will be wet pipe but IT rooms will be a pre-action system.
- A new fire pump will be installed to serve the new addition along with the existing Pavilion.

Electrical Systems:

- A new electrical service will be provided for the Acute Care Pavilion, including 20% future expansion. Two Electrical Secondary Services will be provided at 480Y/277 volts, 3-phase, 4-wire effectively grounded wye system. Electrical service entrance equipment will be configured in a double ended arrangement with a tie breaker.
- For the Acute Care Pavilion, an Emergency Power Supply System (EPSS) will be provided per the requirements of National Electrical Code Article 517. A generator will serve as the EPSS will be located in the south end of the parking garage adjacent to the new pavilion. Emergency Life Safety power will be provided for egress lighting, fire alarm, and telecommunications. Emergency Critical power systems will provide power for patient lighting, nurse call systems, etc. Equipment emergency power will be provided for mechanical systems for patient support, elevators, med-gas systems and general utilization. Each of these power sources will be provided through separate automatic transfer switches. This new EPSS will be dedicated to the Acute Care Pavilion.
- Power isolation panelboards will be provided for the Operating and Procedure rooms within the acute care pavilion per NFPA 99 Requirements.
- A new Fire Alarm System will be provided in accordance with NFPA 72 requirements for the Acute Care Pavilion that will integrate with the existing campus fire alarm system. Fire Alarm System will be a complete microprocessor based, networked, addressable, fire alarm system with true alarm devices with voice notification. The system will be installed to meet ADA requirements.

- A Lightning Protection system will be provided for the acute care pavilion and loading dock addition. Lighting protection equipment will consist of a roof perimeter mounted air terminals with down conductors installed per NFPA 780 requirements. The lightning protection system will be certified by an approved UL certified installer and will have the UL master label.
- The existing hospital electrical service equipment, which are originally installed Switchboards, are obsolete and past their serviceable life. The proposed renovation will include the replacement of this equipment. To continue operation of the existing hospital and limit utility power outages, a phased method of replacement will be utilized incorporating new equipment installed prior to removal of existing equipment.
- To facilitate construction of the new Acute Care Pavilion, the existing loading dock will be demolished, and a new loading dock will be constructed on the east side of the existing hospital. The existing ductbank from the existing generator serving the hospital is routed underground where the proposed new loading dock will be located. It has been noted that during power outages, the existing generator has insufficient power to support currently loads. Therefore, a new generator plant will be provided at the new loading dock. The generator(s) will be sized to account for the existing loads, the new Acute Care Pavilion and loads for future hospital expansions. To accomplish replacement of the existing generator, a temporary generator must be provided for the duration of the loading dock construction project until the new generator plant is completed and online.
- Electrical services serving the Sterile Prep Department and the Core Lab will be upgraded to include additional generator capacity in their new locations. Currently the power needs are not met for these departments utilizing the current existing generator infrastructure.
- Existing electrical services and panelboards for the existing Cardiac Cath department are beyond their useful life and capacity and will be replaced and upgraded. New utilities will be provided for the department with ample capacity and include future upgradability.
- To support the relocated pharmacy, new increased electrical infrastructure, both normal and emergency power, will be developed. Capacity will be provided for current needs as well at future capacity in support of future upgrades.
- For the renovated imaging suite within the main hospital, select imaging equipment will be served from a UPS power system based on owner requirements.
- Throughout the entire project, General Lighting Design Concepts will be developed in collaboration between the architectural and engineering teams, the lighting design concepts will provide holistic integration of electric and natural lighting systems within the architectural environment. The lighting systems will be designed to enrich the building's environments by meeting the visual needs of the building users while complimenting the architecture and surface finishes. The lighting will be developed in full support of programmatic requirements and will be designed to provide illuminance levels in accordance with IESNA recommendations. The lighting system will support the sustainable design and energy efficiency goals of the project and will be designed

to enhance visual quality while minimizing lighting energy use. Lighting power density and lighting control systems will be specified to conform to IECC 2018 and LEED requirements. Efforts will be taken to further reduce the lighting load without compromising functionality or quality of the illuminated environment.

- Throughout the entire project, upgraded lighting controls will be provided. Currently the lighting control systems in place do not comply with current code requirements and are unable to maximize energy efficiency. Lighting control systems will be implemented in such a way to maximize energy efficiency while not negatively impacting the health and safety of patients or staff. New lighting controls will conform to the requirements of the International Energy Conservation Code.

(4) Changes to affected services following completion of the project

See **Exhibit 1**, Table B

(5) Multi-phase project description:

The loading dock relocation, acute care expansion, and the internal department renovations require a phased construction approach to prepare the LHDCMC campus for the new construction. Construction phases include site development projects for a new parking garage, campus roads, site utility upgrades and a loading dock relocation. This site development enables construction of the Acute Care Pavilion. Following completion and activation of the Acute Care Pavilion, interior renovations within the existing hospital will be completed as described below.

The proposed project will be executed in the following phases:

Phase One (16-month duration) – Loading Dock Relocation

Phase Two (24-month duration) – This will involve constructing the new 4 level Acute Care Pavilion, including the obstetric program, penthouse, and connections to the existing hospital.

Phase Three (24-month duration) – Renovations – This phase will involve renovating existing Hospital spaces. Scope of renovation includes.

- Food & Nutrition (Dining, Servery, Storage)
- New Supply Chain Management Area
- Laboratory (partial) modifications in place
- Morgue relocates closer to the service dock area
- Addition of public restrooms
- Gift Shop
- EVS & Linen services
- Staff Lounge / Locker rooms

- Information Technology associated administrative spaces
- Imaging
- Surgical Services PACU, Prep and Recovery Areas
- Cardiac Cath/IR
- Non - Invasive Cardiology
- Pharmacy
- ICU/CCU Admin
- GME administrative areas
- Respiratory Therapy

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: ___40___ acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO ___X__ (If NO, describe below the current status and timetable for receiving necessary approvals.)

The site is located in Lanham, Maryland, and falls under Prince George's County jurisdiction and is subject to regulations and procedures of all requirements. This includes the Department of Permitting, Inspections and Enforcement (DPIE), MNCPPC for Environmental and Site Planning, WSSC for water and sewer, MDE, etc.

Prince George's County passed legislative bill CB-40-2021 allowing LHDCMC to forego the special exception requirement. The preliminary plan of subdivision has been approved by MNCPPC. Subsequent environmental site approvals are in process and will be obtained prior to initiating construction.

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Luminis Health Doctors Community Medical Center, Inc. (f/k/a Doctors Hospital, LLC)
Please provide a copy of the deed. **See Exhibit 2**

(2) Options to purchase held by: ______________________
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: ______________________
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: ______________________
Please provide a copy of the option to lease as an attachment.

(5) Other: ______________________
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	n/a	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	n/a	months
Completion of project from capital obligation or purchase order, as applicable	n/a	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract		months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.	n/a	months
Initiation of Construction within 4 months of the effective date of the binding construction contract.	n/a	months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract	n/a	months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase	n/a	months

Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Contract 1: Loading Dock		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date	6	months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1	4	months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.	18	months
Contract 2: Acute Care Expansion		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on Phase 2 within 4 months of the effective date of binding construction contract for Phase 2	4	months
Completion of Phase 2 within 24 months of the effective date of binding construction contract for Phase 2	24	months
Contract 3: Internal Renovations		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on Phase 3 within 4 months of the effective date of binding construction contract for Phase 3	4	months
Completion of Phase 3 within 24 months of the effective date of binding construction contract for Phase 3	24	months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16" scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as "shell space".

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after

the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

Applicant Response:
Project drawings are attached as **Exhibit 3** (full size drawings filed with the Commission with the hard copies of this Application).

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

C. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

Existing Stormwater Management
Field observations reveal that on the main hospital campus there are few practices that would qualify as "ESD" (Environmental Site Design) devices as defined by stormwater guidelines established by the Maryland Department of the Environment (MDE). There are two places where parking runoff is entering features designed to manage stormwater. One is at the south end of the doctors' parking lot. The second stormwater management feature is in a parking island at the site's northern end.

There are a few underground stormwater management devices around the campus. There are 4 facilities in the parking area on the south side (near the Mallery Drive cul-de-sac). There is one large micro-bioretention facility on the north side of the Rehabilitation Center property. There are bioswales in the northeast corner.

Stormwater management is subject to review by Prince George's County Department of Permits, Inspections and Enforcement (PG DPIE). Stormwater management design will be provided in accordance with the 2000 Maryland Stormwater Design Manual with updates per Maryland's Stormwater management Act of 2007 and the Maryland Stormwater Management Guidelines for State and Federal Projects, February 2015, as well as any more stringent requirements by PG DPIE. Because the existing site is in Prince George's County, the site is treated as new development and all impervious surfaces must be treated. The proposed storm water management strategy is

to utilize micro-bioretention or other ESD facilities to accommodate both quantity storage and quality management of all runoffs.

Storm Drainage
Roof and site surface drainage will be collected in ESD facilities. Treated runoff will be collected by underdrain systems. Due to its location in Prince George's County, the campus is subject to 100-year storm quantity management. A large surface detention pond or underground storage facility will be required.

Water
The 2016 ALTA survey depicts 7 hydrants in proximity to the main hospital campus. Of the 7 hydrants, 6 of them encircle the main hospital complex. The 7th hydrant is on the southeast side of the cul-de-sac at the end of Mallery Drive. The hydrants are served from a water line that enters the property from Good Luck Road at the main driveway. A 2009 hospital site plan depicts this service line coming from a 30-inch water main in Good Luck Road. From that source, the 8-inch service extends north, passing by the main hospital entrance and then turning at a 45-degree angle to enter the corridor between Surgical Services and the North Building/Boiler area. In that corridor, the water line reduces to a 6-inch line that continues wrapping around the east side of the hospital. There is another water service that enters the property from Good Luck Road. This 6-inch service is under the exit road on the east side of the parking deck and extends north to the wall of the Catholic Charities building.

The existing 8" water main will extend to the new building. Existing fire hydrants will be utilized, and new hydrant(s) will be added west of the expansion as required. The new building will require fire department connections (FDC).

Sanitary Lines
The 2016 ALTA shows a sewer easement on the west side of the main entry driveway. Field observations confirm there is a sanitary manhole in the green space beside the road. The 2009 hospital site plan depicts an 8-inch sanitary service following the driveway route and connecting into the public sanitary line via a manhole in Good Luck Road. Visible information suggests a flow route that enters 8-inch public lines in Good Luck Road and then continues flowing west. Another sanitary line exits the property on the east side of the parking deck. That 6-inch service flows from the area around the Behavioral Health Pavilion. On the Rehabilitation Center site, construction drawings show separate 4-inch and 6-inch connections draining east toward the Nightingale Drive right-of-way (residential neighborhood).

A new 8" gravity sanitary service line will be installed from the new building expansion to the point of connection just west of the Emergency Services Building. A new manhole will be required at the point of connection.

Electric

The LHDCMC campus is being converted to a PEPCO primary service. The primary service is being sized to accommodate the new Women's Pavilion.

The new ductbanks are being installed to accommodate this project and will be concrete encased. The ductbanks will be built to National Electric Code and industry standards. No easements are required. The conductors and transformers from the primary service switchgear will be extended to the Women's Pavilion. The electrical feed will be converted from 13.2kV to 480Y/277V.

Gas

The existing gas service shall remain and be modified as required to accommodate the new work.

Telecommunications

The existing telecommunications service shall remain and be modified as required to accommodate the new work

Part II

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

<u>Note</u>: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response:
Table E and related assumptions attached as **Exhibit 1**.

Part III

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. List names and addresses of all owners and individuals responsible for the proposed project.

   Deneen Richmond
   Luminis Health Doctors Community Medical Center, Inc.
   8118 Good Luck Road
   Lanham MD, 20706

   Luminis Health, Inc.
   2001 Medical Parkway
   Annapolis, MD 21401

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2. Is any applicant, owner, or responsible person listed above now involved, or has any such person ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each such facility, including facility name, address, the relationship(s), and dates of involvement.

   Yes. Please refer to **Exhibit 4** (organizational chart).

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3. In the last 5 years, has the Maryland license or certification of the applicant facility, or the license or certification from any state or the District of Columbia of any of the facilities listed in response to Question 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions)? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant(s), owners, or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

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4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses

of the facility, and any final disposition or conclusions reached by the applicable authority.

Please refer to **Exhibit 5** for a description of responsive matters and documentation.

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, or guilty plea(s).

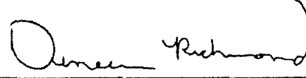
   No

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.

The required authorization is attached as **Exhibit 6**.

April 7, 2023

Date



Signature of Owner or Board-designated Official

President, Doctors Community Medical Center

Position/Title

Deneen Richmond

Printed Name

Part IV

PART IV - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

10.24.01.08G(3)(a). The State Health Plan.

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

Acute Care Hospital Services

COMAR 10.24.10 ACUTE CARE HOSPITAL SERVICES

.04 Standards

A. General Standards

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

1. Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicant Response:

(a) LHDCMC operates under the Luminis Health written policy entitled Patient Financial Services-Hospital Financial Assistance, Billing & Collection Policy (Exhibit 7). That policy sets forth the procedure for providing a Representative List of Services and Charges. The list is available to the public in written for upon request or at any time by accessing https://www.luminishealth.org/en/price-transparency?language_content_entity=en

(b) The Patient Financial Services-Hospital Financial Assistance, Billing & Collection Policy sets forth the procedure for responding to individual request for current charges for specific services and procedures. Requests are directed the ACP Financial Coordinator (or the appropriate department Financial Coordinator) and the Coordinator response to the request promptly according to the prescribed procedure. (Please refer to the final bullet under "Billing" on page 4 of Exhibit 7.)

(c) All Luminis Health and LHDCMC staff and Financial Coordinators are educated and trained on appropriately handling inquiries regarding charges and services, including the use of the Patient Financial Services-Hospital Financial Assistance, Charity Care, and Billing & Collection Policy.

2. Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

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

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospital, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. **(a) The policy shall provide:**	**Provide exact quote from the policy that covers this provision, and provide the section citation...in addition, provide the responses indicated in each cell below.**
Determination of Probable Eligibility. **Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.**	**Policy must guarantee a determination of probable eligibility within two business days of request for charity/reduced fee care or application for Medicaid** **Quote the specific language from the policy that describes the determination *of probable eligibility* (and give a citation to the location within the policy).** **Applicant Response:** LHDCMC maintains a written policy titled *Patient Financial Services — Hospital Financial Assistance.* (**Exhibit 7**). On page 2 under Policies and Procedures the first full bullet states:

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	• The following two-step process shall be followed when a patient or a patient's representative requests or applies for financial assistance, Medical Assistance, or both: o Step One: Determination of Probable Eligibility. Within two business days following the initial request for financial assistance, application for Medical Assistance, or both, Luminis Health shall: (1) make a determination of probable eligibility, and (2) communicate the determination to the patient and/or the patient's representative. In order to make the determination of probable eligibility, the patient or his/her representative will be required to provide information about family size, insurance, assets and income, and the determination of probable eligibility will be based solely on the information provided by the patient or patient's representative. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility. o Step Two: Final Determination of Eligibility. Following a determination of probable eligibility, Luminis Health will make a final determination of eligibility for Financial Assistance, which (except as otherwise provided in this Policy) will be based on a completed Uniform Financial Assistance Application and supporting documentation of eligibility. **Provide copies of any application and/or other forms involved in the process for making a determination of probable eligibility within two business days.** **Applicant Response:** Copies of the application are attached as **Exhibit 8.** **Describe your procedure for making a final determination, including defining any documentation required.** **Applicant Response:**

	Luminis Health's procedure for making a final determination is outlined as well as the documentation required in **Exhibit 9.**
REQUIRED PROVISION	**GUIDANCE FOR APPLICANTS**
(ii) Minimum Required Notice of Charity Care Policy. **1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**	**Quote the specific language from the policy that describes the method of implementing and provide a sample for each communications vehicle(s).** **<u>Applicant Response:</u>** On page 6 the final section reads: Hospital Financial Assistance Communications: • The Financial Assistance Signage is conspicuously displayed in English & Spanish in each hospital's Emergency Department, Cashiering & Financial Counseling office. Patients desiring to discuss financial assistance in another language may call the contact numbers in this policy and interpretive services will be provided. • The Financial Assistance Policy as well as a printable Uniform Financial Assistance Application is posted on the hospitals' websites. • Financial Assistance information is included in each patient guide located in the inpatient rooms. • Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance. • The Uniform Financial Assistance Application is available at all registration points in each hospital, including the Emergency Department. • A brochure "Patient Information Sheet" is available at every patient access point in each hospital and is posted on the Luminis Health website. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish.

	• Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet. • Information is available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital's Financial Counseling office for assistance. **Provide examples of the public information tools.** **<u>Applicant Response:</u>** The Patient Information Sheet (**Exhibit 10**) and Patient Handbook (**Exhibit 11**) are attached.
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.	**Provide copies of postings.** **<u>Applicant Response:</u>** Please see **Exhibit 12** entitled Financial Assistance Signage at LHDCMC as of 05012021.pptx
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.	**Quote from policy with section citation.** **<u>Applicant Response:</u>** On page 6 under Hospital Financial Assistance Communications, the seventh bullet states: • Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet.
(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as	**If level of charity care is in bottom quartile, provide rationale/explanation for this variance.** **<u>Applicant Response:</u>**

reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.	• Please refer to **Exhibit 13** (LHDCMC Charity Care Comparison FY22) which shows when comparing regulated charity care write-offs to total operating expenses, LHDCMC is in the top quartile. The source is the HSCRC Annual Filing schedule and this is most recent data publicly available. • Luminis Health's Policy is to provide 100% free care up to 300% of the Federal Poverty Guideline which exceeds the Maryland mandated minimum of 200%.

3. Quality Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall provide high quality care.

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

Applicant Response:

LHDCMC provides high quality care, as evidenced by the following accreditation and recognitions:

(a) LHDCMC provides high quality care:

(i) LHDCMC is in possession of Maryland Department of Health and Mental Hygiene Office of Health Care Quality License Number 16022. The license is attached as **Exhibit 14**.

(ii) LHDCMC is accredited by The Joint Commission. The last full survey by The Joint Commission successfully concluded on August 8, 2022. See **Exhibit 15** for LHDCMC's Joint Commission accreditation certificate.

(iii) LHDCMC is in full compliance with the Conditions of Participation for CMS.

(b) Based on guidance from MHCC, this standard is outdated as currently written. LHDCMC has identified any "below average" ratings and, of the applicable measures, LHDCMC was below average in a total of 9 measures. **Exhibit 16**.

B. Project Review Standards

The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute care general hospital facilities and services. An applicant for a Certificate of Need must address, and its proposed project will be evaluated for compliance with, all applicable review standards.

1. Geographic Accessibility.
A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area populations optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service are.

Applicant Response:
This standard is not applicable. The proposed project does not involve a new hospital or an existing hospital being relocated to a new site. All services required are within 30 minutes under normal driving conditions for 90% of the LHDCMC service area residents.

2. Identification of Bed Need and Addition of Beds.
Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

 (i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed beds for the hospital made pursuant to Health-General 19-307.2 or

 (ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or

 (iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional beds need projection adopted by the Commission and calculated using the bed need projection methodology Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity exceeds the minimum jurisdictional bed need projection; or

 (iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulations .05 of this Chapter, as applied to the service area of the hospital.

Applicant Response:
This standard is not applicable. The proposed project does not involve an addition of MSGA or pediatric beds.

3. Minimum Average Daily Census for Establishment of a Pediatric Unit.
An acute general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

a. The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit, or
b. The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Applicant Response:
This standard is not applicable as LHDCMC is not proposing new pediatric beds.

4. Adverse Impact.
A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or to access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Care Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital is a fully-adjusted Charge Per Case that exceeds the fully adjusted Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objects of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Applicant Response:

(a) LHDCMC will be seeking an increase to its Global Budget Revenue (GBR) related to this capital project via the HSCRC's Capital Funding Policy. This policy takes an average of the statewide capital ratio and a hospital's proforma capital ratio and subtracts the hospital's current capital ratio to determine eligible additional capital funding. This amount is then adjusted based on the hospital's efficiency ranking in the state. Using the HSCRC's FY22 stand in efficiency LHDCMC ranks 14th out of 43 Maryland hospitals.

LHDCMC estimates $4,161,451 annually in capital rates.

Per MHCC guidance, the HSCRC no longer publishes an average age of plant for peer group, so this provision does not apply.

(b) The project does not reduce the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service.

5. Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that is considered for achieving these primary objectives. For each approach, the hospital must:
   (i) To the extent possible quantify the level of effectiveness of each alternative in achieving each primary objective;
   (ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and
   (iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:
   (i) That it has considered, at a minimum, an alternative project site located within a Primary Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);
   (ii) That is has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;
   (iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and
   (iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located within a Priority Funding Area

Applicant Response:

(a) LHDCMC's primary objectives for the proposed project are:

- Expand and enhance comprehensive, seamless, high-quality obstetric and gynecologic services; driven by a commitment to continuously advance unparalleled, evidence-based care that matters to the community they serve.

- Become the premier destination for women across the continuum of care; providing expert clinical quality, compassionate care and health promotion with access and coordination.
- Provide obstetrics services to the community in an operationally efficient, functional, safe and comforting facility.
- Re-imagine the front door of LHDCMC to the community.
- Improve Support Services that are functionally inadequate and are less than current space planning benchmarks.

LHDCMC evaluated several alternative approaches for implementing obstetrics services and considered the following alternatives:

Option A: Do Nothing
Option B: Convert Existing Hospital Space
Option B: Vertical Expansion of Existing Hospital
Option D: Change Model of Operations from LDR to LDRP
Option E: Construct New Facility (Selected Option)

Option A: Do Nothing

Doing nothing to add obstetric services to the LHDCMC campus was considered and rejected.

Option B: Convert Existing Hospital Space

Reusing the existing hospital space for obstetrics services on the Third Floor East Tower was evaluated as an alternative approach. The Third Floor was evaluated based upon its size and potential horizontal expansion above the existing Critical Care Unit (CCU).

Adding a floor on top of the entire Critical Care Unit would have a negative impact on patient care and LHDCMC's daily operations and ability to treat critically ill patients during the construction phase. A temporary Critical Care Unit would need to be established prior to beginning construction and LHDCMC does not have available swing space to be converted to support this function. In addition to the complexities and impact on existing patient care delivery and not fully meeting the project's primary objectives, this option was not deemed to be a viable solution.

Option C: Vertical Expansion of Existing Hospital

Vertically expanding the existing hospital structure was explored and the only possibility was to construct three (3) floors on top of the Critical Care Unit. Multiple concepts were evaluated, and due to a lack of structural load bearing capacity of the existing hospital super-structure and foundations, a vertical expansion option is not possible.

Option D: Change Model of Operations from Labor Delivery Recovery (LDR) to Labor Delivery Recovery Postpartum (LDRP)

The proposed obstetric program is a labor, delivery, and recovery (LDR) model of care where patients deliver in LDR and transition to a post-partum room. LHDCMC explored alternative LDRP and hybrid care models where the patients remain in their labor and delivery room for the entire inpatient stay. This option required constructing a single patient floor for

an LDRP model and converting to LDR model upon reaching a defined future patient volume threshold. The conversion from a LDRP to LDR care model required constructing an additional patient floor over the top of the existing operational obstetrics unit.

Analysis of the space needs revealed that it was possible to construct the LDR floor to accommodate the required LDRP program. Based upon future patient volume, this configuration could transition to an LDR care model in the future when needed. During the review of the proforma, a hybrid (LDR/LDRP) model would only be feasible if the net present value associated with deferring the build out of the third floor of new construction and any ancillary changes did not exceed the operational savings of approximately $3.0M.

The cost basis, at the time, for the full build out of the LDR model was $37.6M. To build out the LDRP model at the project's onset and by year three (3) converting to an LDR model would cost about $45.2M. The increased cost accounts for escalation, complexities associated with building within an occupied regulated facility, and renovating space on the second floor of new construction. The difference of $7.6M exceeded the operational savings of $3.0M. There was an opportunity to reduce the difference by $1.3M if the Level II Continuing Care Nursery and Well Baby Nursery were constructed on the third floor at the onset of the project. However, this would create operational inefficiencies, separation of mother and baby, and security challenges. With the Level II Continuing Care Nursery and Well Baby Nursery being isolated on a separate floor from Postpartum, it would require an elevator (or stair) trip between floors for mothers and families wanting to be close to their babies. Operationally, this poses the potential impact for additional staff / redundant support, and the additional time for staff to transport infants between floors.

Based upon the complexities of converting clinical models and constructing over top of an active obstetrics unit, this option is not feasible.

Option E: Construct New Facility (*Selected Option*)

The west zone of the LHDCMC campus was identified as the preferred location for new construction. It was selected based on meeting the project objectives established to expand and enhance comprehensive, seamless, high-quality obstetric services while providing strategic clinical adjacencies to the existing hospital.

The new construction allows for key functional adjacencies identified by Luminis Health OB/GYN clinicians, such as the C-Section Suite being located directly above the expanded Surgical Suite achieves and creates clinical efficiencies for patient care delivery and staff efficiency. The location for the new construction connects to the existing LHDCMC support services circulation spine and defines a service zone for the entire LHDCMC existing hospital with efficient distribution patterns and support/ materials flow to both the new construction and existing hospital.

The new construction provides a new front door to the main facility, convenient access to the Acute Care Pavilion and redefines the arrival experience for the community. Constructing a new facility provides LHDCMC the opportunity to implement a

flexible universal grid that accommodates all key clinical rooms to support the proposed Obstetrics program and allows for future flexibility to accommodate all patient care services.

b. LHDCMC addressed the cost-effectiveness in part (a).

c. LHDCMC is not proposing establishment of a new hospital or relocation of an existing hospital.

6. Burden of Proof Regarding Need.
A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Applicant Response:

The need for the establishment of the obstetrics program is addressed below in response to COMAR 10.24.12.04(1).

(a) Need for Support Services and Infrastructure Expansion and Renovations

LHDCMC was originally constructed in 1975, and despite several expansions, remains significantly undersized for the number of patients treated. As modern healthcare practices require new equipment, they also require more space than previously needed. LHDCMC is a significantly undercapitalized facility with outdated and aging infrastructure, and several core hospital support services are undersized for current volumes based on industry standards.

Many of LHDCMC existing support services departments, including Supply Chain/Material Management, Lab/Morgue, Environmental Services (EVS) / Linen, Lab, Food & Nutrition, and Information Technology services, do not meet space planning benchmarks for support services based on a similarly sized facilities and do not have the ability to accommodate the expanding clinical services proposed by the new obstetrics program. The benchmarks contained in **Table 1** below were determined by Cannon Design and reference their internal data of hundreds of their hospital clients located throughout the US. Therefore, the benchmarks represent reasonable, existing facility and support services sizes rather than only the most recent and modern facilities. Based on these benchmarks, LHDCMC is operating support services at sizes from 10% to 85% the size of typical services in hospitals in the US.

Table 1 below shows the current deficiency in space and the targeted expansion for departments and functional areas. Critical support services for LHDCMC are below the Departmental Gross Square Feet (DGSF). 5 of the support services identified below are below 50% of the benchmark for DGSF. These small support services make it difficult to efficiently operate and demonstrate the need for the renovations.

Table 1

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET (DGSF)				
	Existing DGSF	Benchmark DGSF	% Existing to Benchmark DGSF	Provided DGSF	% Provided Benchmark DGSF
LEVEL 1					
Sterile Processing Distribution (SPD)	5,942	9,100	65%	9,008	**99%**
Loading Dock/EVS	347	3,598	10%	3,695	**103%**
Imaging / Nuclear Medicine	7,072	16,400	43%	15,570	**95%**
Linen / Laundry	1,067	3,084	35%	3,294	**107%**
Food & Nutrition - Kitchen	8,715	10,280	85%	11,440	**111%**
Laboratory	6,315	7,710	82%	7,775	**101%**
Morgue	344	1,028	33%	844	**82%**
Supply Chain Management	3,117	4,626	67%	5,680	**123%**
LEVEL 2					
Surgery Services	27,295	46,750	58%	48,009	**103%**
Endoscopy	0	5,600	0%	5,860	**105%**
Cardiac Cath / Interventional Radiology	3,332	10,500	32%	10,435	**99%**
Pharmacy - Inpatient	3,780	6,425	59%	6,450	**100%**
LEVEL 3					
Labor & Delivery / Triage / C-Section	0	24,200	0%	26,060	**108%**
LEVEL 4					
Postpartum / Antepartum	0	16,200	0%	16,124	**100%**

Level II Continuing Care Nursery	0	2,600	0%	2,905	**112%**

Source: Cannon Design created benchmark based on their national database.

As shown in **Table 2**, LHDCMC has a capitalization ratio that is among the lowest of its peer group. LHDCMC has a ratio of depreciation and interest as a percent of total operating expenses of 6.9%, whereas the average of the peer group is 7.9%. The range is from 15.0% to 2.4%; the lowest published is at Fort Washington, and two of the other peers are no longer operating as acute inpatient hospitals (UM Laurel and McCready Memorial). These metrics jointly demonstrate that LHDCMC has not invested in routine capital projects at the same rate as its peers.

Table 2
Maryland Acute Hospitals
Capital Cost Comparison
FY2022, Peer Group 3

Prov Num	Hospital Name	Depreciation + Interest Expense in 000's	Total Operating Expenses in 000's	Capital % of Total Expenses
210010	UM-SRH at Dorchester	$3,318.4	$22,137.5	15.0%
210016	Adventist White Oak	$34,592.1	$276,626.3	12.5%
210027	Western Maryland	$26,641.1	$237,708.1	11.2%
210001	Meritus Medical Cntr	$34,345.0	$347,434.2	9.9%
210063	UM-St. Joseph Med Cntr	$32,234.9	$327,302.8	9.8%
210033	Carroll Co Hospital Cntr	$20,202.8	$212,285.6	9.5%
210039	Calvert Health Med Cntr	$12,614.9	$135,429.3	9.3%
210019	Peninsula Regional	$35,098.0	$404,379.9	8.7%
210037	UM-SRH at Easton	$15,206.5	$180,470.5	8.4%
210040	Northwest Hospital Cntr	$19,495.1	$240,746.5	8.1%
210030	UM-SRH at Chestertown	$2,860.1	$35,804.5	8.0%
210061	Atlantic General	$7,345.8	$91,997.8	8.0%
210017	Garrett Co Memorial	$4,614.7	$58,082.9	7.9%
210006	UM-Harford Memorial	$7,560.8	$95,704.6	7.9%
210005	Frederick Memorial	$26,179.9	$332,628.7	7.9%
210062	MedStar Southern MD	$20,291.8	$258,261.9	7.9%
210049	UM-Upper Chesapeake	$19,614.4	$270,200.8	7.3%
210035	UM-Charles Regional	$9,924.4	$142,479.3	7.0%
210051	Doctors Community	$15,870.5	$229,922.5	6.9%
210018	MedStar Montgomery	$11,258.1	$165,949.0	6.8%
210028	MedStar St. Mary's	$10,532.9	$158,185.3	6.7%
210057	Shady Grove	$25,440.2	$385,177.3	6.6%

210048	Howard County General	$20,232.0	$308,768.7	6.6%
210032	Union Hospital of Cecil Co	$9,439.9	$159,376.7	5.9%
210023	Anne Arundel Medical Cntr	$33,078.0	$612,124.1	5.4%
210060	Ft. Washington	$1,334.4	$54,926.6	2.4%
210055	UM-Laurel Regional	$65.2	$31,793.0	0.2%
210045	McCready Memorial	$0.0	$7,076.8	0.0%
	Peer Group 3 Total	**$459,391.9**	**$5,782,981.3**	**7.9%**

Source: HSCRC Annual Filing, FY2022 Annual Cost Survey
Includes regulated hospital expenses only, excludes operating lease expenses
[1]: FY22 ACS not available for Adventist and Western MD (FY21 used as a placeholder)

(b) Need for Surgical Services Facilities Renovations

Renovations of LHDCMC's surgical services facilities are needed because the existing facilities are inadequate and do not align with current industry standards. LHDCMC is licensed for 12 general purpose operating rooms, but two of them cannot be used at all due to their small size and the others are outdated and inefficient.

The current operating rooms are an average of 526 square feet, too small by contemporary standards. The project will increase the operating rooms to 700 square feet in order to optimize workflows within rooms, fit equipment needs and case types. Additionally, the existing mechanical, electrical, and plumbing for the surgical suite were installed over 30 years ago and are subpar when compared to modern systems. The operating rooms also lack advanced lighting and mechanical controls which leads to less efficient systems with higher energy use. Sterile processing and other support services are not currently collocated for efficiency. The proposed project will improve process flows for sterile supplies, instrumentation, staff, patient and surgeons. Operating rooms, sterile processing, and C-section rooms will create efficiency because they will be adjacent. These services will be connected by dedicated clean and dirty elevators to reduce transport time of surgical instrumentation between the various destinations. Clinical and support functions have been aligned to reduce wasted time and steps in traversing. Finally, the finishes throughout the surgical suite are dated and no longer appropriate. The current operating rooms have wall tiles and coverings, and the project will utilize materials to promote clean sterile environments.

7. Construction Cost of Hospital Space.

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of a good quality Class A hospital construction given in the Marshall Valuation Service guide, updated using Marshall Valuation Service update multipliers, and adjusted as shown in the Marshall Valuation Service guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected constriction cost that exceeds the Marshall Valuation Service benchmark and those portions

of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

The proposed cost of the hospital construction project is reasonable and consistent with current industry cost experience in Maryland, as evidenced by the Marshall Valuation Service (MVS) analysis of construction costs for this project. This analysis is contained in Exhibit 17.

8. Construction Cost of Non-Hospital Space.

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicant Response:

This standard is not applicable. The project does not include construction of non-hospital space.

9. Inpatient Nursing Unit Space.

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type or unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response:

The only inpatient nursing unit space involved in the proposed project is the Postpartum nursing unit. This unit is 508 square feet per bed, slightly exceeding the standard. LHDCMC designed the unit to include one Patient-of-Size room with isolation capabilities, in order to best meet the needs of its bariatric patient population.

The overall Continuing Care Nursery includes four continuing care infant stations (inpatient beds) and also includes other types of spaces such as, two family sleep rooms (with toilet shower suite) which is not required by FGI; and also includes space for four well-baby bassinettes which are not inpatient beds but share the overall support spaces. The

Continuing Care Nursery space, not including the "other" spaces, is 399 square feet per bed which is below the standard.

The Labor and Delivery (OB) unit is not an inpatient nursing unit to which this standard applies.

10. Rate Reduction Agreement.

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response:

This standard is not applicable. LHDCMC has not been designated a high-charge hospital by the Health Services Cost Review Commission, and so, it is not under a rate reduction agreement with the Health Services Cost Review Commission.

11. Efficiency.

A hospital shall operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

Applicant Response:

Women's Services. The new obstetric program was designed with all private rooms to improve the patient experience while increasing privacy. Private rooms can provide patients with a more comfortable and personalized environment leading to improved overall patient satisfaction.

The Antepartum/Postpartum unit was designed for staff efficiency, as well as to have a significant positive impact on patient outcomes. By streamlining workflow and reducing transfers, staff can better manage patients' care and reduce the risk of medication errors, falls, and hospital-acquired infections.

The location of the elevators is an essential aspect of the obstetric program design. Placing the elevators in a central location that is easily accessible can help to reduce patient transport times, improving efficiency as well as being particularly critical in emergencies when time is of the essence.

Overall, the new maternity center's design has taken into account several critical factors, including patient privacy, staff efficiency, and patient safety. These features can have a significant impact on patient outcomes, improving overall efficiency and quality of care provided by the hospital.

Imaging. Efficiency of the imaging department will be achieved through various strategies, including co-locating departments such as emergency services, ensuring convenient access to support services, and proximity to elevators.

One important factor is the proximity of the imaging department to emergency services in the proposed project. Close proximity ensures that patients in need of urgent imaging can receive prompt care without having to travel far. Additionally, locating the imaging department near patient and service elevators can help to minimize patient treatment times, as patients can be easily transported to and from the imaging department.

The internal design of the imaging department is also crucial for achieving efficiency. Building in synergies between different imaging modalities, such as CT scans and MRI, can help to streamline processes and reduce waiting times. Coupling a well-organized imaging suite with efficient scheduling systems and patient flow management, patients are seen promptly, and resources are used effectively.

Overall, achieving imaging efficiency requires careful consideration of various factors, including department location, internal design, and workflow management. By optimizing these elements, healthcare providers can ensure that patients receive prompt, high-quality imaging services that meet their needs.

Surgery. The design of the new Surgery department will improve efficiency, patient safety, and maximize the utilization of space.

Efficiency will be improved in various ways including the prep and recovery area is designed to flex between PreOP, PACU, and Phase I and Phase II recovery that can flex with patient demand. This enables the use of space to be optimized, which is critical in ensuring that the hospital can provide timely high-quality care to patients. Additionally, the location of the prep and recovery area adjacent to the major ORs helps to minimize patient transport time and optimize patient treatment times.

The proposed project will improve process flows for sterile supplies, instrumentation, staff, patient and surgeons. Sterile processing and other support services are not currently collocated for efficiency. With the project, sterile processing is located directly below the OR suite, which is an essential aspect of the department's design. The two designated elevators (clean and soiled) allow for more timely and efficient processing of sterile supplies, further

improving quality and safety. This is important as it ensures that the necessary sterile supplies are readily available for use in the ORs. Operating rooms, sterile processing, and C-section rooms will create efficiency because they will be adjacent. These services will be connected by dedicated clean and dirty elevators to reduce transport time of surgical instrumentation between the various destinations.

The standardized ORs in the new facility will allow for maximum utilization, and the central core allows for staging of case carts for optimum throughput. This helps to reduce the time required to set up ORs between procedures and ensures that the ORs are utilized to their maximum potential.

The current operating rooms also lack advanced lighting and mechanical controls which leads to less efficient systems with higher energy use. The project will incorporate modern lighting and mechanical controls to promote efficient systems and energy efficiency.

Overall, the project design takes into account various critical factors, including patient safety, efficiency, and space utilization. By optimizing these elements, the hospital can provide high-quality surgical care to patients while improving overall efficiency and safety.

Support Services. Efficiency is a key priority for materials management, lab, EVS, food and nutrition, and pharmacy. The design of the new facility ensures these services are strategically located throughout the clinical areas to minimize movement of supplies, patients, and staff throughout the facility. This helps to optimize the use of space and minimize the time required for clinical staff to locate essential items and is critical in providing high-quality care to patients while ensuring efficient operations.

12. Patient Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded and document the manner in which the planning and design of the project took patient safety into account.

Applicant Response:

LHDCMC's proposed new pavilion and renovated hospital spaces were planned and designed with patient and staff safety in mind as reflected in the core design elements. LHDCMC worked closely with CannonDesign, a licensed architect with experience designing healthcare facilities, which specializes in acute care services, obstetrics programs, and surgical services. Clinical leadership and personnel from LHDCMC participated in the planning to identify patient needs and potential safety issues, including infection prevention. The proposed design complies with the applicable FGI Guidelines and ANSI standards.

LHDCMC Surgical Services design was planned to employ the latest programming, planning and design elements to maximize adaptability, efficiency and patient safety and convenience. The design includes the following key safety features:

- Appropriately sized ORs based on the procedures to be performed. Providing necessary space for number of staff and the amount and size of equipment to be used.
- Equipment storage areas adequately sized and located to provide access to ORs. This will eliminate cluttering of hallways, and keep the corridors clear for emergency egress.
- Clinical staff areas adequately sized to support the surgical suite.
- Designed to optimize infection prevention based on the flow of clean and dirty materials and instruments, air flow, and patient flow.
- OR suite divided into three designated areas – unrestricted, semi-restricted and restricted – that are defined by the physical activities performed in each area.
- Properly zoned to maintain the proper storage and flow of dirty to clean to sterile movement for staff, instruments, and supplies.
- Peripheral support areas of the surgical suite, including storage areas, equipment rooms, and scrub sink areas are located off a semi-restricted corridor.
- Clean core directly connects to every operating room and can only be accessed by authorized personnel and patients.
- Mechanical and electrical systems meeting all current guidelines and designed to maintain appropriate pressure relationships, temperature and humidity control and monitoring, appropriate lighting and a dedicated emergency power back-up.
- Direct line of sight from nursing work areas into all prep/recovery rooms
- Universal OR configuration for uniformity of equipment placement and use.
- Prep/recovery patient care stations are sized to accommodate patients, staff, and family and reduce the chance of slip and falls.
- PACU/Prep/Recovery are right sized and configured for acuity flexibility and standard concept of operations.
- PACU/Prep/Recovery functional adjacent to OR suite to minimize patient transport
- Proposed layout supports efficient flow of staff, patients and materials.
- Surgical Services supported by full replacement of SPD. Direct vertical connectivity between OR and SPD.
- (2) two airborne infectious isolation rooms (AIIR) provided in prep/recovery for increased infection prevention.
- (2) two "individuals of size" prep/recovery patient care stations provided that feature special accommodations for patients. The extra clearances will help with patient access and transfers, and will reduce patient and staff injuries.
- Extending the pneumatic tube system to the OR Suite and PACU/prep/recovery to provide easy transport of critical medication and other supplies as well as safe transport and timely turnaround of lab results.

Please refer to COMAR 10.24.12.04(6) below for a description of the patient safety features incorporated into the proposed obstetrics program.

13. Financial Feasibility.
A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service are populations of the hospital or State Health Plan need projections if relevant;

(ii) Revenue estimates are consistent with utilization projections are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, it a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals, and

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate the overall hospital financial performance will be positive and that the services will benefit the hospital's primary service are population.

Applicant Response:

(a) A comprehensive table of the financial projections around revenue and expense are in Tables G and H (**Exhibit 1**). The financial feasibility of LHDCMC's project is based on the following assumptions:

(i) Utilization projections are consistent with observed historic trends (Exhibit 1, Table F).

(ii) Revenue estimates are consistent with utilization projections and are based on current rates of reimbursement, contractual adjustments, discounts, bad debt and charity care provision experienced by LHDCMC (Exhibit 1, Tables G and H).

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on the current expenditure levels and reasonably anticipated future staffing levels (Exhibit 1, Table L).

(iv) The hospital will generate excess revenues over total expenses including debt services and depreciation in FY 2031 Year 5 of the Obstetrics Program.

(v)

14. Emergency Department Treatment Capacity and Space.

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters of the most recent edition of the *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

   (i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;

   (ii) The number of uninsured, underinsured, indigent and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;

   (iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;

   (iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and

   (v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.

Applicant Response:

This standard is not applicable. LHDCMC is not proposing a new or expanded emergency department.

15. Emergency Department Expansion.

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that is has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. The demonstration shall, at a minimum, address feasibility of reducing or redirecting patients with non-emergent illness, injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes emergency department patients.

Applicant Response:

This standard is not applicable. LHDCMC is not proposing a new or expanded emergency department.

16. Shell Space.

(a) Unfinished hospital shell space for which there is no immediate need or use-shell not be built unless the applicant can demonstrate that construction of a shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net value that:

   (i) Considers the most likely use identified by the hospital for the unfinished space;

   (ii) Considers the time frame projected for finishing the space; and

   (iii) Demonstrates that the hospital is likely to need the space foe the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

Applicant Response:

This standard is not applicable. The proposed project will not include shell space.

Obstetric Services

COMAR 10.24.12 Acute Hospital Inpatient Obstetric Services
.04 Review Standards

The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving new acute hospital inpatient obstetric services, existing services proposed to be relocated to a newly constructed space, and existing services proposed to be located in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to applicants for a new perinatal service. Standard (15) applies only to applicants with an existing obstetric service.

1. Need.
All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

Policy 4.1 the burden of demonstrating need for additional obstetric program capacity rests with the applicant. In determining whether a new obstetric service should be established, the Commission shall consider, at a minimum,

(a) the historical and projected service area of the applicant hospital, obstetric service utilization forecasts, the number of providers of hospital obstetric service utilization forecasts, the number of providers of hospital obstetric services in the applicant hospital's service area, the anticipated medical staff which will utilize the proposed obstetric service and the proportion of their patients expected to use the proposed service;
(b) the information on the number of uninsured, underinsured, indigent and otherwise underserved obstetric patients in the applicant's primary service area, and an estimate of the number of women not receiving adequate prenatal care;
(c) any data and/or analyses provided by the applicant outlining improvements in the delivery of obstetric services to the defined service are population anticipated to result from implementation of the proposed project, such as improvements in patient care outcomes, lower costs than that currently available in the service area, improvements in geographic or financial access to care, improvements in continuity of care, or improvements in the acceptability or cultural competency of obstetric care for the defined service area population or specific segments of that population;
(d) any demographic or health service utilization data and/or analyses providing a perspective on the need for the proposed project which is significantly different from that found in the Commission's forecast of obstetric service utilization; and
(e) Any other relevant information on the unmet needs for obstetric services in the service area.

Applicant Response:

Although Prince George's County has the second highest birth rate in the State of Maryland, the total number of licensed obstetric beds in the local region has declined from over 100 obstetric beds in FY2015 to fewer than 50 today. The limited number of obstetric beds in Prince George's County forces over 7,000 women to leave the County each year to

deliver their babies and to receive other related services. Prince George's County has a low OB/GYN physician-to-population ratio. The dependence on out of county obstetric units and OB/GYNs creates inequities through transportation challenges, disjointed medical management of pregnancy and lack of perinatal continuity of care. Compared to the rest of the State, Prince George's County has high infant mortality rates, a high rate of low-birth-weight infants, and high teen birth rates.

The Applicant recognizes the need for both community-based obstetrics care and inpatient obstetric beds in Prince George's County. Easy access to OB/GYNs and local delivery sites are critical for the improvement of maternal and infant outcomes. The women of Prince George's County deserve access to obstetrical care close to home, which this project will provide on the LHDCMC campus. LHDCMC's proposed obstetrics program will improve access to obstetrical care and related services in Prince George's County, including outpatient ambulatory women's care from preconception health to postpartum care, gynecology, and breast health.

(a) *the historical and projected service area of the applicant hospital, obstetric service utilization forecasts, the number of providers of hospital obstetric service utilization forecasts, the number of providers of hospital obstetric services in the applicant hospital's service area, the anticipated medical staff which will utilize the proposed obstetric service and the proportion of their patients expected to use the proposed service;*

Prince George's County Residents Need Access to Obstetrics Services Closer to Home

a. Prince George's County has the second highest birth rate of all Maryland counties.

Prince George's County is the second most populous county in Maryland and reports the second highest birth rate in the State. Women of childbearing age (15 to 44 years) are 20.4% of the county's total population or 185,230 with similar demographics to the county (Maryland Vital Statistic 2020).

Births in Prince George's County declined to a low in 2013 but have increased over the last 7 years. In 2020, Prince George's County had 11,308 births representing 16% of all births in Maryland. **Table 3** shows the number of births per 1,000 women from 2018-2020:

Table 3
Birth Rate by County
Number of Births per 1,000 Population
2018-2020

County	2018	2019	2020
Baltimore City	12.7	13.0	12.6
Prince George's	13.4	13.0	12.4
St. Mary's	11.8	12.1	12.1
Wicomico	12.1	12.1	12.0
Caroline	12.9	12.5	11.9
Dorchester	11.8	10.9	11.8
Anne Arundel	11.8	11.8	11.7
Baltimore County	11.8	11.6	11.3
Washington	11.2	11.0	11.2
Frederick	11.6	11.3	11.2
Montgomery	11.8	11.4	11.1
Charles	11.6	11.5	10.9
Cecil	11.2	11.3	10.6
Howard	10.6	10.3	10.2
Talbot	8.7	8.8	10.2
Calvert	9.6	9.7	10.1
Harford	10.4	10.5	10.0
Carroll	10.5	9.8	9.8
Garrett	9.4	9.1	9.3
Queen Anne's	9.5	10.2	9.3
Allegany	9.5	9.2	9.0
Somerset	8.4	9.1	8.5
Kent	7.0	8.6	7.7
Worcester	7.9	7.5	7.5
State of Maryland	**11.8**	**11.6**	**11.3**

Source: Maryland Vital Statistics Annual Reports, 2018-2020

With close to 200,000 women of childbearing age and the second highest birth rate in the state, access to obstetrics care is critical for the residents of Prince George's County and will be an ongoing need in the future.

b. Although the LHDCMC service area reported 8,758 obstetric discharges FY 2022, there are limited options for obstetrics care in Prince George's

County, forcing 82% of obstetrics patients to travel outside the County for care.

The obstetrics LHDCMC service area is defined as the same service area as the hospital. The service area includes 25 zip codes that account for approximately 80% of the population in Prince George's County (see **Exhibit 18** "Technical Notes" for service area definition). The proposed new obstetrics program aims to serve LHDCMC's established service area population and increase the capacity of OB/GYN clinicians within the service area. The project objective is not to expand market reach, but to better service the current population base, thereby improving outcomes for women and children in Prince George's County.

The LHDCMC service area reported 8,717 obstetric discharges in FY22.

Table 4
LHDCMC Service Area Residents
Obstetric Volume at Maryland & Wash, DC Hospitals
FY2022

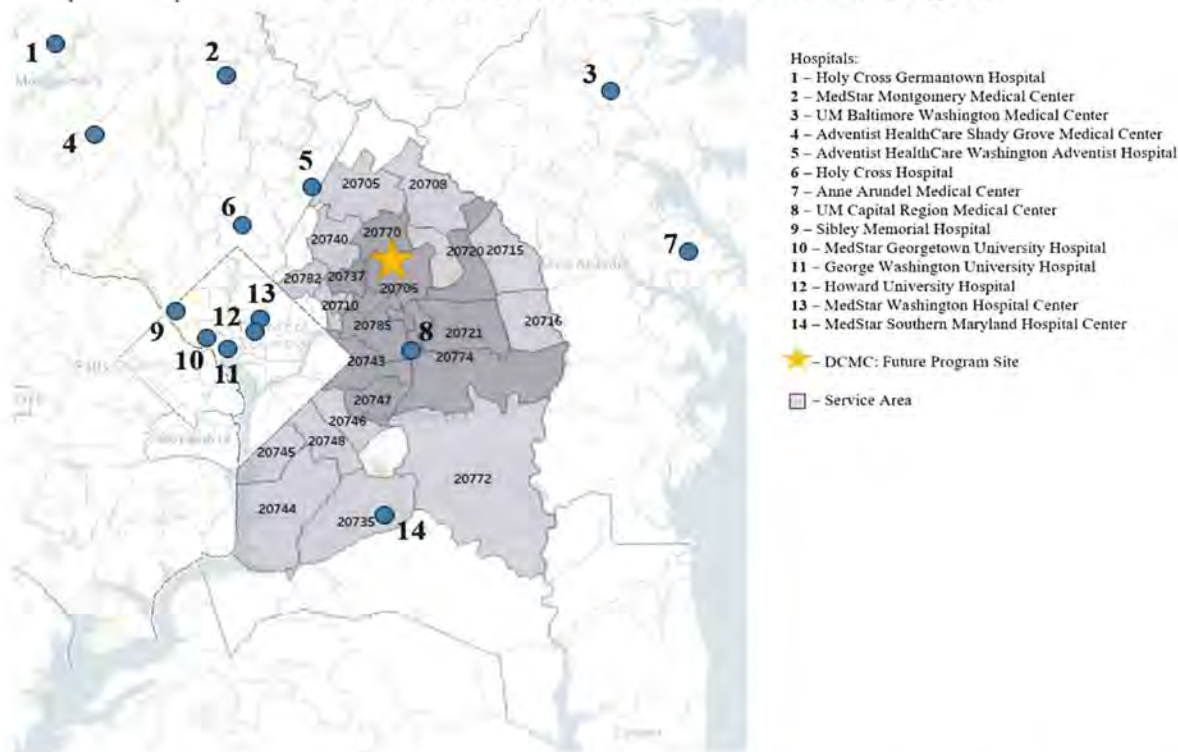
	Cases	ALOS
Maryland hospitals	7,430	2.57
Washington DC hospitals	1,287	2.65
Total Service Area OB Discharges	8,717	2.58
Occupied Beds		62

Source: HSCRC FY22 Abstract dataset for Maryland hospital discharges and
CY21 DCHA discharge database for DC hospital discharges

Despite the high number of Prince George's County women in need of obstetrics care, there are limited obstetrics service options in the County. As a result, approximately 82% of obstetrics patients from the LHDCMC service area (7,154 cases) travel out of the County for obstetrics care each year. The 2022 Prince George's County Community Health Needs Assessment (CHNA) found that "our population is going outside of the county for [their] care."
https://www.princegeorgescountymd.gov/ArchiveCenter/ViewFile/Item/3677

The following map shows the general hospitals with obstetrics units operating in the LHDCMC service area and extended region.

Figure 2
Obstetrics Units in General Hospitals
LHDCMC Service Area and Extended Region



The total number of licensed obstetrics beds in the local region has declined from over 100 obstetric beds in FY2015 to fewer than 50 today. In 2021, UM Capital Region Medical Center, relocated from north of Route 50/New York Avenue corridor, inside the beltway, to south of Route 50, outside the beltway and has fewer licensed beds. Concurrently, Washington Adventist Hospital, with 21 licensed obstetric beds, relocated from Takoma Park to White Oak, a move of only a few miles, but a greater distance to the majority of the LHDCMC service area population.

It is not just the delivery itself for which women who live in Prince George's County are forced to leave the County. Due to the nature of obstetrical care, most physicians locate clinical practices nearby delivery centers. As a result, not only do patients travel out of county for the birth and hospital care, but their entire prenatal care experience is also often dispersed across the State of Maryland and Washington, DC.

This utilization pattern is documented in the table below:

Table 5
LHDCMC Service Area Residents
Obstetrics Discharges
FY 2022

Region	Hospital	Discharges	% of Total
Maryland			
Prince Georges County	UM Capital Region Medical Center	1,183	13.6%
	MedStar Southern Maryland	380	4.4%
Subtotal, Prince Georges County		1,563	17.9%
Montgomery County	Holy Cross	3,350	38.4%
Montgomery County	Adventist HealthCare White Oak Hospital	613	7.0%
Anne Arundel County	Anne Arundel Medical Center	917	10.5%
All Other Maryland Counties	All Other	987	11.3%
Subtotal, Other Maryland		5,867	67.3%
District of Columbia			
Washington, DC	MedStar Washington Hospital Center	753	8.6%
Washington, DC	Sibley	175	2.0%
Washington, DC	All other	359	4.1%
Subtotal, District of Columbia		1,287	14.8%
Total		8,717	100.0%

Source: HSCRC FY22 Abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

c. Prince George's County has a relatively low number of OB/GYNs and an aging OB/GYN physician workforce. A delivery site in close proximity to physician practice sites is critical to recruiting and retaining providers to serve the community.

Without a local obstetrics hospital in the vicinity, fewer OB/GYN practitioners maintain practice sites in the service area. Prince George's County has long been challenged to retain an adequate number of physicians and medical providers to create sufficient access to services throughout the care continuum. It is not immediate access to the facility, necessarily, that results in inequity in outcomes, but the associated dearth of physician access for prenatal health, maternity care, and postnatal care. Together, the inequity of access to both obstetrics beds in northern Prince George's County and the associated OB/GYN ambulatory practices have a combined detrimental impact that is apparent in the disparities in maternal and infant

outcomes in the community.

The OB/GYN physician-to-population ratio in the LHDCMC service area is low, and as current OB/GYN physicians' age and retire, the situation continues to worsen. In 2023, 83 OB/GYNs had primary addresses within the LHDCMC service area (and are assumed to practice there).

Table 6
OB/GYNs Practicing in the LHDCMC Service Area

Capital Women's Care	7
Independent	25
Sibley	2
Luminis Health	4
Medstar	22
UMMS	2
Kaiser	*23*
TOTAL	**85**
Total Excluding Kaiser	***62***

Source: MD Board of Physicians as of February 2023

However, the number includes both hospital-based physicians who may not have ambulatory practices and physicians within the Kaiser network. The 23 Kaiser OB/GYNs are only available to patients with Kaiser insurance coverage. Therefore, in order to estimate the number of physicians relative to the size of the community, both Kaiser OB/GYNs and the percent of the population covered by Kaiser insurance products must be excluded.

There are 833,302 residents of the LHDCMC Service Area, but, using the HSCRC Inpatient Data Set for FY22, 12.6% of the LHDCMC service area population has Kaiser insurance. Therefore, we estimate there are 728,000 people in the service area who do not have Kaiser insurance and do not have access to Kaiser OB/GYNs.

Table 7
LHDCMC Service Area Population & Residents with Kaiser

Population of DCMC Service Area	833,302
Kaiser	12.63%
Population of DCMC Service Area w/o Kaiser	728,056

Population: Advisory Board Demographic Profiler
Kaiser Percentage: MD HSCRC Inpatient Data Set, FY22, LHDCMC Service Area Resident

According to the Advisory Board, the National Low-Cost Quartile of physicians to 100,000 population benchmark for OB/GYNs is 16 OB/GYNs per 100,000 population. The

LHDCMC Service Area currently has 85 OB/GYNs, which translates to 10.2 per 100,000 residents. However, Kaiser Permanente is a closed-system with a large healthcare facility in this service area, which skews the calculations. Kaiser Permanente physicians in the Service Area only serve the patients who have medical coverage through Kaiser; therefore, we excluded both the OB/GYNs within Kaiser and the number of patients served by Kaiser to estimate the available OB/GYN's to the rest of the community.

There are 62 OB/GYNs in the market serving a population of 728,000 who do not have Kaiser medical coverage. This translates to 8.5 OB/GYNs per 100,000 residents. The benchmark indicates that the LHDCMC service area excluding Kaiser should have 116 OB/GYNs. This means that an additional 54 OB/GYNs are needed within the service area to meet the needs of the community (62+54=116).

Table 8
OB/GYNs in LHDCMC Service Area as Compared to National Benchmarks

	Total	Excluding Kaiser
OB/GYNs in Market	85	62
Population of Market	833,302	728,056
OB/GYNs per 100,000	10.2	8.5
National Low Cost Benchmark	16	16
Additional OB/GYNs needed to match benchmark	48	54

Local access to clinicians is critical to promoting prenatal care and improving maternal/infant health outcomes, and the Applicant understands the strategies that are needed to attract more clinicians to Prince George's County to enhance access and support population health improvement goals.

The obstetrics program is designed to attract and retain community clinicians. LHAAMC, LHDCMC's sister hospital, has an established, well-recognized high quality obstetrics program that will expand to the new LHDCMC campus. Luminis Health will partner with the existing neonatology group at LHAAMC, Rindfleisch and Associates, and Children's National Hospital (CNH) for newborn care depending on the clinical need of the newborn. For newborns requiring Level IV care our existing relationship with CNH will be leveraged to meet these newborns needs. For those requiring Level III care our existing partnership with Rindfleisch and Associates will be leveraged wherever possible to keep the mother-newborn couplet intact.

LHDCMC will implement a laborist model of perinatal care which has been show to improve clinical outcomes and is increasingly being utilized to attract obstetrical providers to the community. A laborist is a dedicated Labor and Delivery obstetric provider who manages care throughout delivery as the primary physician and acts as a consultant to other physicians. Published studies show that implementation of the laborist model is correlated with fewer inductions of labor and cesarean sections (https://pubmed.ncbi.nlm.nih.gov/30835985/.)The

laborist model is also expected to support recruitment of physicians to the region by providing physicians with a higher quality of life and providing time for clinicians to focus on providing high quality care in the ambulatory setting. The laborist model will allow physicians to focus on their clinical, office-based practice and the continuum of care with the assurance that their patients are safely delivered at the hospital. Recruitment of additional clinicians to Prince George's County is a critical part of our strategy to improve health outcomes and a local obstetrics site is essential to successful provider recruitment.

Luminis Health has two long standing providers who practice in Bowie and two newer providers that practice in Greenbelt. These practices provide the full continuum of women's healthcare to women in the LHDCMC Service Area, but deliver babies at LHAAMC currently. Luminis Health will further this investment by recruiting and hiring 4 additional OB/GYN providers to the practice area. LHDCMC believes that the laborist model and new program will help attract and retain providers in the LHDCMC service area while creating access to OB/GYN care in the service area. Luminis Health also intends to work with any OB/GYN providers who currently serve the community or who enter into practice in the region to provide support through offering medical staff privileges and access to the range of high acuity care that is currently affiliated with Luminis Health in the region. Luminis Health has a history of partnership with private practice physicians and physicians employed by other, regional health systems, to ensure access to care and a high quality clinical care continuum to local providers and their patients.

The 2022 Prince George's County Community Health Needs Assessment (CHNA) also noted a low number of providers in the service area who are participating in Medicaid, leaving many low-income residents underserved. (https://www.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf). This is problematic for the engagement of prenatal care and puts the burden of limiting access to care on the most vulnerable within the community. All Luminis Health providers currently do and will accept Medicaid, thereby providing maximum access to preventative women's care for Prince George's County residents. Luminis Health is dedicated to patient assistance and will continue to expand services to enroll patients in eligible healthcare programs.

(b) *the information on the number of uninsured, underinsured, indigent and otherwise underserved obstetric patients in the applicant's primary service area, and an estimate of the number of women not receiving adequate prenatal care;*

Prince George's County has a high number of uninsured, underinsured, indigent and otherwise underserved obstetric patients.

In 2020, only 89.7% of Prince George's County residents had insurance compared to 94.1% in Maryland. Hispanic residents were less likely to be insured with nearly 30% lacking insurance, according to the CHNA. LHDCMC is in the top quartile for charity care across the state that charity care delivery will expand through the establishment and growth of the OB program.

Of the 8,717 deliveries in the LHDCMC service area in FY2022, 4,528 deliveries or 65% were Maryland Medicaid deliveries. Of the Maryland Medicaid deliveries from LHDCMC service area, 229 (5% of the Medicaid deliveries in the LHDCMC service area) leave the County to deliver in Washington, DC. **Table 9** below demonstrates the Maryland Medicaid deliveries for the LHDCMC service area.

Table 9
Maryland Medicaid, LHDCMC Service Area
Distribution of OB Volume
FY 2022

		PSA		SSA		Total Service Area (PSA&SSA)	
Hospital	County	Cases	Market Share	Cases	Market Share	Cases	Market Share
Holy Cross Hospital	Montgomery County	1,048	44.8%	854	39.0%	1,902	42.0%
Adventist HealthCare White Oak Hospital	Montgomery County	249	10.6%	298	13.6%	547	12.1%
UM Capital Region Medical Center	Prince George's County	526	22.5%	330	15.1%	856	18.9%
MedStar Southern Maryland Hospital Center	Prince George's County	51	2.2%	171	7.8%	222	4.9%
Anne Arundel Medical Center	Anne Arundel County	148	6.3%	125	5.7%	273	6.0%
Adventist HealthCare Shady Grove Medical Center	Montgomery County	26	1.1%	34	1.6%	60	1.3%
Howard County General Hospital	Howard County	5	0.2%	19	0.9%	24	0.5%
UM Charles Regional Medical Center	Charles County	7	0.3%	40	1.8%	47	1.0%
University of Maryland Medical Center	Baltimore City	22	0.9%	39	1.8%	61	1.3%
Holy Cross Germantown Hospital	Montgomery County	56	2.4%	38	1.7%	94	2.1%
UM Baltimore Washington Medical Center	Anne Arundel County	26	1.1%	54	2.5%	80	1.8%
MedStar Montgomery Medical Center	Montgomery County	9	0.4%	22	1.0%	31	0.7%
The Johns Hopkins Hospital	Baltimore City	11	0.5%	10	0.5%	21	0.5%
Doctors Community Hospital	Prince George's County	20	0.9%	4	0.2%	24	0.5%
Saint Agnes Hospital	Baltimore City	6	0.3%	9	0.4%	15	0.3%
MedStar Harbor Hospital Center	Baltimore City	4	0.2%	5	0.2%	9	0.2%
Johns Hopkins Bayview Medical Center	Baltimore City	3	0.1%	3	0.1%	6	0.1%
MedStar Franklin Square Medical Center	Baltimore County	1	0.0%	4	0.2%	5	0.1%
CalvertHealth Medical Center	Calvert County	-	0.0%	2	0.1%	2	0.0%
UM Laurel Regional Hospital	Prince George's County	-	0.0%	-	0.0%	-	0.0%
Mercy Medical Center	Baltimore City	1	0.0%	3	0.1%	4	0.1%

Sinai Hospital of Baltimore	Baltimore City	3	0.1%	1	0.0%	4	0.1%
Greater Baltimore Medical Center	Baltimore County	1	0.0%	2	0.1%	3	0.1%
UM St. Joseph Medical Center	Baltimore County	1	0.0%	-	0.0%	1	0.0%
MedStar Saint Mary's Hospital	St. Mary's County	1	0.0%	1	0.0%	2	0.0%
Peninsula Regional Medical Center	Wicomico County	-	0.0%	2	0.1%	2	0.0%
Suburban Hospital	Montgomery County	-	0.0%	-	0.0%	-	0.0%
Adventist Fort Washington Medical Center	Prince George's County	-	0.0%	1	0.0%	1	0.0%
Meritus Medical Center	Washington County	-	0.0%	1	0.0%	1	0.0%
UPMC Western Maryland	Allegany County	-	0.0%	-	0.0%	-	0.0%
MedStar Good Samaritan Hospital	Baltimore City	1	0.0%	-	0.0%	1	0.0%
MedStar Union Memorial Hospital	Baltimore City	-	0.0%	-	0.0%	-	0.0%
UM Midtown	Baltimore City	-	0.0%	-	0.0%	-	0.0%
Grace Medical Center	Baltimore City	-	0.0%	-	0.0%	-	0.0%
Northwest Hospital	Baltimore County	-	0.0%	-	0.0%	-	0.0%
Carroll Hospital	Carroll County	-	0.0%	-	0.0%	-	0.0%
Union Hospital of Cecil	Cecil County	-	0.0%	-	0.0%	-	0.0%
UM Shore Dorchester	Dorchester County	-	0.0%	-	0.0%	-	0.0%
Frederick Memorial Hospital	Frederick County	-	0.0%	-	0.0%	-	0.0%
Garrett Regional Medical Center	Garrett County	-	0.0%	-	0.0%	-	0.0%
UM Upper Chesapeake Medical Center	Harford County	-	0.0%	-	0.0%	-	0.0%
UM Harford Memorial Hospital	Harford County	-	0.0%	-	0.0%	-	0.0%
Adventist HealthCare Rehabilitation	Montgomery County	-	0.0%	1	0.0%	1	0.0%
UM Shore Easton	Talbot County	-	0.0%	-	0.0%	-	0.0%
Maryland Subtotal		**2,226**	**95.2%**	**2,073**	**94.7%**	**4,299**	**94.9%**
MedStar Washington Hospital Center	Washington, D.C.	103	4.4%	109	5.0%	212	4.7%
Confidential DC Hospitals		10	0.4%	7	0.3%	17	0.4%
District of Columbia Subtotal		**113**	**4.8%**	**116**	**5.3%**	**229**	**5.1%**
Total OB Service Area		**2,339**	**100.0%**	**2,189**	**100.0%**	**4,528**	**100.0%**
Total Outmigration to DC Hospitals		***113***	***4.8%***	***116***	***5.3%***	***229***	***5.1%***

Source: HSCRC FY22 Abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

The projected obstetrics payer mix is a composite based on the number of patients expected to shift from LHAAMC and LHDCMC service area obstetric inpatient discharges.

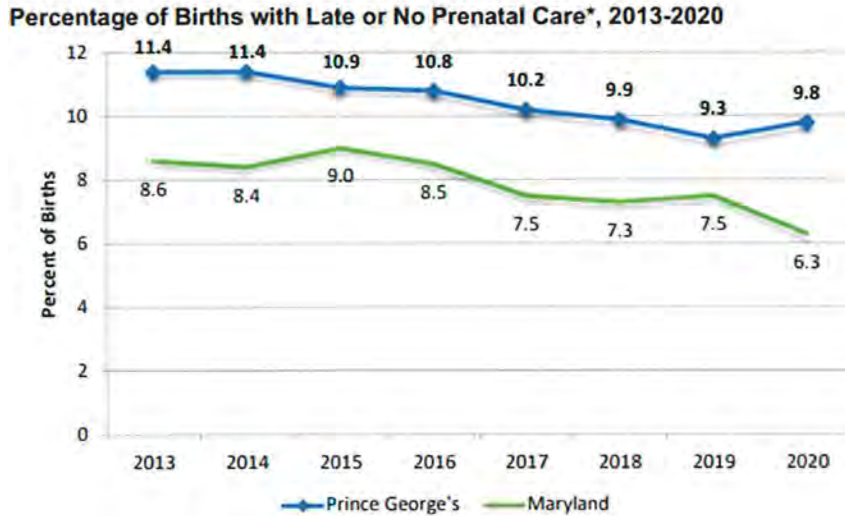
Table 10
New Obstetrics Program at LHDCMC
FY22 Payer Mix

Medicaid	34%
Blue Cross	18%
Other Commercial	44%
Self-Pay	1%
Other	3%
Total	100%

The large proportion of Medicaid deliveries LHDCMC plans to serve reflects our commitment to serving the community and elevating access to care for the most vulnerable members of the population and or commitment to improving health outcomes for the service area.

More women in Prince George's County receive late or no prenatal care at birth compared to other women in the State of Maryland. We do not have this data specifically for the service area, but as the service area represents 84% of the child-bearing population of the County (using 2023 Nielson-Claritas estimates), it is reasonable to assume the percent of births with late or no prenatal care in the service area is equal to or greater than that for the County as a whole.

Figure 3
Late or No Prenatal Care
Prince George's County and Maryland
2013-2020



*Late care refers to care beginning in the third trimester.
Data Source: Maryland Department of Health, Vital Statistics Administration, 2013-2020 Annual Reports

(c) *any data and/or analyses provided by the applicant outlining improvements in the delivery of obstetric services to the defined service are population anticipated to result from implementation of the proposed project, such as improvements in patient care outcomes, lower costs than that currently available in the service area, improvements in geographic or financial access to care, improvements in continuity of care, or improvements in the acceptability or cultural competency of obstetric care for the defined service area population or specific segments of that population;*

An obstetrics program at LHDCMC will meet the County's need for additional obstetrics beds, which is anticipated to improve access for underserved County residents, improve maternal and infant health outcomes.

The proposed obstetrics program will meet Prince George's County's need for additional obstetrics services by improving access to care and maternal and infant health outcomes. The program will provide:

- Local access for patients who now travel to LHAAMC for deliveries.
- Local access for patients who now travel to Montgomery County and Washington, DC for deliveries.

- Additional OB/GYN providers who offer women's healthcare, prenatal care, pregnancy management, and postpartum care through hiring of additional clinicians by Luminis Health who will provide OB/GYN care in the LHDCMC service area.
- Additional OB/GYN providers in the service area who accept all forms of Medicaid and have access to resources to help women obtain health insurance through state programs.
- Effective, integrated management of chronic medical conditions throughout pregnancy.
- Improved quality of care through expansion of existing and development of additional Luminis Health resources, including maternal safety bundles.
- Culturally responsive services and program offerings for a variety of ethnic and religious groups.

LHDCMC will deliver a comprehensive and integrated perinatal program that will incorporate outpatient services from preconception to menopause, and include inpatient labor and delivery, postpartum, antepartum, and special care nursery. LHDCMC will continue to work closely with LHAAMC and community providers to provide coordinated high quality pediatric and neonatal care. A leader in women's services, LHAAMC ranks second among Maryland hospitals for the number of deliveries and has a Level III neonatal intensive care unit, providing complex NICU care for premature and seriously ill newborns.

The obstetrics program will create opportunities for OB/GYNs to successfully provide care in this under resourced region by offering (a) program affiliation with the well-recognized institution of Luminis Health, (b) the laborist model at LHDCMC to attract clinicians seeking to leverage this program model and provide robust clinical care in the community, and (c) a new, locally based facility with progressive design and programmatic features. The obstetrics program will also optimize health system resources locally and efficiently to support the broader health system strategy of Luminis Health.

The proposed program will accomplish these goals through the following program features:

- **Recruitment and deployment of new OB/GYN practitioners:** As part of the proposed program, Luminis Health will add at least 4 additional OB/GYN providers to the existing 4 OB/GYN providers in the service area.

- **Quality Improvement initiatives and clinical protocols across Luminis Health**: Luminis Health will integrate clinical activity, standardized care protocols and quality improvement initiatives across LHAAMC and LHDCMC to improve maternal health and infant health outcomes. The Luminis Health Women's and Children's Committee on Quality and Safety of LHAAMC has also developed a maternal safety bundle of protocols that addresses several obstetrical emergencies including sepsis detection and management, hypertension and hemorrhage.

- **Working relationship and coordination with local pediatricians across the region.** Luminis Health has highly collaborative and productive relationships with community pediatricians, as well as CNH. LHAAMC has established a newborn quality program that addresses newborn hypothermia, hypoglycemia and neonatal abstinence

syndrome. This program will be extended to LHDCMC and modified to address the needs of newborns in the community.

- **Laborist model: Luminis Health will introduce a laborist model of care at LHDCMC**. Published studies shown that implementation of a laborist model of care is associated with fewer inductions of labor and decreased rates of preterm birth (https://pubmed.ncbi.nlm.nih.gov/30835985/). The laborist model is also expected to support recruitment of physicians by providing them a higher quality of life and time to focus on delivering high quality care in the ambulatory setting.

- **Social services and case management services:** Social work and case management will be in place to facilitate outpatient care coordination for families that require these services. The community educator/navigator will work in collaboration with the patient education team, ambulatory services and inpatient providers to ensure consistent and broadly disseminated education. All obstetric patients will have access to a licensed clinical social worker for any psychosocial concerns. Patients will also have access to a domestic violence caseworker at their request or at the request of the attending physician or nurse. The social worker and domestic violence staff member will work with the mother to develop a safe plan of care at the time of discharge. The community educator/navigator will follow-up with the patient after discharge.

Luminis Health can support the implementation of best practices and effective clinical management by localizing obstetric care in the LHDCMC community. Adoption of protocols, checklists and safety bundles are critical to improving health outcomes and are considered to be one of the most effective strategies for lowering maternal morbidity and mortality rates. The Luminis Health Women's and Children's Committee on Quality and Safety at LHAAMC have developed maternal safety bundle of protocols, that address several obstetrical emergencies including sepsis detection and management, hypertension and hemorrhage. The same maternal safety bundle of protocols will be adopted at LHDCMC. LHDCMC's obstetrics program will provide a local delivery site as the center of a coordinated continuum of women's health in Prince George's County.

LHDCMC is committed to not only increasing access to an obstetric delivery pavilion but also to comprehensive women's health care including but not limited to pre-conception, prenatal, and post-partum care; and other co-occurring conditions such as cardiology, psychiatry, oncology and primary care. LHDCMC recognizes that creating access is not enough; the care must be culturally appropriate and designed to break down barriers that prevent women from receiving adequate prenatal care.

The LHDCMC obstetric program is expected to yield the following community and population health benefits:

- **Provide access to a local delivery site and increase the number of ambulatory providers.** Empowering community-based OB/GYN physicians to maintain and increase access to women's health services to address the shortage in this area. In addition, Luminis Health will hire at least 4 additional practice-based OB/GYN providers to their

existing complement of 4, in order to provide preconception, prenatal and postpartum care in Prince George's County. This will help to meet the need for additional clinicians in this undersupplied region. Luminis Health believes that the introduction of this obstetrics program at LHDCMC is critical to recruiting and retaining clinicians in the area.

- **Improve maternal/child health outcomes and reduce health disparities.** Additional physician capacity will provide greater access to OB/GYN services, prenatal through postpartum, as well as screening, prevention, and management of chronic conditions and mental health. Training and protocolized maternity care including integration with Luminis Health Women's and Children's Committee on Quality and Safety at LHAAMC to support best practices and continuous quality improvement. Linkage and direct access to social services and case management and culturally responsive programs to increase patient satisfaction and promote patient engagement.

- **Reduce the C-Section rate through protocol development and utilization of the laborist model**. Reducing the C-Section rate will reduce average length of stay and total cost of care for obstetrics patients in the region. Hospitals across the country have demonstrated the opportunity to reduce low-risk, first birth C-section rates. LHAAMC is actively working to reduce the C-section rate and racial disparities in C-section rates. These initiatives and goals will continue across the Luminis Health system of care at LHDCMC. LHDCMC assumed a lower ALOS of 2.35 compared to the LHDCMC service area of 2.58.

- **Reduce travel time for obstetric care for patients who now rely on delivery sites in Montgomery County, Anne Arundel County, or Washington, DC.** The new program is expected to reduce travel time for more than 2,200 patients and their families including the nearly 800 service area patients who currently travel to LHAAMC. The table provides a comparison of current travel time to the closest obstetrics unit relative to the proposed unit at LHDCMC. (Note: LHAAMC is not listed in the table because it is not the closest obstetrics program for any facility.)

Table 11
Drive Time to Closest Hospital with an OB Unit
Based on new location of WAH (White Oak=20904) & UM Capital Region (Largo=20774)
FY 2022

2,314 = population of deliveries that would be impacted substantially by drive time
(>5 minutes in drive time)

		Closest OB Unit Currently			Drive Time to DCMC		
ZIP Code	Community	Closest hospital	# Miles	Drive Time (minutes)	# Miles	Drive Time (minutes)	# Deliveries FY 2022
Primary Service Area (PSA)							
20706	Lanham	UM Capital	9	16	0	0	543
20785	Hyattsville	UM Capital	8	13	6	9	
20784	Hyattsville	UM Capital	11	16	3	4	443
20774	Upper Marlboro	UM Capital	0	0	9	14	
20737	Riverdale	WAH	10	17	4	7	377
20747	District Heights	UM Capital	10	17	12	16	
20743	Capitol Heights	UM Capital	8	11	9	11	
20770	Greenbelt	WAH	9	16	5	8	327
20720	Bowie	UM Capital	8	15	5	8	213
20721	Bowie	UM Capital	4	8	7	12	
Secondary Service Area (SSA)							
20708	Laurel	WAH	10	15	10	13	
20782	Hyattsville	WAH	10	16	7	12	
20705	Beltsville	WAH	6	11	8	13	
20772	Upper Marlboro	UM Capital	12	17	17	25	
20748	Temple Hills	Southern MD	7	12	16	21	
20744	Fort Washington	Southern MD	20	25	21	25	
20746	Suitland	UM Capital	12	18	14	18	
20740	College Park	WAH	7	11	6	9	
20735	Clinton	Southern MD	0	0	19	24	
20715	Bowie	UM Capital	10	19	7	12	211
20745	Oxon Hill	Southern MD	16	20	18	20	
20716	Bowie	UM Capital	8	13	11	15	
20781	Hyattsville	Wash Hosp Center	7	13	6	9	
20710	Bladensburg	UM Capital	10	16	5	8	143
20769	Glenn Dale	UM Capital	8	14	5	7	57

Total # of Deliveries Impacted by drive time	2,314

Source: Rand McNally available at: http://maps.randmcnally.com/mileage_calculator

The highlighted communities in the LHDCMC service area are the ones who will benefit most significantly by reduced travel time.

(d) *any demographic or health service utilization data and/or analyses providing a perspective on the need for the proposed project which is significantly different from that found in the Commission's forecast of obstetric service utilization; and*

Prince George's County Residents have among the poorest outcomes for maternal and infant health.

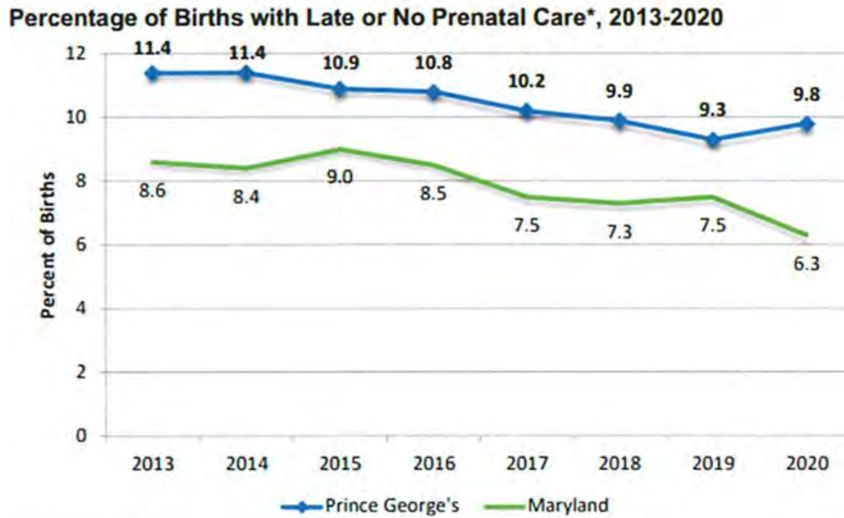
The low number of obstetrics programs and OB/GYN practitioners in Prince George's County, in part, results in lower rates of prenatal and postpartum care. As a result, women and families in Prince George's County experience:

- **Hardship in Traveling**: Women and families in Prince George's County not only leave the county for delivery but for perinatal care throughout pregnancy. Adequate prenatal care for a healthy pregnancy requires numerous visits. Patients and families are forced to travel out of the county dozens of times, which makes it more difficult to stay engaged in care. Additionally, many families depend on public transportation, which is expensive and oftentimes unavailable or unreliable.
- **Disjointed medical and prenatal care**: A significant percentage of pregnant patients also have chronic medical conditions. Out-of-county healthcare makes it difficult to receive comprehensive maternal and medical care.
- **Disruption in continuity of care**: Following discharge from an out-of-county hospital, women and infants must travel to receive care from their established provider.

The CHNA documents comparatively low rates of prenatal care for Prince George's County residents. Low rates of prenatal and postpartum care within Prince George's County cause it to have the poorest maternal and infant health outcomes across all jurisdictions in Maryland. Multiple studies demonstrate the correlation between the number of prenatal visits and poor pregnancy outcomes such as low birthweight, preterm birth and infant mortality. Data indicates that fewer prenatal visits are associated with maternal fatality and severe maternal morbidity (https://pubmed.ncbi.nlm.nih.gov/29346121/).

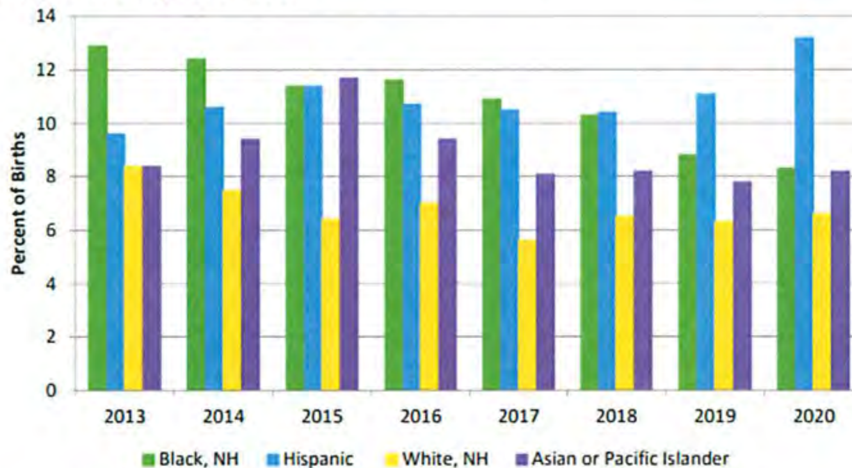
More women in Prince George's County receive late or no prenatal care at birth compared to other women in the State of Maryland.

Figure 4
Late or No Prenatal Care
Prince George's County and Maryland
2013-2020



Engagement in prenatal care varies by race and ethnicity, as shown in **Figure 5**.

Figure 5
Late or No Prenatal Care by Race and Ethnicity
Prince George's County
2013-2020



Hispanic and non-Hispanic Black Women are more likely to receive late or no prenatal care in Prince George's County than across the entire state of Maryland.

a. Prince George's County has high rates of maternal risk factors and pregnancy-related maternal mortality, with significant disparities by race.

An FY 2022 analysis of obstetric cases in Prince George's County shows that 12.0% of women delivering had an accompanying diagnosis of diabetes up from 7% in 2017 and 11.0% of women delivering had an accompanying diagnosis of hypertension. These conditions are recognized to be major risk factors in pregnancy and are correlated with poor maternal health outcomes.

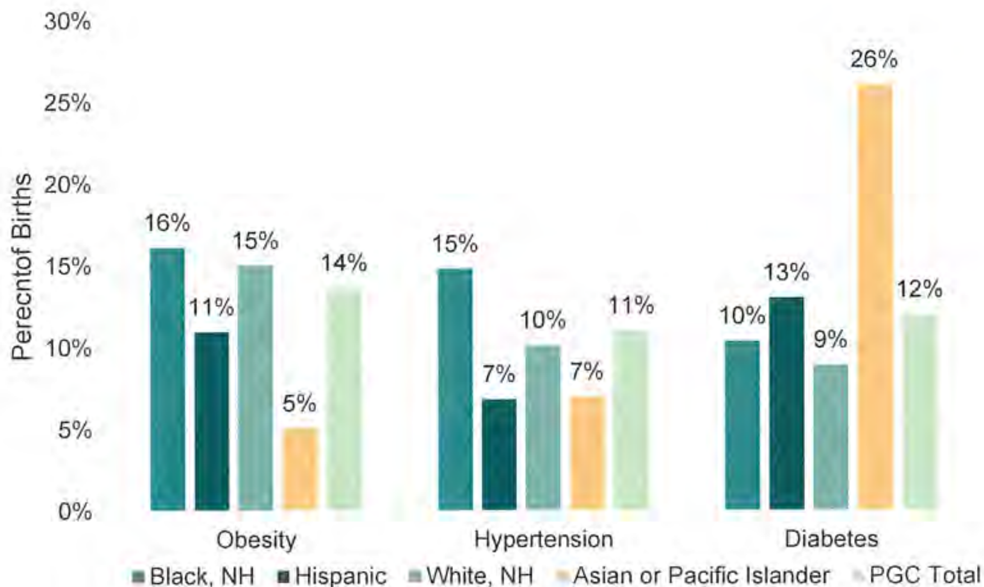
Obesity, diabetes, and hypertension are maternal risk factors that increase the risk of complications during pregnancy. Obesity is associated with an increased risk of gestational diabetes, hypertension, pre-eclampsia, C-section delivery, and postpartum weight retention. Black, non-Hispanic women had a higher obesity and hypertension rate compared to other racial and ethnic groups. The obesity rate for Black women during pregnancy is 7.4% higher that of non-Hispanic white women in the service area, while the rate of hypertension is 46%.

High blood sugar during pregnancy increases the risk of birth defects, preterm birth and fetal loss. Diabetes during pregnancy increases the mother's risk of developing diabetes later in life. Although Asians and Pacific Islanders have lower rates of obesity, they are twice as likely to experience diabetes as other races and ethnicities. Diabetes prevalence for Black, non-Hispanic pregnant women in Prince George's County is 10.5% and 8.3% for White women in FY 2022. Since 2013, the prevalence of diabetes in pregnant women across the County increased from 5.6% to 12.0% in 2022.

Hypertension can cause decreased blood flow to the placenta, slowed or decreased growth of the baby, premature birth, maternal organ damage, and future risk of maternal heart disease. Preeclampsia is gestational hypertension that can advance to organ failure. Both black and white non-Hispanic women are more likely to have hypertension. Maternal Hypertension increased from 5.4% in 2017 to 11.0% in 2022.

Figure 6 demonstrates the maternal risk factors by race and ethnicity in Prince George's County in FY 2022. Maternal risk factors are obesity, hypertension and diabetes.

Figure 6
Percentage of Births with Maternal Risk Factors by Race and Ethnicity
Prince George's County
FY 2022



Source: MD HSCRC Inpatient Data Set, FY22, Deliveries identified by MS-DRG, Prince George's County Residents delivering at MD hospitals.

This data demonstrates the need to invest in prenatal and postpartum care as well as primary care to support effective management and prevention of chronic conditions. Although requesting inpatient beds for obstetrics in this application, Luminis Health is developing the ambulatory platform first to meet the needs of both high risk and low risk obstetrical patients. And while patients with significant and uncontrolled comorbidities are more likely to require support of a NICU at delivery, it is the goal of the Luminis Health Women's and Children's program to reduce the complexity of the delivery through providing comprehensive prenatal care and support, thereby reducing the likelihood these women will have uncontrolled comorbidities going into delivery and require higher acuity birth services.

b. Prince George's County has a high percentage of low birth weight infants, one of the highest infant mortality rates, and one of the largest total number of infant deaths across all jurisdictions, with significant disparities in outcomes by race.

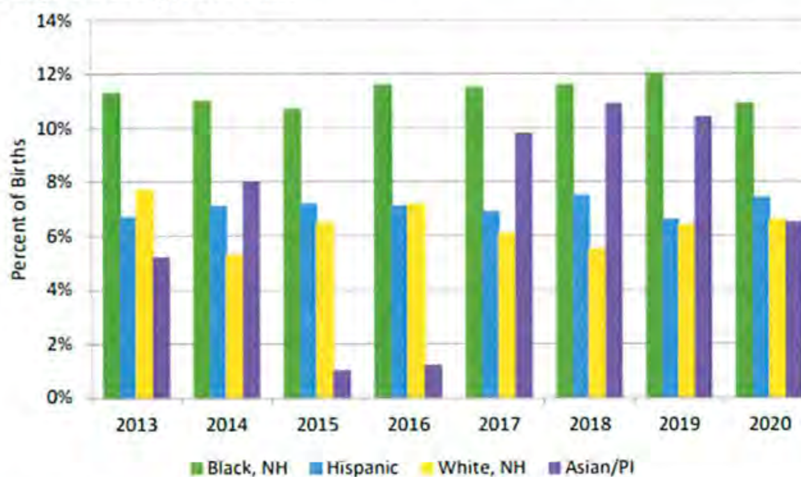
The figures documented below call for significant investment to improve health outcomes and address disparities in care. These statistics reflect the complex dynamics tied to health status, including socioeconomic conditions and cultural factors. LHDCMC seeks to respond to these needs with a local obstetrics program, providing both inpatient obstetrics,

neonatal care, and a network of OB/GYN clinicians. LHDCMC providers will provide easy-to-access prenatal care, steady management of high-risk factors, mental health services, and linkage to social services. A culturally responsive obstetrics program also provides social support groups for pregnancy management, postpartum support, and ongoing health improvement. The proposed obstetric program is a critical investment toward building healthy communities in Prince George's County.

Low Birth Weight Infants

Prince George's County percentage of low birth weight infants is higher than the State of Maryland. Black, non-Hispanic women have the highest likelihood to give birth to a low birth weight infant.

Figure 7
Percentage of Low Birth Weight Infants
Prince George's County, 2013-2020



Source: Prince George's County 2022 Community Health Needs Assessment
https://www.princegeorgescountymd.gov/ArchiveCenter/ViewFile/Item/3677

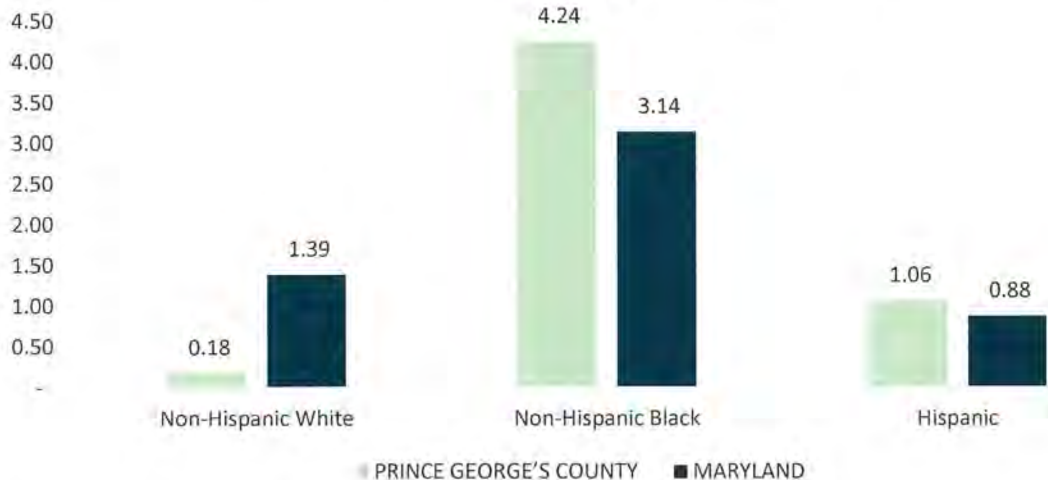
Babies born below 5 lb. 8 oz. are classified as low birth weight. While some low birth weight babies are healthy, others have serious health problems in the short-term and long-term. The primary causes of low birth weight are premature birth and intrauterine growth restrictions (IUGR). Several factors increase the risk of low birth weight including race, age, multiple birth, and the mother's health (https://www.chop.edu/conditions-diseases/low-birthweight;https://www.marchofdimes.org/complications/low-birthweight.aspx).

Infant Mortality Rates

Infant mortality is the death of an infant before a baby's first birthday. The five leading causes of infant mortality across the United States are birth defects, preterm birth, low birth

weight, Sudden Infant Death Syndrome (SIDS), and maternal complications (https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm). Prince George's County infant mortality rate has improved since 2008, however, the County's rate is still higher than the average infant mortality rate of the State of Maryland.

Figure 8
Infant Mortality Rate by Race and Hispanic Origin
Prince George's County and Maryland
CY 2020



Source: Maryland Department of Health, Vital Statistics Administration

Racial disparities in infant mortality rates are evident in Maryland and are even more drastic in Prince George's County. As of 2020, the rate of infant mortality among the Non-Hispanic Black population in Prince George's County was 4.24 deaths per 1000 live births, as compared to a statewide rate of 3.14 deaths per 1000 live births in the same racial and ethnic group. The rate of infant mortality among the Hispanic population in Prince George's County was 1.06 deaths per 1000 live births, as compared to a statewide rate of 0.88 deaths per 1000 live births in the same racial and ethnic group. In contrast, the infant mortality rate among Non-Hispanic Whites was 0.18 and 1.39 deaths per 1,000 live births in Prince George's County and the state of Maryland respectively. This demonstrates a distinct gap in care within the non-White population of Prince George's County as compared with the rest of the state. Prenatal care can identify low birth weight and other risk factors prior to birth through ultrasounds, measurements of the fetus, and patient education to reduce the risk of preterm and low birth weight. LHDCMC is committed to reducing low birth weight in Prince George's County by providing a local site for delivery and providing prenatal.

(e) **Any other relevant information on the unmet needs for obstetric services in the service area.**

LHDCMC has addressed the unmet needs for the obstetric services in section (a) through (d).

2. Maryland Perinatal System Standards.
Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of the Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

Applicant Response:

As demonstrated in **Exhibit 19**, LHDCMC will comply with all applicable requirements of the Maryland Perinatal System Standards.

3. Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:
   (i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);
   (ii) posted notices in the admissions office, business office and emergency areas within the hospital
   (iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and
   (iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination or probable eligibility.

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

Applicant Response:

Please see the response to COMAR 10.24.10.04A(2) Charity Care.

4. Medicaid Access.
Each hospital shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service are, and

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

Applicant Response:

(a) The following table estimates the number of Medical Assistance enrollees in LHDCMC's primary service area:

Table 12
Maryland Medicaid, LHDCMC Service Area
Distribution of OB Volume
FY 2022

Hospital	County	PSA		SSA		Total Service Area (PSA&SSA)	
		Cases	Market Share	Cases	Market Share	Cases	Market Share
Holy Cross Hospital	Montgomery County	1,048	44.8%	854	39.0%	1,902	42.0%
Adventist HealthCare White Oak Hospital	Montgomery County	249	10.6%	298	13.6%	547	12.1%
UM Capital Region Medical Center	Prince George's County	526	22.5%	330	15.1%	856	18.9%
MedStar Southern Maryland Hospital Center	Prince George's County	51	2.2%	171	7.8%	222	4.9%
Anne Arundel Medical Center	Anne Arundel County	148	6.3%	125	5.7%	273	6.0%
Adventist HealthCare Shady Grove Medical Center	Montgomery County	26	1.1%	34	1.6%	60	1.3%
Howard County General Hospital	Howard County	5	0.2%	19	0.9%	24	0.5%
UM Charles Regional Medical Center	Charles County	7	0.3%	40	1.8%	47	1.0%
University of Maryland Medical Center	Baltimore City	22	0.9%	39	1.8%	61	1.3%
Holy Cross Germantown Hospital	Montgomery County	56	2.4%	38	1.7%	94	2.1%
UM Baltimore Washington Medical Center	Anne Arundel County	26	1.1%	54	2.5%	80	1.8%
MedStar Montgomery Medical Center	Montgomery County	9	0.4%	22	1.0%	31	0.7%
The Johns Hopkins Hospital	Baltimore City	11	0.5%	10	0.5%	21	0.5%
Doctors Community Hospital	Prince George's County	20	0.9%	4	0.2%	24	0.5%
Saint Agnes Hospital	Baltimore City	6	0.3%	9	0.4%	15	0.3%
MedStar Harbor Hospital Center	Baltimore City	4	0.2%	5	0.2%	9	0.2%
Johns Hopkins Bayview Medical Center	Baltimore City	3	0.1%	3	0.1%	6	0.1%
MedStar Franklin Square Medical Center	Baltimore County	1	0.0%	4	0.2%	5	0.1%
CalvertHealth Medical Center	Calvert County	-	0.0%	2	0.1%	2	0.0%
UM Laurel Regional Hospital	Prince George's County	-	0.0%	-	0.0%	-	0.0%
Mercy Medical Center	Baltimore City	1	0.0%	3	0.1%	4	0.1%
Sinai Hospital of Baltimore	Baltimore City	3	0.1%	1	0.0%	4	0.1%
Greater Baltimore Medical Center	Baltimore County	1	0.0%	2	0.1%	3	0.1%
UM St. Joseph Medical Center	Baltimore County	1	0.0%	-	0.0%	1	0.0%
MedStar Saint Mary's Hospital	St. Mary's County	1	0.0%	1	0.0%	2	0.0%

Peninsula Regional Medical Center	Wicomico County	-	0.0%	2	0.1%	2	0.0%
Suburban Hospital	Montgomery County	-	0.0%	-	0.0%	-	0.0%
Adventist Fort Washington Medical Center	Prince George's County	-	0.0%	1	0.0%	1	0.0%
Meritus Medical Center	Washington County	-	0.0%	1	0.0%	1	0.0%
UPMC Western Maryland	Allegany County	-	0.0%	-	0.0%	-	0.0%
MedStar Good Samaritan Hospital	Baltimore City	1	0.0%	-	0.0%	1	0.0%
MedStar Union Memorial Hospital	Baltimore City	-	0.0%	-	0.0%	-	0.0%
UM Midtown	Baltimore City	-	0.0%	-	0.0%	-	0.0%
Grace Medical Center	Baltimore City	-	0.0%	-	0.0%	-	0.0%
Northwest Hospital	Baltimore County	-	0.0%	-	0.0%	-	0.0%
Carroll Hospital	Carroll County	-	0.0%	-	0.0%	-	0.0%
Union Hospital of Cecil	Cecil County	-	0.0%	-	0.0%	-	0.0%
UM Shore Dorchester	Dorchester County	-	0.0%	-	0.0%	-	0.0%
Frederick Memorial Hospital	Frederick County	-	0.0%	-	0.0%	-	0.0%
Garrett Regional Medical Center	Garrett County	-	0.0%	-	0.0%	-	0.0%
UM Upper Chesapeake Medical Center	Harford County	-	0.0%	-	0.0%	-	0.0%
UM Harford Memorial Hospital	Harford County	-	0.0%	-	0.0%	-	0.0%
Adventist HealthCare Rehabilitation	Montgomery County	-	0.0%	1	0.0%	1	0.0%
UM Shore Easton	Talbot County	-	0.0%	-	0.0%	-	0.0%
Maryland Subtotal		**2,226**	**95.2%**	**2,073**	**94.7%**	**4,299**	**94.9%**
MedStar Washington Hospital Center	Washington, D.C.	103	4.4%	109	5.0%	212	4.7%
Confidential DC Hospitals		10	0.4%	7	0.3%	17	0.4%
District of Columbia Subtotal		**113**	**4.8%**	**116**	**5.3%**	**229**	**5.1%**
Total OB Service Area		**2,339**	**100.0%**	**2,189**	**100.0%**	**4,528**	**100.0%**
Total Outmigration to DC Hospitals		***113***	***4.8%***	***116***	***5.3%***	***229***	***5.1%***

Source: HSCRC FY22 Abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

Source: HSCRC abstract dataset for Maryland hospital discharges (Payer1 = 2 or 14) and DCHA discharge database for DC hospital discharges

4,528 of the 8,717 deliveries in the LHDCMC PSA/SSA were Medical Assistance. This represents 52% of the inpatient volume for the service are Medical Assistance enrollees.

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

Currently 15 OB/GYN providers have gynecology-service privileges at LHDCMC and all participate in either Medicaid or Medicaid MCO products. Through Luminis Health's planned expansion of services in the region, it is anticipated that between eight and twenty OBGYN providers will ultimately deliver obstetric care at LHDCMC. All physicians currently participate in either Medicaid or Medicaid MCO products and any new providers added to the service area by Luminis Health would participate in Medicaid or Medicaid MCO products.

Currently 34 pediatricians have privileges at LHDCMC and participates in the Medical Assistance Program. There are approximately 70 providers in the area that potentially will have patients in the program and 65% participate in either Medicaid or Medicaid MCO products. The neonatology group that Luminis Health plans to deliver neonatal care will participates in either Medicaid or Medicaid MCO products.

LHDCMC will work with local partners to identify and address the needs of Prince George's County women requiring prenatal and obstetrical care. Local partners include but are not limited to primary care and family medicine providers, OBGYNs, the county health department, social service agencies and community centers. Mechanisms exist at LHAAMC to service the uninsured and underinsured and similar processes will be put in place at LHDCMC. Any women that require obstetrical care will be provided care in the program.

5. Staffing.

Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post-partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

Applicant Response:

LHDCMC's proposed staffing table is below. Year 3 and Year 5 staffing are included. Year 5 is when maximum projected volumes are expected. A 2.5% merit increase is assumed annually, and the table includes salary and benefits.

Table 13
LHDCMC Obstetric Program Staffing

Employee Category	Year 1 FTE	Average Salary per FTE	Year 1 Total Expense	Year 3 FTE	Average Salary per FTE	Year 3 Total Expense	Year 5 FTE	Average Salary per FTE (1)	Year 5 Total Expense
Labor and Delivery									
Nursing Director	0.5	$ 152,214	$ 76,107	1.0	$ 159,920	$ 159,920	1.0	$ 168,016	$ 168,016
L&D Clin Supe - Night	0.5	$ 159,619	$ 71,829	0.9	$ 167,700	$ 150,930	0.9	$ 176,190	$ 158,571
Clinical Educator	0.3	$ 108,909	$ 32,673	0.6	$ 114,422	$ 68,653	0.6	$ 120,215	$ 72,129
Charge/Resource Nurse	2.8	$ 109,158	$ 300,186	3.3	$ 114,685	$ 378,459	3.3	$ 120,490	$ 397,618
Triage Nurse	1.8	$ 109,158	$ 191,027	2.1	$ 114,685	$ 240,838	2.1	$ 120,490	$ 253,030
OR/Recovery Nurse	1.8	$ 109,158	$ 200,124	2.2	$ 114,685	$ 252,306	3.2	$ 120,490	$ 385,569
RN - Laboring and Non-Laboring	10.5	$ 109,158	$ 1,146,163	16.8	$ 114,685	$ 1,926,700	20.4	$ 120,490	$ 2,458,005
OB Surg Tech	4.2	$ 80,309	$ 337,297	4.2	$ 84,374	$ 354,373	4.2	$ 88,646	$ 372,313
Clerical/ Reg. Staff	4.2	$ 49,650	$ 208,528	4.2	$ 52,163	$ 219,085	4.2	$ 54,804	$ 230,176
Anesthesia/Equipment PCT	1.1	$ 69,742	$ 73,230	2.1	$ 73,273	$ 153,874	2.1	$ 76,983	$ 161,663
Perinatal Loss Coordinator	0.2	$ 130,021	$ 19,503	0.3	$ 136,603	$ 40,981	0.6	$ 143,519	$ 86,111
Subtotal	***27.7***		***$ 2,656,666***	***37.7***		***$ 3,946,119***	***42.6***		**$ 4,743,202**
Post Partum									
Community Educator/Navigator	0.45	$108,222.40	$48,700	0.9	$113,701	$102,331	0.9	$119,457	$107,512
Lactation	0.8	$111,550.40	$89,240	2.8	$117,198	$328,153	3.6	$123,131	$443,271
Charge Nurse	2.475	$111,862.40	$276,859	3.3	$117,525	$387,834	3.3	$123,475	$407,468
RN/Special Care Nursery	9.45	$111,862.40	$1,057,100	15	$117,525	$1,762,882	19.6	$123,475	$2,420,113
MBU Clin Supe - Nights	0.45	$130,894.40	$58,902	0.9	$137,521	$123,769	0.9	$144,483	$130,035
MBU Educator	0.3	$116,875.20	$35,063	0.6	$122,792	$73,675	0.6	$129,008	$77,405
PCT Techs	2.1	$46,051.20	$96,708	4.2	$48,383	$203,207	4.2	$50,832	$213,494
Clerical Staff and Vital Statistics	2.1	$49,649.60	$104,264	4.2	$52,163	$219,085	4.2	$54,804	$230,176
Subtotal	***18.1***		***$ 1,766,836***	***31.9***		***$ 3,200,936***	***37.3***		**$ 4,029,473**
Support Staff									
Social Work/Case Management	1.4	$ 80,059	$ 112,083	2.8	$ 84,112	$ 235,514	2.8	$ 88,370	$247,437
EVS	3.0	$ 43,597	$ 128,611	7.1	$ 45,804	$ 325,208	8.3	$ 48,123	$399,418
Respiratory Therapy	0.2	$ 111,176	$ 16,676	0.3	$ 116,804	$ 35,041	0.3	$ 122,718	$36,815
BioMed	0.2	$ 81,869	$ 12,280	0.3	$ 86,013	$ 25,804	0.5	$ 90,367.84	$45,184
Security Officer	1.5	$ 55,786	$ 83,678	3.0	$ 58,610	$ 175,829	5	$ 61,576.86	$307,884
Pharmacist	0.7	$ 148,803	$ 104,162	2.1	$ 156,336	$ 328,306	2.1	$ 164,250.89	$344,927
Subtotal	***6.9***		***$ 457,491***	***15.6***		***$ 1,125,703***	***19.0***		**$ 1,381,666**
Total Salaries							98.9		**$ 10,154,342**
Benefits @ 17%									$ 1,726,238
Total Salaries and Benefits									**$ 11,880,580**

6. Physical Plant Design and New Technology.

All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

Applicant Response:

Investment in the physical infrastructure and technology will promote patient safety measures, enhance LHDCMC's healing environment, and support clinicians who deliver quality care for patients, infants, and families. LHDCMC anticipates the following will have positive impacts on patient safety within the obstetrics program space:

The proposed obstetrics facilities will enhance patient safety for LHDCMC's obstetric population. The new obstetrics program has been designed based on best practices, standard room design concepts, and are designed with patient, infant and staff safety as a core design element. The key rooms will meet current 2018 FGI Guidelines and include the following safety features:

- The Labor and Delivery offers an LDR model of care, and Antepartum rooms and Birthing Center (Midwife) rooms on Level 3 are designed with a standard layout to allow for greater flexibility and standard patient care.
    - The typical LDR, patient room meets/exceeds the minimum of 325 sf clear space including the infant stabilization and resuscitation area of at least 40 square feet; excluding the built-in patient clothing storage and desk and the entry vestibule.
    - LDR patient rooms will have inboard private patient toilet rooms with a toilet, sink, and shower.
- The Postpartum / Antepartum Unit, on Level 4, was developed as a flexible unit based on the programs ideal nurse to-patient ratio and standard patient care.
    - The typical Postpartum room meets/exceeds the minimum of 150 sf clear space in single patient rooms.
    - Postpartum rooms in the addition will have inboard private patient toilet rooms with a toilet, sink, and shower.
- The typical C-Section room meets/exceeds the minimum of 440 sf clear space including the infant resuscitation area of 80 sf.
- For the well-baby nursery, each station meets/exceeds the minimum of 24 sf clear space.
- For the Level II Continuing Care Nursery, each station meets/exceeds the minimum of 120 sf clear space.
- The Postpartum / Antepartum Unit and Level II Continuing Care Nursery units are all designed to accommodate Airborne Infection Isolation Rooms (AIIR) should the need arise. Each AIIR meets/exceeds the minimum code requirements.
- Code minimum patient clearances on all sides of the bed for portable equipment access, larger team access, and enough space required for an emergency situation.
- Handwashing sinks are immediately accessible upon entering the room and are located on the opposite wall from the patient to minimize the risk of infection.
- A bedside computer in every room to minimize the risk of cross-contamination by moving portable computers from room to room and facilitates timely, accurate documentation and safe delivery of medications.
- Same-handed room design with similar features from room to room to standardize patient care.
- Individuals of Size rooms are provided. One (1) Postpartum Room and one (1) Antepartum Room. The extra clearances will help with patient access, patient transfers, and will reduce patient and staff injuries.
- Ventilation and filtration systems to control and prevent the spread of infections and use of surfaces that can be easily decontaminated.
- Headwall design that provides easy staff access to critical infrastructure such as medical gasses and emergency power.
- Inboard patient toilet rooms to maximize patient privacy and maximize views.

- Patient toilet rooms that are sufficiently sized to allow for staff to assist patients with toilet and shower needs.
- Dedicated family space to encourage family members to remain at the bedside as much as possible, which has been shown to have a positive outcome on patient care.

In addition to the safety features in every room, several key safety features have been included in the overall unit(s) design:

- In addition to the central nurse station, decentralized stations are provided to enable better visibility to more patient rooms.
- Distributing key support spaces to locate nurses closer to the patient in case of an emergency and reduce steps.
- Providing negative pressure Airborne Infection Isolation rooms (AIIR) in the Level II Continuing Care Nursery (two private rooms and one multiples room (two stations)) and the Postpartum/Antepartum Unit (three (3) total) for increased infection prevention.
- Providing a patient and family lounge to encourage families to remain close to patients and encourage patients to move around the unit as soon as possible.
- Medication rooms, located on each floor, are sufficiently sized to accommodate automated medication dispensing units and reduce potential for errors caused by interruptions and distractions. Providing automated dispensing for almost all medication will also greatly reduce the risk of medication errors.
- Extending the existing pneumatic tube system to Triage, LDR, C-Section, Level II Continuing Care Nursery, and Postpartum / Antepartum Unit to provide easy transport of critical medication and other supplies as well as safe transport and timely turnaround of lab results.
- Pharmacy Clean Room and Anteroom located adjacent to the Level II Continuing Care Nursery on Level 4 to allow for IV medications preparation and reduced delivery time.
- Respiratory Therapy Decontamination and Clean Equipment Storage is located on Level 4 to support the Level II Continuing Care Nursery and mitigate transport of critical equipment to the existing remote Respiratory Therapy area.
- As part of the Acute Care Pavilion project there are many security features to prevent infant abduction. To address these issues the facility will emphasize safety and security, as well as infant security best practices and functional design features.
- Each zone of the Obstetrics care area will have sophisticated security systems that ensure infant security. These security systems may include electronic card readers for secure staff access. This system also enables patients with privileges to access and flow to designated zones of the facility that they are authorized to use.
- Facility configuration also ensures security and safety through secured doors and/or vestibules at all entries and selected entrances and stairs.

- Design and safety features will be evaluated by the design team, the clinical team, the LHDCMC safety office personnel and a host of others to ensure that the final product as well as the materials and furniture, fixtures, and equipment to be used in the project will be consistent with those that lend to illuminating a healing and safe environment for patients, infants and families.
- Incorporating evidenced-based care into the design and use of key rooms is a goal of the proposed project. Applicable literature confirms that hospital design can enhance patient safety and create healthier environments for patients, families, and staff by preventing injury from falls, infections, and medical errors; minimizing environmental stressors associated with noise and inefficient room and unit layout; and using nature, color, light and sound to control potential stressors.

7. Nursery.

An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

Applicant Response:

The level of perinatal care will be consistent with the needs of LHDCMC's service area. The following table shows deliveries by NICU level in LHDCMC's service area:

Table 14
Deliveries by NICU Level
LHDCMC Service Area
FY 2022

	Cases	% of Cases
Level I	3,431	**89%**
Level II	288	**8%**
Level III	119	**3%**
Subtotal: PSA	3,838	**100%**
Level I	3,693	**92%**
Level II	240	**6%**
Level III	103	**3%**
Subtotal: SSA	4,036	**100%**
Level I	7,124	**90%**
Level II	528	**7%**
Level III	222	**3%**
Total PSA/SSA	**7,874**	**100%**

Source: FY2022 HSCRC inpatient abstract dataset for Maryland hospitals and CY2019 DCHA inpatient dataset for DC hospitals

Notes:

Includes all Newborn cases defined as MS-DRG 789-795

Level III NICU defined as all cases where any Dx in position 1-20 is one of the following ICD-10-CM codes: P0501, P0502,

P0503, P0504, P0505, P0510, P0511, P0512, P0513, P0514, P0515, P070, P0702, P0703, P0714, P0715, P0720, P0721, P0722, P0723, P0724, P0725, P0726, P0731, P0732, P0733, P0734

Level II NICU defined as all cases not identifed as Level III where any Dx in position 1-20 is one of the following ICD-10-CM codes: P0500, P0506, P0507, P0508, P0516, P0517, P0518, P0710, P0716, P0717, P0718, P0730, P0735, P0736, P0737,

LHDCMC will have a Level II perinatal program which will provide specialty care to pregnant women and infants in accordance with the Maryland Perinatal System Standards. 97% of the deliveries in LHDCMC's service area are Level I or II deliveries. LHDCMC will partner with board-certified neonatal perinatal medicine specialists. Appropriate respiratory support including brief utilization of mechanical ventilation will be available. Care processes and staff competence will support care delivery for moderately ill infants > 1500 grams and > 32 weeks gestation for problems that are expected to resolve quickly and when urgent subspecialty services are not anticipated. Programmatic management of obstetrical services will be conducted by board-certified obstetricians. Quality and operational metrics will be utilized to assess outcomes and program effectiveness and drive continuous improvement of care delivery processes.

8. Community Benefit Plan.

Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population. This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required. At a minimum, the Community Benefit Plan must include:

(i) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,

(ii) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and;

(iii) information on the structure, staffing, and funding of the Plan;

(iv) documentation of community support and involvement in program planning for the Plan by other agencies organizations and institutions which will be involved directly or indirectly, with the Plan;

(v) an implementation scheme the Community Benefit Plan.

(vi) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(vii) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

Applicant Response:

a. *Needs assessment related to obstetrics and nursery services for the service area, including a description of the manner in which the proposed service will satisfy unmet needs identified in the needs assessment:*

Based on the 2022 CHNA for Prince George's County https://www.princegeorgescountymd.gov/ArchiveCenter/ViewFile/Item/3677 several gaps in care related to women's and infant's health services were identified. Access to OB/GYN providers is limited. There are an insufficient number of providers to meet the needs of the women in the County. In addition, providers must demonstrate the ability to care for and understand the diverse needs of the growing community. Pregnancy rates are rising among the growing Hispanic population in the County and the number of obstetricians is not keeping pace with this growth (Prince George's median age of resident 37.8, with Black patients being 40.1 and Hispanic being 28.8).

There are other factors that contribute to the lack of access to healthcare. An inadequate public transportation system in the County is a significant issue particularly for underserved women to receive appropriate healthcare. Furthermore, inadequate health insurance is a problem for many women. They either do not have health insurance or they participate in health plans that have high co-pays and deductibles. Many residents lack the knowledge to navigate the health care system properly. All of these factors contribute to a lack of adequate, quality healthcare.

Poor access to healthcare includes a lack of appropriate prenatal care and often results in poor health outcomes. There is a very disparate infant mortality rate in the County for black infants as compared to white and Hispanic infants. In 2020, the infant mortality rate in Prince George's County was 12.4/1,000 live births vs. 11.3/1,000 in the State of Maryland and U. S. Department of Health and Human Services Healthy People 2020 goal of 6.0. In 2020, the infant mortality rate for blacks was 8/1,000 live births vs. Hispanic rate of 3.1/1,000 births. Infant mortality rates are highest among black, non-Hispanic Prince George's County residents creating a growing racial disparity in outcomes for infants. The drivers of these disparities are multi-factorial but are due in large part to low birth weight (<2,500 gms) which was 10.9% for black infants vs. 7.4% for Hispanic infants – with highest rates among older mothers, 13.6% are ages 40 years and older. Late or no prenatal care also accounts for poor health outcomes and 8% of black and 13% of Hispanic women compared to 6% of white mothers receive late or no pre-natal care.

The following tables from the CHNA (see pages 49 and 51) illustrate the disparity by zip code as it relates to low birth weight and women who receive late or no pre-natal care.

Table 15
Low Birth Weight by Zip Code (Primary and Secondary Service Areas); Prince George's County Health Department, 2020

Primary Service Area		Low Birth Weight			
ZIPCode	**Area**	**% Overall**	**Black, NH**	**Hispanic**	**White, NH**
20706	Lanham	9.5%	13.3%	**	**
20720	Bowie	10.1%	12.6%	**	**
20721	Bowie	11.3%	13.1%	**	**
20737	Riverdale	8.3%	13.3%	7.3%	**
20743	Capitol Heights	10.5%	11.4%	**	**
20747	District Heights	13.1%	13.9%	**	**
20770	Greenbelt	7.1%	9.0%	**	**
20774	Upper Marlboro	12.4%	13.2%	**	**
20784	Hyattsville	10.3%	9.7%	10.1%	**
20785	Hyattsville	8.8%	10.0%	**	**
Secondary Service Area					
ZIPCode	**Area**				
20705	Beltsville	8.5%	11.0%	8.0%	**
20708	Laurel	12.8%	13.0%	9.4%	**
20710	Bladensburg	6.2%	**	**	**
20715	Bowie	7.5%	**	**	**
20716	Bowie	10.8%	14.2%	**	**
20735	Clinton	10.6%	11.4%	**	**
20740	College Park	7.9%	**	**	**
20744	Fort Washington	8.9%	13.4%	**	**
20745	Oxon Hill	10.6%	12.8%	**	**
20746	Suitland	13.6%	15.8%	**	**
20748	Temple Hills	8.9%	8.7%	**	**
20769	Glenn Dale	16.0%	**	**	**
20772	Upper Marlboro	10.4%	9.9%	**	**
20781	Hyattsville	8.4%	**	**	**
20782	Hyattsville	9.2%	12.6%	7.9%	**
All	**Prince George's**	**9.7%**	**11.6%**	**7.5%**	**5.5%**

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Table 16
Percentage of Mothers who Received Late or No Prenatal Care by Zip Code (Primary and Secondary Service Areas)
Prince George's County Health Department, 2020

Primary Service Area		Late/No Prenatal Care			
ZIPCode	**Area**	**Overall**	**Black, NH**	**Hispanic**	**White, NH**
20706	Lanham	10.6%	12.3%	9.0%	**
20720	Bowie	11.6%	12.2%	**	**
20721	Bowie	7.6%	8.1%	**	**
20737	Riverdale	13.8%	15.7%	13.5%	**
20743	Capitol Heights	11.7%	10.9%	16.7%	**
20747	District Heights	12.0%	11.9%	**	**
20770	Greenbelt	12.6%	13.9%	**	**
20774	Upper Marlboro	11.3%	12.5%	**	**
20784	Hyattsville	17.0%	22.5%	12.6%	**
20785	Hyattsville	12.8%	14.7%	**	**
Secondary Service Area					
ZIPCode	**Area**				
20705	Beltsville	12.2%	17.0%	11.4%	**
20708	Laurel	12.2%	14.3%	8.6%	**
20710	Bladensburg	17.1%	**	20.7%	**
20715	Bowie	6.6%	**	**	**
20716	Bowie	8.2%	9.0%	**	**
20735	Clinton	11.4%	9.7%	**	**
20740	College Park	8.0%	**	**	**
20744	Fort Washington	13.3%	11.5%	13.7%	**
20745	Oxon Hill	12.1%	9.6%	16.9%	**
20746	Suitland	11.4%	9.0%	**	**
20748	Temple Hills	13.2%	10.8%	22.9%	**
20769	Glenn Dale	**	**	**	**
20772	Upper Marlboro	7.0%	6.9%	**	**
20781	Hyattsville	10.9%	**	**	**
20782	Hyattsville	10.6%	11.5%	11.2%	**
All	**Prince George's**	**10.9%**	**11.3%**	**11.7%**	**6.9%**

The data by zip code shows a very disparate rate of infant mortality in Riverdale, Beltsville, Bowie, Fort Washington, and Suitland. The zip codes that include Riverdale, Hyattsville, Bladensburg, and Laurel have disproportionately higher rates of women who

receive late or no-prenatal care. Outreach and education efforts should initially focus on these zip codes to promote early and continued prenatal care and infant care.

There are other disparities that should be documented as well. Disparity in c-section rates exist with 40.9% of black patients, 28.1% Hispanic patients and 29 % white patients receiving a C-section. That is an 11-12 % disparity in C-sections between black and white births.

Finally, teen birth rates among Hispanic teen mothers are as much as four times higher than black teenage mothers and white teenage mothers. Specifically, the 2020 data shows the teen birth rate among Hispanic women is 42.2/1,000 live births, compared to Black women (10.2/1,000) and White women (2.4/1,000) in Prince George's County. The highest rate of teen pregnancy is in the zip code of Riverdale. Prevention efforts and safe sex practice education should be focused in this zip code.

b. *Measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated:*

Goals and objectives for the health status improvements of the county will be driven from the overarching strategic plan for the Luminis Health Women's and Children's service line but will be specific to targeted areas within Prince George's County. Goals will be established on an annual basis with a focus on continuous improvement in the metrics. There will be a focus on infant mortality, low birth weight, timely prenatal care, teen birth rate and the reduction of NTSV C-section rates upon initiation of the program. Goals for each area will be established based on existing targets for the State of Maryland as well as those developed by the U.S. Department of Health and Human Services (i.e. Healthy People 2030). See below for examples of proposed goals based on current information:

Table 17
LHDCMC Proposed Goals

Description	Baseline	MD SHIP Goal	HP 2030 Goal	LHDCMC Goal
Infant mortality rate	5.5	6.3	5.0	5.0
% Low birth weight infants	9.2%	8.0%	N/A	7.8%
% of births with late or not prenatal care	9.8%			6.3% (MD average)
Teen birth rate	16.5	17.8	N/A	14.2 (MD rate)
NTSV C-section rate	25.9%	TBD	23.6%	23.6%

Efforts and targets may be focused on specific disparities that are seen within the data. For example, teen birth rate is significantly higher for the Hispanic population (42.2) compared to the Black, non-Hispanic (10.2) and the White, non-Hispanic population (2.4). Therefore, goals and tactics may be geared to a subset of the population.

In addition, maternal risk factors have increased in the County (2019 Maternal and Infant Health Report, Prince George's County Health Department). Obesity, diabetes and

hypertension have seen a rise. The maternal mortality rate of 28.6 deaths per 100,000 births is higher than the state at 26.9. Areas of focus will be identified to address with a multidisciplinary approach and targets established.

c. *Information on the structure, staffing and funding of the Plan:*

LHDCMC will build upon the current infrastructure in place to support community health needs. A major component of community engagement is conducted through the utilization of a Wellness Van to prioritized initiatives. LHDCMC currently spends approximately $175,000 annually to operate the Wellness Van. LHDCMC is committed to this funding and will modify current use practices in order to accommodate travel and visits to the high-risk zip codes outlined in this section.

Luminis Health is committed to allocating in-kind services and will partner with community-based organizations to expand our outreach efforts. The Luminis Health Women's and Children's service line and the Community Health Improvement team will provide leadership and support with implementing the plan.

The program will also develop programmatic initiatives to reduce pre-term and low birth infants, increase early access to prenatal care, and implement intrapartum labor support to decrease C-sections. LHDCMC, under the guidance of Luminis Health, will replicate and expand the educational offerings in the LHAAMC Women's Education Program and include free classes on a healthy pregnancy, birthing classes, infant care classes, safe sleep education, and new parent support groups. This will help raise awareness and increase knowledge among women and their families about the importance of pre-natal care, infant care and safe sleep practices.

Community Benefit Plan – Programmatic Initiatives

Luminis Health's Community Benefit Plan will target the gaps identified in the 2022 Prince George's CHNA and address several of the obligations all perinatal programs have to the women and families they serve (ref). Critical responsibilities of perinatal programs as they deliver culturally competent, patient centric care per ACOG and AAP guidelines include: 1) the provision of access to comprehensive perinatal services, 2) education of the public about reproductive health and key drivers of adverse maternal, fetal and infant outcomes and 3) engagement of all stakeholders to ensure the efficient use of resources. See https://www.acog.org/store/products/clinical-resources/guidelines-for-perinatal-care The Community Benefit plan will outline:

- Access to physicians and healthcare providers;
- Create continuous pipeline of physicians, APP's and nurses through educational collaborations with San Jorges Medical School in Puerto Rico/George Washington University/John Hopkins Medical Center /and area community colleges;
- Programmatic initiatives to target reduction in preterm, low birth infants;
- Pre-conception Health program;
- Ambulatory models of care;
- Early prenatal visit campaign;
- Centering (https://www.centeringhealthcare.org/;)

- Post-partum Long-Acting Reversible Contraception (LARC);
- Increase education of the community (engagement of medical & nursing students and faculty) through Health Fairs/Civic organization presentations; and
- Engage community, industry, insurers and government partners in our health system efforts to decrease disparities in infant mortality and teen pregnancy. The engagement of multiple stakeholders across diverse disciplines positively impact outcomes for the medically underserved.

Pre-conception Health Program and Tool Kit

Pre-conception counseling and care facilitates improving health prior to pregnancy. Blood pressure, weight, and glycemic control as well as decreasing tobacco and illicit drug use prior to pregnancy have all be shown to improve health during pregnancy. Control of these health conditions prior to pregnancy reduces the likelihood of a pregnancy complication from hypertension, diabetes and/or obesity. This will in turn reduce the likelihood preterm delivery, very low birth rate, and infant mortality, commonly associated with these conditions. The Women's and Children's committee on community engagement and population health will work to develop a preconception counseling and care tool kit for use in the ambulatory setting of our health system.

This tool kit will promote patient education around: immunizations, chronic disease, medication use, substance abuse, previous pregnancy outcomes, genetic history, mental health history and interpersonal violence.

We will implement the pre-conception counseling tool kit to general ob/gyn and primary care practices within the Prince Georgie's County Health Coalition. The tool kit will be intended for women of reproductive age that are currently not using contraception and present for routine preventive services. Centers for Disease Control and Prevention Recommendations to improve preconception health and health care[19].

Ambulatory care models and programs to reduce infant morbidity mortality and preterm birth

Early Prenatal Visit Campaign

Several studies have shown late presentation for prenatal care increases the likelihood of preterm delivery. The window for risk stratifying patients predisposed to preterm delivery narrows with each passing trimester. In practices affiliated with Luminis Health we will implement an early prenatal visit campaign.

- Aspirin compliance beginning week 11-13 or pregnancy for the prevention of pre-eclampsia
- Assessing cervical length transvaginal ultrasonography between 15-29 weeks gestations predicts the likelihood of delivery <37 weeks. Will permit consideration of use of progesterone therapy, or cervical cerclage.

Centering Pregnancy

The Centering model of prenatal care as established by the Centering Healthcare Institute (CHI, Boston, MA), affords ten prenatal sessions to 8 – 12 women in which health assessments (blood pressure, weight and fetal growth) are ascertained with simultaneous group education sessions on nutrition, normal fetal growth and development, labor education and breast feeding. Centering prenatal care also provides a natural support group for mothers

at similar gestations which has been shown to increase psychological well-being for participants. Centering prenatal care has been shown to decrease pre-term and low birthweight deliveries. Additionally, centering prenatal care has a 97.4% patient satisfaction rate. This year, Luminis Health OB/GYN practices have initiated centering pregnancy with the goal of decreasing preterm deliveries and improving breast-feeding. The Luminis Health Women's and Children's service line will have outcome data from this program to help guide implementation of the Centering model within Luminis Health physician practices in Prince George's County. See https://www.centeringhealthcare.org/.

Post-partum long-acting reversible contraception

Long-acting reversible contraception (LARC) provided immediately post-partum has been shown to decrease subsequent short-interval pregnancies and therefore preterm and low birth weight infants. These contribute to adverse neonatal outcome and infant mortality.

We will implement immediate post-partum intrauterine device placement for women at risk for preterm delivery within LHDCMC practices. Beginning with practices that have the highest rate of preterm delivery. The program will consist of:

- Antenatal counseling regarding post-partum LARC
- Education of all providers regarding the technique of post-partum LARC placement
- Ensure re-imbursement for placement
- Ensure availability of LARC (see https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2016/08/immediate-postpartum-long-acting-reversible-contraception).

b. *Documentation of Community Support:*

Please refer to **Exhibit 20** for documentation of strong community support, including letters from Prince George's County Executive Angela Alsobrooks, the NAACP of Prince George's County, United Communities Against Poverty, the Southern Christian Leadership Conference, and several other community organizations. Additionally, we have support from the medical community, Greater Baden Medical Services and obstetrical and gynecological providers in the region.

LHDCMC looks forward to continuing its successful partnership with the community through this new healthcare program.

c. *An implementation scheme for the Community Benefit Plan:*

LHDCMC has a history of providing outreach to the community through education, screenings, and early detection for chronic disease. In FY2021 and FY2022, LHDCMC clinical staff provided educational programs such as health fairs and health talks, support groups, free screenings and community based clinical services to community members. This accounted for a combined total of nearly $800,000 in community benefit expenses.

In addition, LHDCMC has sponsored a Wellness of Wheels mobile health clinic that travels to various locations in the county to assist residents maintain or improve their health conditions. Specifically, diabetes, cholesterol and blood pressure screenings are offered to individuals ages 18 and over. Medication review and education is provided to those individuals

with chronic disease.

LHDCMC will continue to use the Wellness of Wheels to travel to the existing sites and include the other zip codes for outreach to underserved women as described in Section 8A (zip codes of Riverdale, Beltsville, Bowie, Fort Washington, Suitland, Hyattsville, Bladensburg, and Laurel).

Collaboration and partnering with community organizations will be imperative for the success of the program. Access to high quality, culturally diverse providers will be created by having an on-going and continuous pipeline of physicians, Advanced Practice Providers, and nurses through area educational institutions. This will be spearheaded by the clinical leaders in the Women and Children's service line.

LHDCMC will need to engage community, industry, insurers and government partners in the health system efforts to decrease disparities in infant mortality and teen pregnancy. The engagement of multiple stakeholders across diverse disciplines positively impact outcomes for the medically underserved. Current efforts are as follows:

- Participate and collaborate on county-based coalitions.
- Network with local pregnancy clinics and low-income clinics to develop a provider referral network to increase access to prenatal care.
- Collaborate with partners to expand insurance enrollment and other subsidies such as WIC for participants.

Additional community partnerships and linkages will be made to advance these goals. This includes community and civic groups, schools, faith based organizations, and other non-profits who have missions to support and educate women and children.

d. *Commitment to implement Community Benefit Plan:*

LHDCMC is committed to implementing the Community Benefit Plan. It is part of the mission to improve care for the community, including the underserved areas. Luminis Health is re-imagining what community health means and advancing LHDCMC's commitment to compassionate care, delivered when and where people need it most. Luminis Health was formed in 2019 in order to expand access, improve population health and provide high-quality care closer to home for our community.

g. *Applicants must agree to submit an Annual Report to the Commission which will include:*
  i. an evaluation of the achievement of the goal and objective of the Community Benefit Plan
  i. *information on staffing levels and total costs of programs implemented as part of Community Benefit Plan*

LHDCMC will submit an annual report to the Commission which will include an evaluation of the achievement of the goals and objectives of the Community Benefit Plan, as well as information on staffing levels and total costs of programs implemented as part of the Community Benefit Plan. LHDCMC is compliant with the regulatory requirement to submit the Community Benefit Report to the HSCRC and with other regulatory institutions annually (Schedule 990).

9. Source of Patients.
An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

Applicant Response:

The majority of patients for the new obstetric service will come from LHDCMC's primary service area. Volume projections for the LHDCMC program are based on the realignment of physician practices currently serving the region and an investment by Luminis Health in additional providers in the LHDCMC service area.

(a) LHDCMC anticipates that 776 patients will follow the physicians who currently deliver at LHAAMC to LHDCMC. These 776 patients live in the LHDCMC service area and will have a delivery site closer to home.

(b) Luminis Health will add providers to the LHDCMC service area.

- LHDCMC intends to create additional access to women's health providers by deploying new providers to service area residents. Through these new practices, LHDCMC will draw further market share from the PSA and SSA.
- LHDCMC currently does not provide obstetrical services to the PSA or SSA. By the end of year 5, LHDCMC assumes a 25% market share of the PSA and SSA, with 51% of the volume for the program originating from within the PSA.

Table 18
LHDCMC Projected Discharges: Key Metrics
FY 2022-2031

	FY 2022	FY 2027	FY 2028	FY 2029	FY 2030	FY2031
Projected Service Area		(Note 1)				
Obstetrics Discharges (Note 2)	8,717	8,727	8,730	8,732	8,734	8,736
DCMC Projected Obstetrics Volume						
PSA		284	749	896	1,067	1,219
SSA		232	613	733	873	997
Total Service Area		517	1,362	1,629	1,940	2,216
Out of Area		40	105	126	150	171
Total Obstetrics Discharges		556	1,467	1,754	2,090	2,387
Key Metrics						
DCMC Market Share, Total Service Area		6%	16%	19%	22%	25%
% of Hospital OB Discharges from the PSA		51%	51%	51%	51%	51%

Note 1: FY 2027 reflects 6 months of volume assuming a January 1, 2027 opening
Note 2: Source is HSCRC FY22 abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

10. Non-metropolitan Jurisdictions.
A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

Applicant Response:

This standard is not applicable. LHDCMC is not in a non-metropolitan jurisdiction.

11. Designated Bed Capacity.
An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

Applicant Response:

The proposed new obstetrics program will create 29 dedicated beds, including 21 licensed beds, 18 postpartum and 3 antepartum beds. The program will also include 8 LDRs. These will be new beds, not taking away from the hospital's existing licensed acute care beds.

12. Minimum Volume.

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 1,000 admissions annually in metropolitan jurisdictions or 500 cases annually in non-metropolitan jurisdictions within 36 months of initiation of the program.

(b) As a condition of approval the applicant shall accept a requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two year period.

Applicant Response:

(a) LHDCMC expects to serve 1,754 obstetrics discharges by Year 3 of program operations. This is based on the following analysis:

The service area for the program is defined as the same service are defined for the overall hospital. LHDCMC aims to serve its established service area population to increase the capacity of OB/GYN clinicians in its current service area. The objective of the project is to better serve LHDCMC's current population base.

Based on the Nielson-Claritas population projection and compound annual growth rate

through FY 2031, the total volume of the service area obstetric discharges across Maryland and Washington, DC hospital market is presented below. The female adult population is projected to increase only slightly, and the total discharge volume for the service area remains above 8,700 cases annually.

LHDCMC projected volume by Year 3 is expected to be 1,754 obstetric discharges. This translates into a 19% obstetric market share across Maryland and Washington, DC hospitals, a market share similar to LHDCMC's current share for medical/surgical services across the same service area.

Table 19
LHDCMC Projected Obstetric and Market Share
Based on Neilsen Claritas Populations & Stable Use Rate
FY 2022- 2031

			Projected				
		FY 2022	**FY 2027**	**FY 2028**	**FY 2029**	**FY 2030**	**FY2031**
Service Area Projections							
Population (Female 15-44)	(Note 1)	156,228	156,412	156,452	156,493	156,534	156,575
Discharges per 1,000		55.8	55.8	55.8	55.8	55.8	55.8
Total OB Discharges	(Note 2)	8,717	8,727	8,730	8,732	8,734	8,736
ALOS		2.58	2.40	2.40	2.40	2.40	2.40
# of Occupied OB Beds		62	57	57	57	57	57
DCMC Projections							
# of Service Area OB Discharges			517	1,362	1,629	1,940	2,216
# of Out of Area OB Discharges			40	105	126	150	171
# Total OB Discharges			556	1,467	1,754	2,090	2,387
DCMC Service Area Market Share			6%	16%	19%	22%	25%

Note 1: Source is Neilsen Claritas estimates for Calendar Year 2020 and projections for CY 2021 through 2031 based on CY 2020 estimates
Note 2: Source is HSCRC FY22 abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

LHDCMC's Year 5 projected market share is 25% across Maryland and Washington, DC hospitals. This market share target reflects the following:

- The new program consolidates existing Luminis Health volume from LHAAMC and the new program base at LHDCMC.
- The new program will add clinical capacity and access through the expansion of office locations to under resourced portions of the service area.
- LHDCMC will build market share by redirecting service area volume that is currently served at out-of-area facilities

(b) LHDCMC accepts the requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide a good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.

13. Impact on the Health Care System.

(a) An application for a new perinatal program will be approved only if its likely impact on the volumes of the obstetric discharges at any existing obstetric program, after the three year start-up period will not exceed 20% of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program the Commission will consider whether an existing program's payer mix of obstetric patients will significantly change as a result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetric patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure projects for which it has pledged pursuant to H-G Article 19-120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

i. from an applicant as to why rules (a) through (c) should not apply to the applicant, or;

ii. from a very low volume program (fewer than 500 annual obstetric discharges) as to why to lower volume impact should apply.

Applicant Response:

(a) The volume shifts associated with LHDCMC's proposed program will not exceed 20% of an existing program's current or projected volume and will not adversely affect any existing obstetrics unit as to compromise the financial viability of the program. No other obstetrics program in the region is expected to see a decline of more than 10% of total obstetrics discharges (with the exception of LHAAMC), and no obstetric program is expected to decline below 1,000 total obstetric discharges.

The table below shows the current distribution of LHDCMC's service area discharges and the market share distribution across Maryland and Washington, DC hospitals. The table documents that fewer than 20% of service area patients are delivered at a hospital in Prince George's County. More than 80% of service area patients, approximately 7,000 patients were served at out-of-County Hospitals.

Table 20
Obstetric Discharges
Residents of LHDCMC Service Area
FY 2022

Hospital	County	PSA		SSA		Total Service Area (PSA&SSA)	
		Cases	Market Share	Cases	Market Share	Cases	Market Share
Holy Cross Hospital	Montgomery County	1,723	40.4%	1,627	36.6%	3,350	38.4%
UM Capital Region Medical Center	Prince George's County	724	17.0%	459	10.3%	1,183	13.6%
Adventist HealthCare White Oak Hospital	Montgomery County	279	6.5%	334	7.5%	613	7.0%
Anne Arundel Medical Center	Anne Arundel County	452	10.6%	465	10.5%	917	10.5%
MedStar Washington Hospital Center	Washington, D.C.	362	8.5%	391	8.8%	753	8.6%
MedStar Southern Maryland Hospital Center	Prince George's County	77	1.8%	303	6.8%	380	4.4%
Sibley Memorial Hospital	Washington, D.C.	83	1.9%	92	2.1%	175	2.0%
George Washington University	Washington, D.C.	83	1.9%	123	2.8%	206	2.4%
Adventist HealthCare Shady Grove Medical Center	Montgomery County	61	1.4%	92	2.1%	153	1.8%
MedStar Georgetown University Hospital	Washington, D.C.	47	1.1%	66	1.5%	113	1.3%
All Other Maryland	Maryland	353	8.3%	481	10.8%	834	9.6%
All Other Washington, D.C.	Washington, D.C.	24	0.6%	16	0.4%	40	0.5%
Total OB Service Area		**4,268**	**100.0%**	**4,449**	**100.0%**	**8,717**	**100.0%**

Source: HSCRC FY22 Abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

LHDCMC is projected to have the largest impact on obstetrics volume at LHAAMC. The volume shift from LHAAMC is supported by Luminis Health in its commitment to provide a local delivery site to Prince George's County residents and to position more OB/GYN providers in the communities most in need of additional OB/GYN providers within the LHDCMC service area.

Patients are currently disperesed among many hospital serving northern Prince George's County, signalling a lack of care coordination. LHDCMC seeks to address this problem by investing in providers who will serve the residents of LHDCMC's service area in the service area. Hospitals with a larger market share have NICUs. LHDCMC is proposing a Level II Nursery, so it will only take a small percentage of market share from those hospitals because high risk patients will still need to deliver at those hospitals.

Table 21 below demonstrates the proposed impact to other hospitals.

Table 21
Impact of LHDCMC Obstetrics Program on Existing Obstetric Units In FY 2022 Volumes

Hospital	County	Total Shift of Discharges FY 2022 (Note 1)	Hospital's Total OB FY 2022 (Note 2) (Note 3)	Shift as a % of Total Hospital OB, FY 2022
Anne Arundel Medical Center	Anne Arundel County	778	5,897	13.2%
Holy Cross Hospital	Montgomery County	613	9,142	6.7%
Adventist HealthCare White Oak Hospital	Montgomery County	103	1,528	6.8%
UM Capital Region Medical Center	Prince George's County	103	1,526	6.8%
MedStar Southern Maryland Hospital Center	Prince George's County	48	1,072	4.5%
Adventist HealthCare Shady Grove Medical Center	Montgomery County	45	1,528	2.9%
All Other Maryland Hospitals		243	46,891	0.5%
Total Maryland		**1,934**	**67,584**	**2.9%**
MedStar Washington Hospital Center	Washington, D.C.	240		
George Washington University	Washington, D.C.	54		
Sibley Memorial Hospital	Washington, D.C.	68		
MedStar Georgetown University Hospital	Washington, D.C.	36		
All Other Washington, D.C.		*30*		
Total Washington, D.C.		**428**		
Total FY22 Discharges to shift to DCMC		**2,362**		

Note 1: Projected Discharges & Source of Volume, Fiscal Years 2027 through 2031
Note 2: HSCRC FY22 Abstract dataset for Maryland hospital discharges
Note 3: CY21 DCHA discharge database for DC hospital discharges Maryland discharges only

(b) The actual payer mix for the practices currently delivering at LHAAMC was used to estimate the payer mix for these deliveries at LHDCMC under this CON, as well as the resulting impact to the payer mix at LHAAMC. As the current payer mix for the practices delivering at LHAAMC have a similar payer mix to LHAAMC deliveries, overall, there is no resultant change in LHAAMC's payer mix.

For other hospitals, the patients shifting from other hospitals to LHDCMC were assumed to reflect the average payer mix of each hospital, therefore the remaining payer mix at each Maryland hospital will be unchanged, as well. These assumptions regarding potential impacts to other programs are conservative as the payer mix in Prince George's County overall is higher in Medicaid and self-pay than in the

surrounding areas. If LHDCMC overestimated the commercial payers in this program, and the actual mix of LHDCMC deliveries has more Medicaid and less commercial coverage, the resulting impact on surrounding hospitals will be a decrease of their portion of Medicaid deliveries and an increase in their percentage of deliveries covered by commercial payers. LHDCMC is committed to serving the Medicaid population.

14. Financial Feasibility.
Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,
(b) the proposed unit rates and/or average charge per case for the perinatal services,
(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and
(d) the written opinions or recommendations of the HSCRC.

Applicant Response:

(a) LHDCMC will absorb the cost to run the obstetric program. LHDCMC has sufficient revenues evident in Tables G and H, Exhibit 1 to cover the cost of the program for the first three years of operation.
(b) LHDCMC proposes an obstetric average cost per case without inflation to be $11,312 and the newborn average charge per case without inflation to be $2,635. This average cost per case was estimated by using the FY19 RVUs per case from AAMC at the FY23 DCMC rates and utilizing the FY23 state wide median rates for Obstetrics, Nursery, and Delivery.
(c) As shown in Exhibit 1, Tables J and K, the perinatal program's revenues cover expenses in FY2030 or year 4 of the program. At the minimum volume of 1,000 in FY2028, LHDCMC can absorb the loss of the perinatal program.
(d) LHDCMC met with the HSCRC staff prior to submission of this application.

15. Outreach Program.
Each program with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

Applicant Response:

This standard is not applicable as LHDCMC does not have an existing program but is

establishing a new program.

General Surgical Services

COMAR 10.24.11 General Surgical Services
.05 Standards
B. Project Review Standards

The standards in this regulation govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards, unless an applicant is eligible for an exemption covered in Regulation .06. of this chapter.

1. Service Area

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Applicant Response:

This standard is not applicable, as LHDCMC is not establishing a new hospital providing surgical service or a new ambulatory surgical facility.

2. Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for the number of operating rooms proposed for the facility, consistent with the operating room capacity assumptions and other guidance included in Regulation .07 of this chapter.

(b) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility, consistent with Regulation .07 of this chapter.

(c) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

- (i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;
- (ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and
- (iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(d) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

- (i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and
(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

Applicant Response:

This standard is not applicable, as LHDCMC is not establishing a new hospital providing surgical service or a new ambulatory surgical facility.

3. Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .07 of this chapter;
(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and
(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity, consistent with Regulation .07 of this chapter. The needs assessment shall include the following:
  (i) Historic and projected trends in the demand for specific types of surgery among the population in the proposed service area;
  (ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and
  (iii) Projected cases to be performed in each proposed additional operating room.

Applicant Response:

This standard is not applicable, as LHDCMC is not expanding its number of operating rooms.

4. Design Requirements.

Floor plans submitted by an applicant must be consistent with the current Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines):

(a) A hospital shall meet the requirements in current Section 2.2 of the FGI Guidelines.
(b) An ASF shall meet the requirements in current Section 3.7 of the FGI Guidelines.
(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Applicant Response:

(a) The proposed LHDCMC Surgical Services shall meet the requirements of current Section 2.2 of the FGI Guidelines.

(b) This standard is not applicable as the proposed project does not include an ASF.

(c) This standard is not applicable as there are no design features planned for hospital surgical services that are at variance with the FGI Guidelines.

5. Support Services.

Each applicant shall agree to provide laboratory, radiology, and pathology services as needed, either directly or through contractual agreements.

Applicant Response:

LHDCMC will provide all necessary laboratory, radiology, and pathology services, including point of care testing, as needed for surgical services either directly or through contractual agreements with the LHAAMC campus/system.

6. Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

Applicant Response:

(a) LHDCMC planned and designed surgical services with patient and staff safety in mind as reflected in the core design elements. LHDCMC and Luminis Health planning staff as well as the Luminis Health capital facility planning team worked closely with CannonDesign, a licensed architect with experience designing healthcare facilities, which specializes in acute care, obstetrical and surgical services. Clinical leadership and infection prevention personnel from LHDCMC participated in the planning to identify patient needs and potential safety issues, including infection prevention. The proposed design complies with the applicable FGI Guidelines and ANSI standards.

(b) LHDCMC surgical services design was planned to include the latest programming, planning and design elements to maximize adaptability, efficiency and patient safety and convenience. The design includes the following key safety features:

- Appropriately sized ORs based on the procedures to be performed. Providing necessary space for number of staff and the amount and size of equipment to be used.
- Universal OR configuration for uniformity of equipment placement and use.
- Equipment storage areas adequately sized and located to provide access to ORs. This will eliminate cluttering of hallways, and keep the corridors clear for emergency egress.

- Clinical staff areas adequately sized to support the surgical suite.
- Designed and zoned to optimize infection prevention based on the flow of clean and dirty materials and instruments, air flow, and patient flow.
- OR suite divided into three designated areas – unrestricted, semi-restricted and restricted – that are defined by the physical activities performed in each area.
- Properly zoned to maintain proper storage.
- Mechanical and electrical systems meeting all current guidelines and designed to maintain appropriate pressure relationships, temperature and humidity control and monitoring, appropriate lighting and a dedicated emergency power back-up.
- Prep/recovery patient care stations are sized to accommodate patients, staff, and family and reduce the chance of slip and falls.
- Three airborne infectious isolation rooms (AIIR) provided in the prep/recovery area for increased infection prevention.
- Two "individuals of size" prep/recovery patient care stations provided feature special accommodations for patients. The extra clearances will help with patient access and transfers, and will reduce patient and staff injuries.
- Direct line of sight from nursing work areas into all prep/recovery rooms.
- Enhancing the pneumatic tube system to the OR Suite and prep/recovery to provide easy transport of critical medication and other supplies as well as safe transport and timely turnaround of lab results.

7. Construction Costs.
The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and
2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of new construction shall be compared to the benchmark cost of good quality Class A construction given in the Marshall

Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. This standard does not apply to the costs of renovation or the fitting out of shell space.

(ii) If the projected cost per square foot of new construction exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Applicant Response:

(a) The proposed cost of the hospital construction project is reasonable and consistent with current industry cost experience in Maryland, as evidenced by the Marshall Valuation Service (MVS) analysis of construction costs for this project. This analysis is in **Exhibit 17**.

(b) This standard is not applicable. LHDCMC is not proposing an Ambulatory Surgical Facilities.

8. Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of each applicable service by the likely service area population of the facility;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant facility or, if a new facility, the recent experience of similar facilities;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Applicant Response:

(i) Utilization projections are consistent with observed historic trends. LHDCMC currently has 12 licensed general purpose operating rooms, but can only operate 8 of them because the others are inappropriately sized operating rooms for modern surgical operations and equipment and support services (including sterile processing services) are undersized. As further described in response to COMAR 10.24.10.04A(6), being unable to operate all of its licensed ORs and inadequacies in support services, LHDCMC is unable to provide the needed care for the community at its hospital facility without construction or renovations.

LHDCMC efficiently operates its 8 functioning ORs, as shown in **Table 22**.

Table 22
LHDCMC Current Cases at Average Time per Case
Actual FY 2022

Hospital	Inpatient				Outpatient				
	Cases	Avg time per Case	Total Cases	Total Minutes	Cases	Avg time per Case	Total Cases	Total Minutes	# ORs
Luminis Health Doctors Community Medical Center	2,224	136	2,224	380,857	4,037	97	4,037	534,485	8.03

Source: Inpatient and outpatient HSCRC data for FY 2022 within the DCMC Service Area. DCMC volume reflects total surgical volume. Surgical cases defined as any inpatient or outpatient case with a surgical DRG or procedure code, excluding Transplants and Cardiac Surgery.

LHDCMC has initiated long range clinical planning to reduce outmigration from Prince George's County bringing care (including surgical care) closer to home for residents. Based on its analysis, LHDCMC projects that by FY2027, physician recruitment will account for an additional 1,200 bariatric, joint, spine, general, vascular, breast and gynecology surgical cases.

Luminis Health Clinical Enterprise (LHCE) employs an array of medical and surgical providers who staff both ambulatory and hospital services across the system. The system plan is to continue to expand care delivery to the regions with the greatest need for access, and the overall LHDCMC service area has lower than average provider placement compared to the rest of the state. As programs are expanded into the region, physicians and surgical care will be located at LHDCMC to be convenient and accessible to our patients and community. These service expansions include leveraging our existing strong programs into the community. LHCE currently has one of the largest and most comprehensive orthopedics programs in the region with 65 physicians, nurse practitioners, and physician assistants. In 2018, Luminis Health Orthopedics received the American College of Surgeons' Exemplary designation for several quality measures. This is given to hospitals whose rates of complications, such as infections, are among the lowest in the country.

Women's surgical care is renowned at Luminis Health, which aligns with the reputation of the system for outstanding obstetric care. Women who deliver babies at LHAAMC often return for surgeries later in life, from gynecologic surgeries to

urogynecology and incontinence care, to women's cancer care, such as breast and gynecologic cancers. Establishing an obstetrics program at LHDCMC will similarly extend Luminis Health's reputation for excellence in women's care to the northern Prince George's County region. Access and care delivery at LHDCMC will also expand through its Gynecologic Oncology program, which has three credentialed, Fellowship-training LHCE physicians already serving the community, and its breast program, where two of eight breast specialists already serve the LHDCMC community.

Bariatric surgery is recognized as an effective way to lose weight, manage chronic conditions, and live longer. Obesity rates in Prince George's County are above statewide averages and there is a lack of programs to treat obesity located within the service area. LHCE offers a robust, comprehensive weight loss surgery program including ongoing education, counseling, nutritional consulting designed for success before and after surgery.

Each of these programs, which already exist within Luminis Health, is planned for expansion throughout the LHDCMC service area. There is sufficient evidence that the community in northern Prince George's County lacks access to care within the region and seeks care in other counties and Washington, DC. As with the obstetric program, Luminis Health believes the best care is the most comprehensive, which begins with access and convenience for patients and their families. While Luminis Health offers a range of services, including even higher acuity surgical care outside the County, LHDCMC intends to provide community-oriented care that it has long been known for among residents of Northern Prince George's County.

(ii) LHDCMC's revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision. Tables G and H with the assumptions are included in **Exhibit 1**. No additional revenue was assumed with the increase in surgical cases.

(iii) Renovations of the operating rooms are estimated to be completed in January 2030. Starting in FY2030, additional staff for 2 additional operating rooms were added to Tables G and H and documented in Table L.

Table 23
Additional Staffing for 2 Operating Rooms

Staff Nurse	4.16
Surgical Tech	2.92
Operating Room Assistant	1.62

(iv) LHDCMC generates excess revenues over expenses under its utilization projections within 5 years of initiation of services in the renovated space.

9. Impact.

(a) An application to establish a new ambulatory surgical facility shall present the following data as part of its impact assessment, in addition to addressing COMAR 10.24.01.08G(3)(f):

(i) The number of surgical cases projected for the facility and for each physician and practitioner;

(ii) A minimum of two years of historic surgical case volume data for each physician or practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year or fiscal year data may be provided as long as the time period is identified and is consistent for all physicians; and

(iii) The proportion of case volume expected to shift from each existing facility to the proposed facility.

(b) An application shall assess the impact of the proposed project on surgical case volume at general hospitals:

(i) If the applicant's needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent or more of the operating room time in use at a hospital, then the applicant shall include, as part of its impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility.

(ii) The operating room capacity assumptions in Regulation .07A of this chapter and the operating room inventory rules in Regulation .07C of this chapter shall be used in the impact assessment.

Applicant Response:

This standard is not applicable. LHDCMC is not establishing a new ambulatory surgical facility.

CON Review Criteria

COMAR 10.24.01.08G(3) General Review Criteria

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.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response:

Tables F and I are attached in **Exhibit 1**.

The needs analysis for the obstetrics program is contained in the response to COMAR

10.24.12.04(6).

The need analysis for the capital renovations is contained in the response to COMAR 10.24.10.04B(6).

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.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

Please refer to the response to COMAR 10.24.10.04B(5).

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.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response

Tables:

The required tables are included in **Exhibit 1** (CON Table Package). These demonstrate the proposed project is sustainable because revenues cover expenses two years beyond completion of the project.

Funding Plan:

As shown in **Exhibit 1**, Table E, the total cost of the project is $286.0 million. The sources of funding for the project include cash flow from operations ($33.1 million), philanthropic gifts ($5.0 million), proceeds from debt financing ($152.9 million), and State support ($95.0 million).

The cash flow from operations of $33.1 million sources are from consecutive years of operating cash flows generated to support capital investment and a disciplined approach to reserving cash flows for the future LHDCMC Obstetric Program.

The philanthropic target of raising $5.0 million from the Prince George's County communities has been established at this phase of the process. Efforts to achieve this target will include private philanthropy and community funding support for what will be a significant construction project involving the development of much needed health access expansion for Prince George's County. As the CON application is being reviewed by State agencies, LHDCMC will initiate the silent phase of its capital campaign, meeting with potential donors and identifying lead gifts for the project. When formal approval for the project has been obtained, LHDCMC intends to launch a formal capital campaign to raise funds from the community. Key Board and Foundation Board members will be joined by philanthropic community members to establish and run the capital campaign.

The largest source of funding for the project are the proceeds from debt financing. While the current market conditions may be a factor, LHDCMC anticipates that it is capable of financing the $152.9 million of bond proceeds at its current credit ratings. Luminis Health and LHDMC were most recently rated in Spring 2022, Moody's affirms Luminis Health Inc.'s, MD A3 and upgrades Doctor's Community Hospital, MD to A3. An A3 ratings infers that the issuer has financial backing and some cash reserves with a low risk of default. The A3 rating was confirmed during the Covid-19 pandemic that roiled health care and temporarily negatively impacted many hospitals and healthcare system's financial performance across the nation.

The award of a State capital grant in the total amount of $95.0 million has been requested from the State over multiple years. Of this total request, LHDCMC has already been awarded $21 million by the State to support this expansion of much-needed access to services in Prince George's County ($6 million in the State's FY2024 Capital Budget and another $15 million preauthorized by the General Assembly in the FY2025 Capital Budget).

Other alternative financing methods were not explored. The current proposed mix of cash flows, debt, philanthropy, and State support are consistent with the historical approach to funding large, system-wide strategic initiatives.

Staffing Plan:

LHDCMC will recruit staff utilizing the recruitment expertise of the Luminis Health recruitment services. We anticipate facing the same challenges all health care facilities are facing with a tighter job market. However, we expect to fill staffing needs through a variety of recruitment practices, such as incorporation of diversity, equity and inclusion into our hiring strategies to increase the diversity of candidates, reaching out to past employees, our employee referral program, and our nursing externship and residency programs.

LHDCMC salaries and wages increased approximately $16.5M from FY2022 to FY2024 as shown in Exhibit 1, Table G. This is due to a strategic investment in salaries and benefits and a significant amount of overtime and incentive pay to address the workforce challenges and retain our workforce. LHDCMC projected salaries and wages from FY2024 to continue to account for these workforce challenges.

Community Support:

Please refer to **Exhibit 20** for documentation of strong community support, including letters from Prince George's County Executive Angela Alsobrooks, the NAACP of Prince George's County, United Communities Against Poverty, the Southern Christian Leadership Conference, and several other community organizations. Additionally, we have support from the medical community, Greater Baden Medical Services and obstetrical and gynecological providers in the region.

LHDCMC looks forward to continuing its successful partnership with the community through this new healthcare program.

- **Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.**

Applicant Response:

If the project is approved, LHDCMC will obligate 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase, initiate construction within no more than 4 months of the effective date of binding contract for each phase and complete each phase within 24 months of the effective date of the binding construction contract.

LHDCMC has selected an architectural firm (A/E), Cannon Design of Baltimore, MD, as the lead planner for the Certificate of Need application. Their team includes in-house and external consultants which include a civil engineering firm, mechanical and electrical designers, and various other consultants. Meetings have occurred between LHDCMC, the design team and the Prince George's County planning and zoning and permitting staff to discuss the project, zoning, other related requirements, and schedule. When the project progresses, an architectural design firm will be selected to provide design and engineering services.

A construction management (CM) firm will be engaged early in the project to provide preconstruction services and selection will follow LHDCMC's procurement policies. After the pre-construction is completed and permit documents are submitted to the respective authorities, a construction management firm will be selected and contracted for the project.

- **Audited financial statements for the past two years should be provided by all applicant entities and parent companies.**

Applicant Response: Please refer to **Exhibit 21**.

10.24.01.08G(3)(e). <u>Compliance with Conditions of Previous Certificates of Need</u>.

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.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:
LHDCMC has been issued the following CONs since 2000 and has complied with all conditions:

1. 2006 CON-Waiver to provide Primary PCI without Cardiac Surgery On Site-Docket No. 06-16-0011
2. 2007 CON-Renewal of the Primary PCI without Cardiac Surgery Waiver- Docket No. 07-16-0025

   Granted extension for 6 months then recommended to cease Primary PCI.

3. 2021 CON-Application to provide inpatient Mental Health – Docket No. 21-16-2448

LHAAMC has been issued the following CONs since 2000 and has complied with all conditions:

1. 2016 CON-Application to build an inpatient Mental Health Hospital - Docket No. 16-02-2375
2. 2015 CON-Application to provide Cardiac Surgery - Docket No. 15-02-2360
3. 2004 CON-Application to Construct a Patient Tower – Docket No. 04-02-2153

10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, 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.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[1];

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

a. On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

LHDCMC is projected to have the largest impact on obstetrics volume at LHAAMC. The volume shift from LHAAMC is supported by Luminis Health in its commitment to provide a local delivery site to LHDCMC residents, which will also position more OB/GYN providers in the communities most in need of additional OB/GYN providers within the LHDCMC service areas.

Patients are currently dispersed among many hospitals serving northern Prince George's County, which signals a lack of care coordination which LHDCMC intends to address by investing in providers who will serve the residents of LHDCMC's service area within the service area. Hospitals with a larger market share have NICUs. LHDCMC is proposing a

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Level II Nursery so it will only take a small percentage of market share from those hospitals as high risk patients will still need to deliver at those hospitals.

Table 24 below demonstrates the projected impact to other hospitals.

Table 24
Impact of LHDCMC Obstetrics Program on Existing Obstetric Units
In FY 2022 Volumes

Hospital	County	Total Shift of Discharges FY 2022 (Note 1)	Hospital's Total OB FY 2022 (Note 2 Note 3)	Shift as a % of Total Hospital OB, FY 2022
Anne Arundel Medical Center	Anne Arundel County	778	5,897	13.2%
Holy Cross Hospital	Montgomery County	613	9,142	6.7%
Adventist HealthCare White Oak Hospital	Montgomery County	103	1,528	6.8%
UM Capital Region Medical Center	Prince George's County	103	1,526	6.8%
MedStar Southern Maryland Hospital Center	Prince George's County	48	1,072	4.5%
Adventist HealthCare Shady Grove Medical Center	Montgomery County	45	1,528	2.9%
All Other Maryland Hospitals		243	46,891	0.5%
Total Maryland		**1,934**	**67,584**	**2.9%**
MedStar Washington Hospital Center	Washington, D.C.	240		
George Washington University	Washington, D.C.	54		
Sibley Memorial Hospital	Washington, D.C.	68		
MedStar Georgetown University Hospital	Washington, D.C.	36		
All Other Washington, D.C.		*30*		
Total Washington, D.C.		**428**		
Total FY22 Discharges to shift to DCMC		**2,362**		

Note 1: Projected Discharges & Source of Volume, Fiscal Years 2027 through 2031
Note 2: HSCRC FY22 Abstract dataset for Maryland hospital discharges
Note 3: CY21 DCHA discharge database for DC hospital discharges Maryland discharges only

From operating two additional operating rooms, LHDCMC projects to have the largest impact to Anne Arundel Medical Center. **Table 25** shows the impact to hospitals of their LHDCMC service area volume not total volume. Other Maryland hospital includes 31 hospitals and each hospital will only shift 3% of their LHDCMC service area volume for no more than 48 cases annually.

Table 25
Impact of LHDCMC Additional Operating Rooms on Existing Operating Rooms
In FY 2022 Volumes for LHDCMC Service Area

Hospital	Total Shift of OR Cases FY2022	Hospital's Total Cases in LHDCMC Service Area FY 2022	Shift as a% of LHDCMC Service Area OR Cases, FY 2022
Anne Arundel Medical Center	140	761	18%
Other Maryland Hospitals	332	4,994	7%
Washington, DC Hospitals**	694	5,637	12%
Total	**1,166**	**11,392**	**10%**

Source: Inpatient and outpatient HSCRC data for FY 2022 within the DCMC Service Area. DCMC volume reflects total surgical volume.
Note: Surgical cases defined as any inpatient or outpatient case with a surgical DRG or procedure code, excluding Transplants and Cardiac Surgery.

**Estimated 41.1% surgical outmigration to DC from the DCMC Service Area based on outmigration report prepared by BRG in August 2019.

b. On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

The new obstetrics program at LHDCMC will improve access by creating a local delivery site and increasing the number of ambulatory providers. A local delivery site will empower community-based OB/GYN physicians to maintain and increase access to women's health services. Luminis Health has already hired one OB/GYN who practices in Greenbelt. Luminis Health will further this investment by recruiting and hiring 5 new OB/GYNs to the practice area. LHDCMC believes that the laborist model and new program will help attract and retain providers at LHDCMC while creating access to OB/GYNs in the service area and that the introduction of this obstetrics program at LHDCMC is critical to recruiting and retaining clinicians in the area.

Over 700 patients from the LHDCMC service area currently travel to LHAAMC in Annapolis for obstetric services annually. With the new obstetrics program at LHDCMC, residents will have local access to the same high quality obstetrics program.

Likewise, the surgical services renovations will improve access by allowing LHDCMC to utilize two general purpose ORs for which it is currently licensed but is currently unable to use due to the deficiencies described above in response to COMAR 10.24.10.04A(6).

c. On costs to the health care delivery system.

The new obstetrics program at LHDCMC is expected to redirect over 400 obstetric discharges from Washington, DC hospitals. Over 200 deliveries from the LHDCMC service area are Medicaid deliveries at Washington, DC hospitals and LHDCMC is committed to service these patients. In FY 2022, the average charge per case for deliveries was $30,434. The obstetrics program at LHDCMC is projected to have an average charge per care of $11,312 while the obstetric service average charge per case across all hospitals is $14,166.

LHDCMC will operate with obstetric charges comparable to other obstetrics providers in Maryland. Therefore, the LHDCMC obstetrics program will improve access to Prince George's County residents while keeping the charge per case comparable to the service area average.

Table 26
Total Hospital Average Charge per Case (CPC) Comparison for Obstetrics Care
LHDCMC Service Area
FY 2022

Hospital	IP Discharges					Average Charge				
	Deliveries			Other OB	Total	Deliveries			Other OB	Total
Hospital	Vaginal	C-Section	Total Deliveries	Non-Delivery OB	Total OB	Vaginal	C-Section	Total Deliveries	Non-Delivery OB	Total OB
Holy Cross Hospital	$2,140	$1,053	$3,193	$157	$3,350	$9,128	$11,083	$9,773	$10,139	$9,790
Adventist HealthCare White Oak Hospital	$419	$162	$581	$32	$613	$10,056	$12,142	$10,638	$9,649	$10,586
UM Capital Region Medical Center	$715	$310	$1,025	$158	$1,183	$12,893	$16,342	$13,936	$12,376	$13,727
MedStar Southern Maryland Hospital Center	$203	$114	$317	$63	$380	$13,744	$16,908	$14,882	$9,106	$13,924
Anne Arundel Medical Center	$555	$297	$852	$65	$917	$8,461	$10,236	$9,080	$7,058	$8,937
Adventist HealthCare Shady Grove Medical Center	$81	$56	$137	$16	$153	$8,501	$8,831	$8,636	$10,892	$8,872
Howard County General Hospital	$52	$32	$84	$12	$96	$11,086	$13,516	$12,012	$9,211	$11,662
UM Charles Regional Medical Center	$33	$21	$54	$7	$61	$10,244	$13,290	$11,428	$8,292	$11,069
University of Maryland Medical Center	$32	$28	$60	$27	$87	$19,065	$23,147	$20,970	$24,971	$22,211
Holy Cross Germantown Hospital	$131	$62	$193	$4	$197	$10,511	$10,710	$10,575	$7,193	$10,506
UM Baltimore Washington Medical Center	$78	$21	$99	$5	$104	$10,761	$12,201	$11,066	$9,718	$11,001
MedStar Montgomery Medical Center	$37	$17	$54	$1	$55	$13,640	$12,230	$13,196	$12,879	$13,191
The Johns Hopkins Hospital	$19	$22	$41	$18	$59	$27,985	$26,244	$27,051	$18,940	$24,576
Doctors Community Hospital	$0	$0	$0	$48	$48	$0	$0	$0	$9,204	$9,204
Saint Agnes Hospital	$24	$12	$36	$1	$37	$12,932	$14,855	$13,573	$12,700	$13,549
MedStar Harbor Hospital Center	$9	$6	$15	$1	$16	$10,432	$14,760	$12,163	$4,592	$11,690
Johns Hopkins Bayview Medical Center	$7	$5	$12	$1	$13	$12,478	$24,204	$17,364	$34,483	$18,681
MedStar Franklin Square Medical Center	$4	$3	$7	$1	$8	$9,546	$9,498	$9,525	$5,185	$8,983
CalvertHealth Medical Center	$1	$6	$7	$0	$7	$10,175	$11,480	$11,293	$0	$11,293
UM Laurel Regional Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Mercy Medical Center	$8	$5	$13	$1	$14	$10,161	$10,978	$10,475	$4,010	$10,014
Sinai Hospital of Baltimore	$4	$1	$5	$1	$6	$12,212	$157,522	$41,274	$19,255	$37,604
Greater Baltimore Medical Center	$2	$6	$8	$2	$10	$8,438	$9,600	$9,310	$5,674	$8,582
UM St. Joseph Medical Center	$2	$0	$2	$0	$2	$9,624	$0	$9,624	$0	$9,624
MedStar Saint Mary's Hospital	$0	$2	$2	$0	$2	$0	$14,013	$14,013	$0	$14,013
Suburban Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adventist Fort Washington Medical Center	$0	$0	$0	$6	$6	$0	$0	$0	$18,784	$18,784
Meritus Medical Center	$1	$0	$1	$0	$1	$10,518	$0	$10,518	$0	$10,518
UPMC Western Maryland	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
MedStar Good Samaritan Hospital	$0	$0	$0	$1	$1	$0	$0	$0	$44,969	$44,969
MedStar Union Memorial Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UM Midtown	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grace Medical Center	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Northwest Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Carroll Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Union Hospital of Cecil	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UM Shore Dorchester	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Frederick Memorial Hospital	$0	$1	$1	$0	$1	$0	$8,581	$8,581	$0	$8,581
Garrett Regional Medical Center	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Peninsula Regional Medical Center	$1	$0	$1	$1	$2	$10,037	$0	$10,037	$8,982	$9,510
UM Upper Chesapeake Medical Center	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UM Harford Memorial Hospital	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Adventist Healthcare Rehabilitation	$0	$0	$0	$1	$1	$0	$0	$0	$15,372	$15,372
UM Shore Easton	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maryland Subtotal	4,558	2,242	6,800	630	7,430	$10,233	$12,499	$10,980	$11,194	$10,999
MedStar Washington Hospital Center	$440	$260	$700	$53	$753	$24,816	$36,287	$29,077	$42,926	$30,052
Sibley Memorial Hospital	$92	$74	$166	$9	$175	$19,930	$27,045	$23,102	$10,250	$22,441
George Washington University	$118	$49	$167	$39	$206	$36,700	$71,274	$46,845	$38,420	$45,250
MedStar Georgetown University Hospital	$71	$27	$98	$15	$113	$28,849	$40,009	$31,924	$100,194	$40,986
Confidential DC Hospitals	$26	$7	$33	$4	$37	$32,078	$45,002	$34,820	$16,016	$32,787
District of Columbia Subtotal	$747	$417	$1,164	$120	$1,284	$26,728	$39,145	$31,176	$45,273	$32,494
Total OB Service Area	$5,305	$2,659	$7,964	$750	$8,714	$12,556	$16,678	$13,932	$16,646	$14,166

Source: HSCRC FY22 Abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

With being able to operate two licensed general purpose ORs that it cannot currently utilize currently, LHDCMC anticipates capturing additional surgical cases unrelated to obstetrics. This volume, and the costs associated with it, would be funded via the HSCRC market shift policy. LHDCMC would receive GBR funding in the year subsequent to capturing the volume.

Affirmation

AFFIRMATION

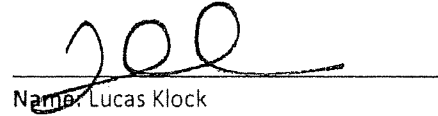
I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.

Jessica Farrar

Name: Jessica Farrar
Title: Vice President, Strategic Planning
Date: April 4, 2023

AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.



Name: Lucas Klock
Title: Director, Capital Projects
Date: 4/3/2023

AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.

URVASHI SAGAR

Name:

Title: DIRECTOR, FINANCIAL PLANNING

Date: 04/08/18

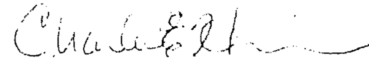
AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.

Name: Zachary Pietsch
Title: Sr Manager, Hospital Reimbursement
Date: 4/3/2023

AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.



Name: Charlene E. Harrison, MHA
Title: Vice President, Women's & Children's
Date: 4/3/23

AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.

Marguerite Crandall

Name: Marguerite Crandall
Title: Manager, Business Development
Date: 4/4/23

AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.

Name: Jeanette M Cross, CPA, FHFMA, CSAF, CPC
Title: Managing Director, Berkeley Research Group
Date: 4/3/2023

AFFIRMATION

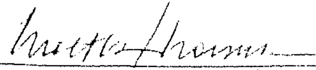
I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief.

Meredith Shilling

Name: Meredith Shilling
Title: Principal
Date: 3/4/23

AFFIRMATION

I hereby declare and affirm under the penalties of perjury the facts stated in the foregoing Certificate of Need Application by Luminis Health Doctors Community Medical Center to conduct a facility expansion with renovation and establish an obstetric program are true and correct to the best of my knowledge, information and belief



Name: SCOTT R. THOMAS
Title: PRINCIPAL, CANNONDESIGN
Date: 4/4/23