Luminis Health Doctors Community Medical Center
CON Application -- Obstetrics and Facility Modernization (Docket No. 23-16-2466)

Supplement to Response to MHCC Request for Completeness Information Dated April 25, 2023 (Question #23)

Designated Bed Capacity

23. The standard states that "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." However, the CON application, page 100 states that the beds "will be new beds, not taking away from the hospital's existing licensed acute care beds." Please explain how this plan complies and why the applicant is not designating MSGA beds for the Obstetrics program.

    (a) Exhibit 1, Table A and Table F show 20 Obstetric beds. Please reconcile this number with the number under the Designated Bed Capacity standard on page 100 which states there will be 21 licensed beds.

    (b) Page 8 states there will be six LDRs and three Antepartum rooms, however the line diagram shows seven LDRs and two Antepartum. Please reconcile these numbers.

Applicant Response:

COMAR 10.24.12.04(11) (Designated Bed Capacity) states that the applicant is required to "designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program." As explained in the Application, LHDCMC will designate 21 new beds for the proposed OB program. The Applicant stated that the beds would be new beds because it did not interpret the standard to require it to eliminate 21 licensed MSGA beds in order to establish the OB program. Rather, the Applicant understood the standard to require it to state the total number of designated OB beds that will be part of its overall licensed capacity if the Commission determines that the OB beds are needed and issues the CON. LHDCMC designated new beds for the OB program, just as it designated new beds for the inpatient psychiatric program for which the Commission granted a CON in 2019. Because licensed acute care capacity is based on historical (prior year) average daily census, LHDCMC's licensed capacity at the time the new OB program opens will not account for the new OB program, and will be based only on the prior year ADC in existing programs (MSGA and psychiatric). As a result, if LHDCMC was required to eliminate 21 beds in order to open the OB program, it will be left with less beds than the statutory licensure standard provides for, which could strain DCMC's ability to manage its beds and meet patient demands in high census times. This interpretation of standard appears to be at odds with the statutory

licensure formula, as well as being obsolete in terms of lessons learned over the last three years.

Additionally, the fact that the standard refers to designating beds from within the hospital's "licensed acute care beds" (the number of which is governed by statute) not its physical acute care beds is further indication that the standard was not intended to prevent a hospital from adding to its physical bed capacity, and indicates that it simply requires the hospital to state the number of beds from within its licensed capacity that will be designated to the OB program.

If this standard is interpreted to require that LHDCMC reduce its MSGA beds by the number of new OB beds being opened that year, in light of the fact that the new OB program will ramp up to full utilization over several years, rather than allocate all 21 MSGA beds to the OB unit in the first year it opens (when census projections for OB are at their lowest), LHDCMC would propose to allocate only the number of beds needed each year as the OB program matures. This will allow LHDCMC to retain as many beds for MSGA admissions as possible, reducing the likelihood that it would need to make multiple temporary adjustments of bed capacity through OHCQ over the course of any year to manage its MSGA census. The revenue and expense projections in the Application are based on the following ramp up of projected OB census (based on total projected patient days for antepartum patients and deliveries), with full ramp up at 75% occupancy projected in FY31:

Fiscal Year	2027	2028	2029	2030	2031
OB Beds	5	13	16	19	21

LHDCMC expects to be notified this month that it will have 211 licensed MSGA beds in FY2024. On the assumption it continues to have 211 total licensed acute care beds when the OB program opens, based on the above projections, LHDCMC would allocate MSGA beds to OB in the same manner (5 in FY27, an additional 8 in FY28, an additional 3 in each of FY29 and FY 30, and the final 2 beds in 2031). To the extent that LHDCMC's licensed capacity in any of these years exceeds 211, it is our understanding that this would reduce the number of MSGA beds it would eliminate so they can be allocated to OB in that year by the same number.