



Sinai Hospital  
Northwest Hospital  
Carroll Hospital  
Levindale Hebrew Geriatric Center and Hospital

5 October 2015

Kevin McDonald  
Chief, Certificate of Need  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Re: Baltimore Nursing and Rehabilitation, LLC - Matter No.15-24-2366

Dear Mr. McDonald:

LifeBridge Health, Inc. ("LifeBridge") hereby submits the following comments pursuant to COMAR 10.24.01.08 regarding the application for a certificate of need (the "Application") submitted by Baltimore Nursing and Rehabilitation, LLC ("BN&R").

LifeBridge requests that it be recognized as an interested party in the review of the Application. Through its subsidiary Levindale Hebrew Geriatric Center and Hospital ("Levindale"), LifeBridge provides comprehensive care facility ("CCF") services in the same planning area as proposed in the Application (Baltimore City). LifeBridge would be adversely affected by the approval of the Application. As discussed below, there is no need for additional CCF beds in Baltimore City, and BN&R has not demonstrated an unmet need on the part of the population to be served. The Application does not meet the following review criteria and State Health Plan ("SHP") standards.

**COMAR 10.24.01.08G(3)(a) - State Health Plan**

The applicable SHP chapter is COMAR 10.24.08 (Nursing Home and Home Health Agency Services). References below are to standards within that chapter.

**.05A.(1) Bed Need**

The bed need in effect when the Commission receives a letter of intent for the application will be the need projection applicable to the review. The applicable bed need projection is for 2016 and was published in the *Maryland Register* on October 3, 2014. It shows a surplus of 500 CCF beds for Baltimore City. The Application therefore does not meet this standard.

BN&R argues in its application (pages 18-19) that the bed need standard should not apply because it is proposing to relocate temporarily delicensed beds. This is not correct, for the reasons stated in the Staff Report and Recommendation dated April 1, 2015, *In the Matter of Ingleside at King Farm*, Docket No. 14-15-2355, page 12 and Appendix 5, which are incorporated herein by reference. The main reason why the Commission has been willing, in some cases, to approve the relocation of temporarily delicensed beds in a jurisdiction with a lack of projected bed need is the replacement and/or modernization of aging facilities. In contrast, the Application proposes to use the temporarily delicensed beds for an entirely new facility, *not* for the replacement or modernization of an existing nursing home.

BN&R has made several arguments as to why there is a need for the facility even though there is no projected bed need (see the June 9, 2015 Response to Completeness Questions dated May 11, 2015, pages 21-23), but these arguments do not withstand scrutiny:

1. BN&R argues that there are unmet needs for certain post-acute specialty services (dialysis, bariatric, etc.). These supposedly unmet needs are in fact being met by existing providers, as discussed below.
2. BN&R argues that “the projected population for the elderly cohort will result in a significant increase in demand for nursing home care in Baltimore City facilities”, corresponding to an additional need for 214 beds in Baltimore City from 2013 through 2019. Projected demographic changes through 2016 are already factored into the Commission’s bed need projections. The additional need allegedly based on the projected population changes from 2016 to 2019 (three years) is approximately one-half of the projected additional need projected from 2013 to 2019 (six years), which equates to 107 beds. This is much less than the projected Baltimore City surplus of 500 nursing home beds. Although the Commission’s projection of bed need includes an adjustment for the anticipated development of community-based services, the increasing focus on community health, home health, and telehealth is likely to further reduce the future need for these services.
3. BN&R argues that there will be cost savings attributable to “substituting nursing home days for hospital days”. In fact, under the HSCRC’s Global Budget Revenue (“GBR”), hospitals would be paid the *same amount* if nursing home days (or even admissions) are substituted for hospital care, while nursing homes would be paid *additional dollars* for the nursing home days, most of it by Medicare under the SNF payment system. The net effect of “substituting nursing home days for hospital

days”, all other things being equal, would be *additional costs* paid by the health care system, not savings.

4. BN&R claims that it will reduce readmissions to hospitals. There is no evidence that BN&R would accomplish this, but in any case it should not require the construction of a new nursing home to do it. If such reductions can be accomplished through better skills, care management, protocols for effective communications, and protocols for symptom management in the nursing home, as BN&R asserts, then they can and should be attained through the capacity which is already available at existing comprehensive care facilities in Baltimore City.

#### **.05A.(2) Medical Assistance Participation**

The applicant must agree to serve a proportion of Medicaid patient days that is at least equal to the proportion of Medicaid patient days in all other nursing homes in the jurisdiction, calculated as the weighted mean minus 15.5%. The Commission’s latest calculations of the required participation rates were published in the *Maryland Register* on March 20, 2015, and show a required rate of 58.18% for Baltimore City. While BN&R stated in its application that it would comply with this standard, the projections in Table G of the Application, at line 4.b.2, show a projected 47% Medicaid patient days. The Application therefore does not meet this standard.

In Appendix E to its first response to completeness questions, in response to the staff’s question 10, BN&R provided alternative hypothetical projections of revenues and expenses based on assumed proportions of Medicaid days equal to 69% and 66%, respectively. However, BN&R’s response to question 10 indicates that it continues to expect the facility’s payor mix to be similar to that of Fairfield Nursing and Rehabilitation in Anne Arundel County, which “maintains a focus on short stay rehabilitation in similar fashion to the proposed facility”. As BN&R stated at Exhibit F to the Application:

“Another key assumption is the payor mix at the facility. We have modeled our payor mix to be comparable to Fairfield, one of our Maryland-based facilities that has a similar resident mix and is a similar size (96 beds). As mentioned elsewhere in the application, we have projected a 47.01% census for Medicaid which is the average of all the nursing homes in the jurisdiction within which the Facility operates. Beyond that, given the focus on aggressive return to home rehabilitation residents and other more acute conditions, we estimate a high percentage of patients (42%) to be Medicare patients. This is a similar percentage to the payor mix operating at Mid-Atlantic’s Fairfield facility.”

In other words, if BN&R succeeds in its declared objective of serving primarily short-stay, post-acute patients, for which Medicare is the primary payor, *it will not meet the required minimum standard for serving Medicaid patients.*

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### **.05B.(1) New Construction – Bed Need**

An applicant for a facility involving new construction using beds currently in the Commission's inventory "must address in detail the need for the beds to be developed in the proposed project" by submitting data on demographic changes in the target population, utilization trends, and "demonstrated unmet needs of the target population". Although BN&R has submitted certain data and has argued that there are unmet needs of the target population, it has not demonstrated that the beds to be developed are needed, and therefore does not meet this standard.

At pages 25 – 27 of the Application BN&R presents several tables intended to address this standard. Table M shows projected changes for different age cohorts 2009 – 2025. The Commission's bed need projections already take into account projected changes in demographics through 2016, and in any event these figures only reflect projected population, not projected utilization of nursing homes in Baltimore City. The projections in Table M actually show a *decline* through 2020 for the age cohorts 75-84 and 85+, which are the most intensive users of these services. Table K, showing total discharges of Baltimore City residents from nursing homes throughout the state, is not very relevant because (a) it includes utilization of nursing homes located outside of Baltimore City, and (b) it reflects patient discharges, not patient days. (If short-term post-acute stays are increasing as a proportion of total patient days, there could be a decline in total days utilized even if discharges are increasing.) Table K, showing the actual utilization (in patient days) of nursing homes located in Baltimore City, shows a decline in utilization for every year 2009 – 2013, for a cumulative decline in utilization of 10.3%. BN&R attempts to put a positive spin on this data by asserting that the "decline has begun to moderate", but in fact the data shows that the decline for the last year (2.829% reduction in utilization for 2013) was slightly larger than the average annual reduction during the four-year period 2009 – 2013 ( $10.3\%/4 = 2.6\%$ ). In other words, the data indicates declining utilization of nursing homes in Baltimore City, which does not support the need for the proposed facility.

At pages 27 – 30 of the Application, BN&R presents several arguments about allegedly unmet needs for nursing home care:

**Dialysis Patients.** BN&R asserts that: "Only a limited number of facilities in Baltimore City accept patients who require dialysis, and oftentimes these facilities are operating at capacity and cannot accept additional dialysis patients."

**Dialysis/Ventilator Patients.** BN&R says: "Case managers at UMMC note that capacity is even more limited for patients on ventilators who also require dialysis. Restore Health will be equipped to accept these patients." At page 34, BN&R notes that one of its affiliated Mid-Atlantic facilities "is in the process of developing the capacity for bedside dialysis for patients on ventilators."

Medical Monitoring after Acute Episode. BN&R claims that “clinicians are often uneasy about discharging cardiac patients from the acute care setting due to concerns about the level of attention and monitoring that is provided at area nursing homes.”

Patients with More Complex Medical Needs. BN&R says: “Baltimore City requires a nursing home setting that can serve patients with more complex medical needs and that can provide the ability for ‘step up’ care when necessary. This will permit earlier discharge from the hospital and minimize the need to transfer patients to the acute care hospital.”

Many of these medically-intensive post-acute care services, including dialysis, ventilator care, and cardiac monitoring, are provided by LifeBridge at Levindale. Levindale is a 330-licensed-bed facility. Levindale's geriatric center includes 119 comprehensive care (long-term care) beds, 42 subacute rehabilitation beds, 28 dementia care beds and a 21-bed respiratory care unit. The Specialty Hospital at Levindale (licensed as a chronic hospital) consists of a 40-bed High Intensity Care Unit (“HICU”) and an 80-bed behavioral health unit.

Levindale's HICU offers round-the-clock care for patients with critical and complex conditions, including in-house dialysis services. The HICU has respiratory therapists and registered nurses who are all certified in Advanced Cardiac Life Support, and the ratio of nurses to patients is adapted to this level of care. The treatment team also includes licensed social workers, licensed practical nurses, physical therapists, occupational therapists and speech-language pathologists. Adding to the continuum of care is an onsite pharmacy, laboratory and diagnostic radiological services.

Patients in the Levindale High Intensity Care Unit are monitored for cardiac conditions and serious complex conditions. They may be admitted directly from intensive care units, coronary care units or intermediate care units for ongoing care, or may be transferred within the facility due to a change in condition. The unit accepts patients 18 years or older.

Candidates for the High Intensity Care Unit are patients who meet the chronic criteria and who have a medical or surgical problem that requires cardiac or intensive monitoring. This includes patients with:

- Increasing heart failure who are hemodynamically stable
- Recent cardiothoracic surgery
- Drug toxicities with arrhythmogenic compounds such as digitalis and tricyclic antidepressants
- Electrolyte disturbances with a potential for life-threatening arrhythmias

Regular cardiology and pulmonary critical care support in the HICU are combined with continuous heart monitoring for life-threatening arrhythmia and other therapies. These

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therapies include ventilator management and weaning, chest tube management and complex airway management.

The Levindale High Intensity Care Unit also treats other conditions that require:

- IV medications
- Peripherally inserted central catheter (PICC) lines
- Dialysis
- Wound care and rehabilitation services
- Total parenteral nutrition
- Additional nutritional interventions

During FY2015 the average daily census in the 40-bed HICU was 22.9, with a total of 8,358 patient days (57.2% utilization). Levindale therefore has available capacity in its HICU to treat additional patients needing these services.

BNR also says that it will focus on short-stay rehabilitation patients, including non-elderly patients “discharged from acute care hospitals after injury, trauma, elective surgery, and similar reasons for hospitalization who require active rehabilitation programs” (Application, p. 21). As noted above, Levindale has a 42-bed subacute rehabilitation unit which provides short-stay rehabilitation services. In addition, LifeBridge provides specialty hospital (rehabilitation) services at Sinai Hospital in a 57-bed rehab unit. The short-term rehabilitation services described by BNR appear to overlap with the subacute rehabilitation services at Levindale and the acute rehabilitation services offered at Sinai. There is available capacity in Sinai’s rehab unit: the average census for FY2015 was 33, with a total of 11,820 patient days (56.8% utilization). Levindale recently increased the size of its subacute rehabilitation unit from 35 to 42 beds by reallocating long-term beds. (Since the subacute beds and the long-term beds are both licensed as CCF, this was accomplished with no change in the facility’s licensed bed complement.) Should the need for subacute rehabilitation services increase in the future, Levindale would be able meet this demand with additional increases in the unit’s capacity.

#### **.05B.(3) Jurisdictional Occupancy**

The SHP standard states that the Commission “may approve a CON application for a new nursing home only if the jurisdictional occupancy for all nursing homes in that jurisdiction equals or exceeds a 90 percent occupancy level for at least the most recent 12 month period.” According to the latest information published by the Commission (*Maryland Register*, March 20, 2015), the jurisdictional occupancy rate for Baltimore City nursing homes was 87.81%. The Application therefore does not meet this standard.

Subsection (b) of the standard states that an applicant may show evidence why this rule should not apply, and BN&R made some arguments on this issue at pages 36 – 38 of

the Application. It argued that the standard “appears to be aimed at new facilities proposing a bed increase” and therefore should not apply to a new facility using relocated temporarily delicensed beds. There is no basis for ignoring this standard; it applies to the approval of “a new nursing home”, which the BN&R facility certainly would be. If a rationale is needed for applying the standard to such a project, it is the avoidance of unnecessary capital costs, which in this case would be approximately \$17 million.

### **Other CON Review Criteria**

#### **COMAR 10.24.01.08G(3)(b) – Need**

The standard states that the Commission shall consider the applicable need analysis in the State Health Plan. As discussed above, the SHP need analysis shows a surplus of 500 nursing home beds in Baltimore City. The Application therefore does not meet this standard.

#### **COMAR 10.24.01.08(G)(c) - Availability of More Cost-Effective Alternatives**

The standard states that the Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities. The Application does not meet this standard because the services proposed by BN&R can be provided more cost effectively by existing providers. Since there is existing capacity and existing capability at alternative facilities – including LifeBridge’s facilities – the services can be provided without the substantial capital costs required to build a new nursing home.

As previously noted, BN&R argues that there will be cost savings attributable to “substituting nursing home days for hospital days”. In fact, under the HSCRC’s Global Budget Revenue (“GBR”), hospitals would be paid the *same amount* if nursing home days (or even admissions) are substituted for hospital care, while nursing homes would be paid *additional dollars* for the nursing home days, most of it by Medicare under the SNF payment system. The hospital inpatient per diem and observation rates cited by BN&R are used for charges to individual patients, but whether an individual patient is charged or not is not relevant to the calculation of a hospital’s total budgeted revenue.

The net effect of “substituting nursing home days for hospital days”, all other things being equal, would be *additional costs* to the health care system, not savings. BN&R effectively concedes this by stating: “Under the GBR model, this would make hospital budget dollars more available for reinvestment in the West Baltimore community.”

In particular, the short-term post-acute services proposed by BN&R can be provided more cost effectively by LifeBridge, especially in Levindale’s High Intensity Care Unit. Likewise, short-term rehabilitation services beyond those which can be provided in a nursing home can be provided more cost effectively by Sinai’s acute rehab unit. Both

the Levindale HICU and the Sinai rehab unit are included in LifeBridge's Global Budget Agreement with the HSCRC, so that (except for relatively minor adjustments) the provision of those services to additional patients would not generate additional costs to the health care system. In contrast, if BN&R were approved and provided the same services, there would be additional costs to the system equal to what Medicare and other payors would pay BN&R.

**COMAR 10.24.01.08G(3)(f) – Impact on Existing Providers and the Health Delivery System**

The standard states that an applicant must 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 access, occupancy, costs and charges of other providers, and on costs to the health care system. The discussion at pages 53 – 55 of the Application does not provide any information or any analysis of the impact of the project on existing providers. The Application therefore does not meet this standard. BN&R argues, instead, that its services for “traditional, long stay patients” will be limited to those for which “demand is growing and/or supply is constrained” – notably dialysis and vent/dialysis. As discussed above, there is no overall growth in utilization projected in Baltimore City, and the services mentioned are not in fact constrained.

For all these reasons, LifeBridge urges the Commission to deny the application of Baltimore Nursing and Rehabilitation, LLC.

Very truly yours,



Neil Carpenter

LifeBridge Strategic Planning

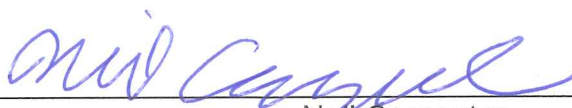
Attachment: Affidavit of Neil Carpenter

cc: Leana S. Wen, M.D., MSc., FAAEM



I hereby declare and affirm under the penalties of perjury that the facts stated in the Comments of LifeBridge Health, Inc. are true and correct to the best of my knowledge, information, and belief.

Date: October 5, 2015



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Neil Carpenter  
Strategic Planning  
LifeBridge Health