MARYLAND
Health Care
Commission

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

MEMORANDUM

TO: Commissioners

FROM: Jeanne Marie Gawel, Acting CON Chief

DATE: January 18, 2024

SUBJECT: University of Maryland Shore Health System Certificate of Need for a Replacement Hospital in Easton, Talbot County, Maryland (Docket No.) 23-20-2463

Shore Health System, Inc. (UM SHS) is the applicant in this review. UM SHS operates University of Maryland Shore Medical Center at Easton (UM SMC Easton, or hospital), University of Maryland Shore Medical Center at Cambridge (UM SMC Cambridge), and University of Maryland Shore Emergency Center at Queenstown (UM SMC Queenstown). UM SHS also operates a number of outpatient facilities in Easton, Denton, Cambridge, and Centreville. UM SHS proposes to relocate and replace UM SMC Easton, a general acute care hospital operating in Easton, to an undeveloped 200-acre site located at 10000 Longwoods Road in Easton, Talbot County, approximately 3 miles from the existing campus.

The proposed replacement hospital will include 110 acute care beds, 12 special hospital rehabilitation beds, and 25 observation beds. The hospital will also include an emergency department (ED) with 27 treatment spaces and three behavioral health holding rooms, regulated outpatient clinics, a full-service laboratory, and space for administrative and education functions. UM SHS explains that the existing UM SMC Easton is outdated and obsolete, with the majority of the hospital building built between 1955 and 1975. The existing campus is in a residential neighborhood that limits any expansion and creates access issues for patients and staff.

The estimated project cost is $539,558,871 for the relocation and replacement of UM SMC Easton. UM SHS proposes to finance the project with approximately $39 million in cash, $50 million in philanthropy, $333 million in proceeds from debt financing, $100 million in state funding, and approximately $18 million in interest income.

Based on the review of the proposed project's compliance with the Certificate of Need review criteria, and with the applicable standards in the State Health Plan, staff concludes that the project complies with the applicable standards, is needed, is cost-effective, viable and will have a positive impact with respect to the applicant's ability to provide comprehensive health

care services to the Eastern Shore region. Therefore, staff recommends that the Commission APPROVE the University of Maryland Shore Health Systems certificate of need application to build a replacement hospital in Easton, Talbot County, with the following conditions:

1. The University of Maryland Shore Medical Center at Easton shall provide to the patient, upon inquiry or as required by applicable regulations or law, information concerning an estimate of out-of-pocket charges prior to arrival for surgery.

2. Shore Health System shall provide, in its quarterly project reports, detailed updates on its progress towards obtaining the anticipated State funding, including how much has been obtained and efforts made to secure the remaining funds..

3. If Shore Health System fails to secure the projected State source of funds by July 2027, UM SHS shall request a project change to amend the project source of funds.

IN THE MATTER OF	*	**BEFORE THE**
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	*	
SHORE HEALTH SYSTEM, INC.	*	**MARYLAND HEALTH**
	*	
	*	
Docket No.: 23-20-2463	*	**CARE COMMISSION**
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STAFF REPORT AND RECOMMENDATION

January 18, 2024

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I. INTRODUCTION

A. The Applicant

Shore Health System, Inc. (UM SHS, or applicant) is the applicant in this review. UM SHS includes University of Maryland Shore Medical Center at Easton (UM SMC Easton, or hospital), University of Maryland Shore Medical Center at Cambridge (UM SMC Cambridge), and University of Maryland Shore Emergency Center at Queenstown (UM SMC Queenstown). UM SHS also operates a number of outpatient facilities in Easton, Denton, Cambridge, and Centreville.

UM SHS was formed in 1996 when UM SMC Easton merged with Dorchester General Hospital (UM SMC at Dorchester). UM SMC at Dorchester converted to a freestanding medical facility (FMF) which was renamed the University of Maryland Shore Medical Center at Cambridge (UM SMC Cambridge). In 2010, UM SHS opened The University of Maryland Shore Emergency Center at Queenstown (UM SMC Queenstown), an FMF located in Queen Anne's County.

In 2006, UM SHS affiliated with the University of Maryland Medical System (UMMS). and in 2013, UM SHS joined with the University of Maryland Shore Medical Center Chestertown (Chestertown) to become the University of Maryland Shore Regional Health, Inc. (UM SRH). UM SRH is the sole corporate member of UM SHS and a subsidiary of UMMS. The UM SRH network serves five counties: Caroline, Dorchester, Kent, Queen Anne's, and Talbot. In addition to the hospitals located in Easton and Chestertown and the FMFs in Dorchester and Queenstown, UM SRH includes a network of outpatient centers offering diagnostic imaging, laboratory testing, primary care, specialty treatment, and rehabilitation services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. UM SRH also has ambulatory surgery centers in Easton, Queenstown, and Cambridge.

B. The Project

UM SHS proposes to relocate and replace UM SMC Easton, a general acute care hospital operating in downtown Easton, to an undeveloped 200-acre site located at 10000 Longwoods Road in Easton, Talbot County, approximately 3 miles from the existing campus.

Applicant explains that the existing hospital is outdated and obsolete, with the majority of the building having been built between 1955 and 1975. The existing campus is located in a residential neighborhood that limits any expansion and creates access issues for patients and staff. A summary of the specific identified issues at the current location that have generated the need to relocate and replace UM SMC Easton includes:

- The existing hospital is outdated and undersized;
- A significant number of rooms are semi-private rooms;
- The hospital contains undersized elevators, operating rooms, and helipad;
- There is insufficient and inconveniently located storage space;
- The hospital has deteriorating plumbing, air handling, and steam system; and
- There is a lack of sufficient and suitable space for the laboratory and food service departments. (DI #3, pp. 197-203).

The proposed replacement hospital will include 110 acute care beds, 12 special hospital rehabilitation beds, and 25 observation beds. The hospital will also include an emergency department (ED) with 27 treatment spaces and three behavioral health holding rooms, regulated outpatient clinics, a full-service laboratory, and space for administrative and education functions.

Table I-1: UM SMC Easton
Existing and Post-Project Capacity

Service	Existing Capacity	Proposed Capacity
MSGA beds	62	74
Intensive/critical care beds	10	12
Obstetric beds	13	11
Psychiatric beds	10	12
Pediatric beds	3	1
Rehabilitation beds	20	12
Observation beds	0	25
Emergency department treatment spaces	32	27
Behavioral health holding rooms	0	3
Operating rooms	6	7

Source: DI #11, Exhibit 27, Table A.

The estimated project cost is $539,558,871 for the relocation and replacement of UM SMC Easton. UM SHS proposes to finance the project with approximately $39 million in cash, $50 million in philanthropy, $333 million in proceeds from debt financing, $100 million in state funding, and approximately $18 million in interest income. An itemized project budget follows in Table I-2.

Table I-2: Estimated Uses and Sources of Funds
Replacement and Relocation of the General Hospital Facilities of UM SMC Easton

Uses of Funds			
	Hospital Building	**CUP[1]**	**Total**
Land Purchase	$2,464,658		$2,464,658
New Construction			
Building	$210,528,602	$6,110,000	$216,638,602
Fixed Equipment	In Building	In Building	In Building
Site and Infrastructure	$36,933,315	$7,476,645	$44,409,960
Architect/Engineering Fees	$9,013,929	$1,986,071	$11,000,000
Permits (Building, Utilities, Etc.)	$5,027,314	$1,107,686	$6,135,000
Subtotal	**$261,503,160**	**$16,680,402**	**$278,183,562**
Movable Equipment	$85,060,730	$40,000,000	$125,060,730
Contingency Allowance	$16,974,712	$2,478,023	$19,452,735
Gross interest during construction period	$44,210,733	$5,788,267	$49,999,000
Easton Utility Fees	$9,000,000		$9,000,000
Impact Fee (Town) / County	$1,500,000		$1,500,000
Builder's Risk Insurance	$500,000		$500,000
HOSPITAL MOVE	$2,000,000		$2,000,000
UMMS/OVHO	$1,500,000		$1,500,000
Previous Expenditures (Design/Planning/Etc.)	$10,078,129		$10,078,129
Subtotal	**$170,824,304**	**$48,266,290**	**$219,090,594**
TOTAL CURRENT CAPITAL COSTS	**$434,792,122**	**$64,946,691**	**$499,738,814**
Inflation Allowance	$25,435,020	$3,305,038	$28,740,058
TOTAL CAPITAL COSTS	**$460,227,142**	**$68,251,729**	**$528,478,871**
Financing Cost and Other Cash Requirements			
Loan Placement Fees	$2,635,012	$344,988	$2,980,000
CON Application legal fees	$150,000		$150,000
Accounting, Architectural, Planning	$850,000		$850,000
IT Design	$75,000		$75,000
SHA Study	$300,000		$300,000
Geo-tech consult (if needed)	$75,000		$75,000
Project Development Consultant	$4,500,000		$4,500,000
CM Preconstruction Fees	$200,000		$200,000
Exterior Wall Mock Up & Testing	$500,000		$500,000
Scheduling	$200,000		$200,000
Third Party Inspections	$750,000		$750,000
Third Party Building Permit Review	$400,000		$400,000
Curtainwall Testing	$100,000		$100,000

[1] CUP-Central Utility Plant

SUBTOTAL	***$10,735,012***	***$344,988***	**$11,080,000**
Total Uses of Funds	***$470,962,155***	***$68,596,717***	***$539,558,871***
Sources of Funds			
Cash	$38,588,871		$38,588,871
Philanthropy (to date and expected)	$50,000,000		$50,000,000
Authorized Bonds	$264,727,283	$68,596,717	$333,324,000
Interest Income from bond proceeds	$17,646,000		$17,646,000
State Grant	$100,000,000		$100,000,000
TOTAL USES OF FUNDS	***$470,962,155***	***$68,596,717***	***$539,558,871***

Source: DI #11, Ex. 27, Table E.

C. Recommended Decision

Commission staff concludes that this project complies with the State Health Plan standards and that the applicant has demonstrated the need for the project, its cost-effectiveness, its viability, and its positive impact. Staff summarizes its findings below.

Need and Capacity

Staff concludes that the applicant has successfully demonstrated the need for this project. This includes the need for a comprehensive modernization of the current physical facilities, and for the proposed services and capacities. Staff concluded that the applicant's assessment of need to be reasonable and consistent with current trends in hospital use and the changing hospital service delivery environment and payment for hospital services.

Cost and Effectiveness

UM SHS has adequately demonstrated that the proposed relocation and replacement of UM SMC Easton is a cost effective approach to the needed modernization of the hospital and the new site offers reasonable access to service area residents. Applicant has demonstrated that the drive time and distance to other facilities in the region is far for patients in the primary service area. Applicant has shown there are no appropriate alternatives to the proposed project. The applicant also provided a comprehensive list of population health initiatives to avoid or reduce hospital admissions and readmissions.

Efficiency

Replacing the current outdated facility with a modern facility will improve adjacencies and workflow. Private rooms will allow for more efficient use of the hospital's bed capacity and the new facility design will allow for a reduction in staffing. UM SHS provided a cost saving estimate that is driven by the new facility's design, which is projected to have a net savings of $321,000 per year.

Financial Feasibility and Viability

The staffing, revenue and expense projections demonstrate that the project can be both financially feasible and viable. Staff reviewed applicant's financial plans and projections and anticipates that the hospital, once completed, will likely be profitable, assuming the applicant maximizes on the increased efficiencies planned in the project. There remains a question, however, about the outstanding $70 million in state funds, and whether this source of funding will be realized. Applicant explains that State funding for large capital projects such as UM SMC Easton often require a series of State budget cycles to be realized, and stated their expectation the additional funds will be approved. Staff also considered the applicant's plan for raising the required philanthropic funds and concluded the plan is credible. UM SHS has committed to using other UM Memorial Hospital Foundation unrestricted funds and/or increasing borrowing to cover any shortfall in philanthropic fundraising.

Impact

The proposed project impact on existing health care providers in the service area, including geographic and demographic access to services, occupancy, costs and charges of other providers, and costs to the health care delivery system has been evaluated. Staff concludes that there will not be a negative impact on other providers or the health care delivery system as a result of this project.

Conclusion

Staff recommends that the Maryland Health Care Commission approve this project based on its finding that: the proposed project complies with the applicable State Health Plan standards; and that the need for the project, its costs and effectiveness, and its viability have been demonstrated. Staff concludes that the project is likely to have a positive impact on hospital care, safety and quality and will improve access and health care services for residents of the Eastern Shore. Staff recommends that the Commission find that the project's impact is acceptable.

Staff recommends that the Commission APPROVE the Certificate of Need application with the following conditions:

1. The University of Maryland Shore Medical Center at Easton shall provide to the patient, upon inquiry or as required by applicable regulations or law, information concerning an estimate of out-of-pocket charges prior to arrival for surgery.

2. Shore Health System shall provide, in its quarterly project reports, detailed updates on its progress towards obtaining the anticipated State funding, including how much has been obtained and efforts made to secure the remaining funds..

3. If Shore Health System fails to secure the projected State source of funds by July 2027, UM SHS shall request a project change to amend the project source of funds.

II. PROCEDURAL HISTORY

A. Record of the Review

See Appendix 1.

B. Interested Parties in the Review

There are no interested parties in the review.

C. Local Government Review and Comment

The application included letters of support from Health Officers in Queen Anne's, Dorchester, Talbot, Caroline, and Kent counties; the Mayors of Chestertown, Cambridge, and Easton; County Commissioners in Caroline, Kent, and Queen Anne's counties; and the County Councils in Dorchester, Talbot, and Caroline counties.

D. Community Support

The applicant submitted 47 letters of support from the State and local government officials listed above, as well as clinicians, business owners, educators, associations and other healthcare facilities. The names of the individuals and organizations that expressed support of the hospital relocation are listed below.

LETTERS OF SUPPORT

1. Christopher T. Adams, Maryland State Delegate, Legislative District 37B
2. Donna L. Beitel, M.D. Board Certified Psychiatrist Marshy Hope Family Services, LLC
3. Shyam Bhayani, Chief Administrator Community Behavioral Health
4. James Travis Breeding, President, Caroline County Commissioners Office
5. David H. Breimhurst, President the Commissioners of St. Michaels
6. Tina Marie Brown, LCSW-C, Director Affiliated Sante's Eastern Shore Crisis Response
7. Chuck F. Callahan, President County Council of Talbot County
8. Cathy Cassell, LCSW-C, CEO, Channel Marker, Inc.
9. William Christopher, President/CEO, Dorchester Chamber of Commerce, Inc.
10. Joseph Ciotola, Jr., M.D. Health Officer, Queen Anne's County Department of Health
11. Clifford P. Coppersmith, Ph.D., President, Chesapeake College
12. Jonathan Dayton, MS, NREMT, Executive Director, Maryland Rural Health Association
13. Kathryn G. Dilley, LCSW-C, Executive Director, Mid-Shore Behavioral Health
14. Theodore R. Delbridge, MD, MPH, Executive Director, Maryland Institute for Emergency Medical Services Systems
15. W.W. "Buck" Duncan, President, Mid-Shore Community Foundation
16. Addie C. Eckardt, Senator, Maryland State Senate, Legislative District 37
17. Ronald H. Fithian, President, Albert H. Nickerson, Member, John F. Price, Member of the

County Commissioners of Kent County
18. David Foster, Mayor of Chestertown
19. Scott W. Getchell, Town Administrator, Town of Denton
20. Heather A. Guerieri, RN, MSN, CEO, Compass Regional Hospice
21. Roger L. Harrell, MHA, Health Officer, Dorchester County Department of Health
22. Michael S. Hiner, President, Willow Construction
23. Holly R. Ireland, Executive Director, Corsica River
24. James Jaramillo, Commission President, Brian Wells, Commissioner, Tom Costigan, Commissioner, Commissioners of Oxford
25. Amy L. Kreiner, President/CEO, Talbot County Chamber of Commerce
26. Beth Anne Dorman (Langrell), President/CEO, For All Seasons Inc.
27. Maria Maguire, Health Officer, Talbot County Health Department
28. Johnny Mautz, Member, Maryland State Delegate, Legislative District 37B
29. Michael A. Meoli, President, The Meoli Companies
30. David Milligan, Chair, UM Shore Regional Health Board of Directors
31. James J. Moran, President, The County Commissioners of Queen Anne's County
32. Nicole Morris, MSN, RN, Director, Mid Shore Health Improvement Coalition
33. Patrick Mutch, President and CEO, Chase Brexton Health Care
34. Laurence J. Pezor, MD, Medical Director and Chairman, University of Maryland Shore Regional Health
35. Sara Rich, MPA, President and CEO, Choptank Community Health
36. Stephen W. Rideout, Mayor, City of Cambridge
37. William Rosenberg, M.S., NRP, CCEMT, President and CEO, Butler Medical Transport
38. Tracey Snyder, Executive Director, Caroline County Chamber of Commerce
39. William Webb, MS, Health Officer, Kent County Health Department
40. Robert C. Willey, Mayor, Town of Easton
41. Scott Warner, Executive Director, Mid Shore Regional Council
42. Richard Barker, Chairman, University of Maryland Chester River Foundation
43. Robin Cahill, Health Officer, Caroline County
44. C. Edmund Connelly, Dorchester General Hospital Foundation
45. Linda Friday, President, Queen Anne's County Chamber of Commerce
46. Sarah King, Executive Director, Kent County Chamber of Commerce
47. Nicholas Newman, Council President, The Town of Trappe

Sources: (DI #3, Exhibit 23, DI #10).

III. BACKGROUND

A. Population Change, Race, and Income

Population Projections

The existing and the proposed UM SMC Easton replacement hospital site are both located in the town of Easton in Talbot County. The replacement hospital will rely on the Mid- Shore as the source for the majority of its patients, which includes Talbot, Caroline, Dorchester, Kent, and Queen Anne's counties. These five counties make up the service area and project an overall growth in the population by 2040 as shown in Tables III-1 and III-2. The combined growth rate for the five counties is greater than the state growth rate of 10.68 percent.

Table III-1: 2020 Population and Population Growth Rate Projections

	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Total
2020	36,050	34,800	21,400	53,600	40,850	186,700
2025	38,250	36,550	22,100	57,350	42,050	196,300
2030	40,450	37,850	22,600	60,350	42,900	204,150
2035	42,750	39,100	23,050	63,150	43,550	211,600
2040	44,950	40,000	23,500	65,750	44,000	218,200
Change	8,900	5,200	2,100	12,150	3,150	31,500
Growth %	24.68%	14.94%	9.81%	22.66%	7.71%	16.87%

Source: Maryland Department of Planning, Prepared July 2014, Updated October 2018; Maryland Historical and Projected Population by Jurisdiction (Out to 2040).

In Table III-2, population projections of the jurisdictions served by UM SMC Easton show that the proportion of residents in the age group of 75+ is increasing in four of five counties in the replacement hospital service area. Only Caroline County shows a more significant growth in the younger age groups.

Table III-2: 2020 and Projected Population Age Distribution

	Jurisdiction	0-14	15-44	45-64	65-74	75+
2020	Caroline	19.4%	35.1%	27.0%	13.0%	5.5%
	Dorchester	17.6%	33.2%	28.7%	11.9%	8.7%
	Kent	12.8%	31.6%	27.9%	15.1%	12.6%
	Queen Anne's	16.6%	32.0%	31.1%	11.8%	8.5%
	Talbot	14.6%	30.7%	27.3%	15.8%	14.3%
	Maryland	17.9%	39.3%	26.7%	9.5%	6.6%
2030	Caroline	19.9%	35.2%	24.0%	12.4%	8.3%
	Dorchester	16.5%	33.4%	25.6%	13.9%	10.4%
	Kent	11.3%	29.6%	24.1%	18.5%	16.7%
	Queen Anne's	16.9%	32.3%	24.6%	14.7%	11.5%
	Talbot	14.4%	28.0%	23.1%	16.9%	17.6%
	Maryland	17.7%	38.3%	23.8%	9.5%	9.2%
2040	Caroline	22.3%	34.6%	22.6%	10.0%	10.4%
	Dorchester	17.6%	32.1%	25.4%	11.3%	12.6%
	Kent	11.3%	26.8%	24.7%	15.3%	21.8%
	Queen Anne's	18.3%	31.5%	23.9%	11.5%	14.8%
	Talbot	15.2%	27.7%	22.6%	14.1%	20.3%
	Maryland	17.9%	36.7%	24.1%	11.0%	11.7%

Source: Maryland Department of Planning, August 2018 Total Population Projections by Age, Sex and Race (Out to 2045).

Racial Composition

The five counties presented in Table III-3, represent UM SMC Easton's primary service area, and is comprised of a predominantly white population. The second largest racial group in these counties is Black/African Americans. The proportion of the white population is notably higher than the overall demographic makeup of Maryland. While an estimated 11.5 percent of the State's total population is Hispanic or Latino, the Hispanic and Latino demographic constitutes a smaller proportion of the populations residing in Caroline County (8.9%), Dorchester County (6.4%), Kent County (5.0%), Queen Anne's County (4.9%), and Talbot County (7.1%).[2]

Table III-3: Population by Race
Primary Service Area and Maryland, 2022

Jurisdiction	White, not Hispanic or Latino	Black or African American	Asian	Hispanic or Latino*	Other†	Two or More Races
Caroline	74.0%	13.8%	1.2%	8.9%	1.3%	3.0%
Dorchester	61.8%	29.2%	1.1%	6.4%	0.6%	2.6%
Kent	77.9%	14.2%	1.5%	5.0%	0.6%	2.3%
Queen Anne's	85.6%	6.2%	1.3%	4.9%	0.6%	2.2%
Talbot	76.5%	12.8%	1.5%	7.9%	0.8%	2.2%
Maryland	48.3%	31.7%	7.1%	11.5%	0.8%	3.2%

Source: 2020 U.S. Census of Population
Note: All racial categories, with the exception of "two or more," reported as "alone."
* Hispanics may be of any race, so also are included in applicable race categories.
† Other includes American Indian and Alaskan Native, Native Hawaiian, and other Pacific Islander.

Economic Status

The five counties which comprise the primary service area for UM SMC Easton are economically diverse, with Queen Anne's County ranked as the 5th wealthiest jurisdiction in the state with a median household income of $99,597 and Dorchester ranked at 21st with a median household income of $55,652. In comparison, the median household income in the state is $91,431.[3]

In 2022, the U.S. Bureau of the Census reported that 9.6 percent of Maryland residents were living in poverty, based on the official poverty line as defined by the Office of Management and Budget.[4] Table III-4 shows the economic indicators for the counties that make up the primary service area for UM SMC Easton. Three of the five counties (Caroline, Dorchester, and Kent) had poverty rates higher than the Maryland average, while Queen Anne's and Talbot had

[2] Source: 2022 U.S. Census of Population.
[3] *ibid*
[4] Historical Poverty Tables: People and Families - 1959 to 2022: https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-people.html

averages lower than the state.

Table III-4: Economic Indicators of Primary Service Area

	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Maryland[5]
Residents living in poverty*	13.5%	15.0%	12.0%	8.0%	9.4%	9.6%
Homeownership rate, 2017-2021	72.1%	68.9%	68.0%	81.5%	72.1%	67.3%
Median value of owner-occupied housing units, 2017-2021	$225,200	$190,200	$266,900	$374,100	$337,200	$338,500
In civilian labor force over 16 years, 2017-2021	64.3%	60.0%	56.3%	66.3%	56.9%	66.8%
Median Household Income	$63,027	$55,652	$64,451	$99,597	$79,349	$91,431

*Source: 2022 U.S. Census, Persons in poverty by percent (based on Federal Poverty Threshold[6]).

B. General Acute Care Hospitals

Maryland's Eastern Shore is served by seven acute care hospitals with a total of 1,128 acute care beds, which include 965 MSGA beds, 106 obstetric beds, 22 pediatric beds and 35 psychiatric beds.

Table III-5: General Acute Care Hospitals Serving Eastern Shore
Licensed Acute Care Bed Inventories, FY 2024 (effective July 1, 2023)

General Hospitals	Location		Licensed Acute Care Beds – FY 2024			
		MSGA	Obstetric	Pediatric	Psychiatric	Total
UM SMC Easton	Easton	72	13	3	10	98
Atlantic General Hospital	Berlin	45	0	0	0	45
ChristianaCare Union Hospital	Elkton	90	4	2	12	108
Peninsula Regional Med Ctr	Salisbury	242	20	8	13	283
UM Upper Chesapeake Med Ctr	Bel Air	192	9	2	0	203
UM SMC Chestertown	Chestertown	5	0	0	0	5
Anne Arundel Med Ctr	Annapolis	309	60	8	0	377
	Total	955	106	22	35	1,128

Source: Maryland Health Care Commission, Licensed Acute Care Bed Inventories, FY2024 (effective July 1, 2023).[7]

[5] Available at: https://www.census.gov/quickfacts/fact/table/MD/.
[6] Poverty guidelines and the poverty threshold: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/frequently-asked-questions-related-poverty-guidelines-poverty
[7] Source: Maryland Health Care Commission, Licensed Acute Care Bed Inventories, FY2024 (effective July 1, 2023).

Licensed acute care bed capacity, which is established in Maryland each year based on a retrospective look at the average daily patient census, has been broadly declining throughout the state. To put these numbers into perspective, the number of licensed acute care beds in Maryland dropped from 10,880 in FY2010 to 9,406 in FY2024, a 14.5 percent decline.[6,8] This decline is shown in Table III-6 in the breakdown of the general acute care hospitals serving the Eastern Shore.

Table III-6: Change in Acute Care Bed Inventories Serving Eastern Shore General Acute Care Hospitals FY2013-FY2024

General Hospitals	Licensed Beds FY13[9]	Licensed Beds FY24[4]	Change FY13 to FY24	Percent Change FY13 to FY24
UM SMC Easton	112	98	-14	-12.5%
Atlantic General Hospital	48	45	-3	-6.25%
ChristianaCare Union Hospital	92	108	16	17.39%
Peninsula Regional Med Ctr	317	283	-34	-10.72%
UM Upper Chesapeake Med Ctr	181	203	22	12.15%
UM SMC Chestertown[10]	42	5	-37	-88.09%
Anne Arundel Med Ctr	380	377	-3	0.78%
Edward W. McCready Memorial Hospital[11]	5	0	-5	-100%
Dorchester General Hospital[12]	46	0	-46	-100%
Total	**1,223**	**1,119**	**-104**	**-8.5%**

Source: Maryland Health Care Commission (*see footnote for specific references*).

C. Hospital Utilization Trends

Acute Care Discharges are Declining

[8] Source: Maryland Health Care Commission, Annual report on Selected Maryland Acute Care and Special Hospital Services, FY2012 (effective July 2011)

[9] Source: Maryland Health Care Commission, Annual Report on Selected Maryland Acute Care and Special Hospital Services, Fiscal Year 2013 (Effective July 1, 2012).

[10] UM SMC Chestertown obtained the designation of "Rural Hospital" in 2021, which allowed for a reduction in licensed beds.

[11] The Edward W. McCready Memorial Hospital was converted to a freestanding Medical Facility (FMF) in January 2020 TidalHealth McCready Pavilion.

[12] Dorchester General Hospital converted to a FMF in April 2019 which was renamed the University of Maryland Shore Medical Center at Cambridge.

Between the calendar years 2017 and 2022, there was a notable decrease of 14.73 percent in total acute care discharges for hospitals serving the Eastern Shore, compared to a larger decline of 15.5 percent statewide (Table III-7).

The reduction in discharges was primarily observed in two hospitals: Anne Arundel Medical Center and UM SMC Chestertown. Other hospitals serving the Eastern Shore, including Atlantic General, Peninsula Regional, UM SMC Easton, Union Hospital, and Upper Chesapeake Medical Center, saw an increase in discharges from 2017 to 2022. It is worth noting that UM SMC Dorchester (now UM SMC Cambridge) and McCready Memorial Hospital (now Tidal Health McCready Pavilion) closed as acute care hospitals in 2019 and 2020, respectively, and converted to FMFs.

Table III-7: Total Acute Care Discharges
Hospitals Serving the Eastern Shore, CY 2017 – 2022

ACUTE CARE DISCHARGES							
	2017	**2018**	**2019**	**2020**	**2021**	**2022**	**% Change from CY17 to 21**
Anne Arundel Med Ctr	19,684	18,678	19,322	16,673	17,528	16,571	-15.81%
Atlantic General Hospital	3,176	3,178	2,955	2,526	2607	2,663	-16.15%
ChristianaCare, Union Hospital	4,128	3,823	3,707	3,548	4276	5,151	24.78%
Peninsula Regional Med Ctr	14,037	13,355	12,387	10,743	11548	12,668	-9.75%
UM - Upper Chesapeake Med Ctr	8,979	9,288	9,241	9,194	9364	9,451	5.25%
UM SMC Chestertown	1,559	926	652	538	414	267	-82.87%
UM SMC Dorchester (now Cambridge)	1,741	1,255	812	490	214		
UM SMC Easton	5,905	5,375	4,645	3,879	3780	3,954	-33.04%
Edward W. McCready Memorial Hospital (Now Tidal Health McCready Pavilion)	280	228	185	93			
Total for Hospitals Serving Eastern Shore	59,489	56,606	53,906	47,684	49,731	50,725	-14.73%
Total for State of Maryland	613,079	598,753	582,029	522,200	532,224	518,249	-15.46%

Source: HSCRC Discharge Database.

The number of patient days at hospitals serving the Eastern Shore rose eight percent between 2017 and 2022, from 246,250 to 264,587. Patient days had dropped to 223,799 in 2020, so the increase from 2020 to 2022 may be partially attributed to the COVID-19 pandemic.

Table III-8: Total Acute Care Patient Days
Hospitals Serving the Eastern Shore, CY 2017 – 2022

ACUTE CARE PATIENT DAYS						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Anne Arundel Med Ctr	79,180	76,358	77,823	78,075	87,401	87,302
Atlantic General Hospital	11,482	10,995	10,011	10,502	12,151	12,102
ChristianaCare, Union Hospital	15,411	15,223	15,852	16,162	22,749	25,877
Peninsula Regional Med Ctr	64,586	61,784	56,883	53,776	61,854	66,277
UM - Upper Chesapeake Med Ctr	35,812	37,873	39,147	42,018	49,702	48,429
UM SMC Chestertown	6,223	3,641	2,542	2,179	1,655	1,174
UM SMC Dorchester (Cambridge)	7,523	5,451	3,540	1,987	876	
UM SMC Easton	25,169	22,863	20,030	18,793	19,668	23,426
Edward W. McCready Memorial Hospital (TidalHealth McCready Pavilion)	864	759	613	307		
Total	246,250	234,947	226,441	223,799	256,056	264,587

Source: HSCRC Discharge Database.

Length of Stay is Increasing

MSGA average length of stay (ALOS) is increasing in the hospitals serving the Eastern Shore, similar to the trend noted throughout Maryland. In 2017, ALOS was 4.0 days for hospitals serving the Eastern Shore, rising to 5.1 days in 2022. There was a spike in ALOS in 2021 to 5.6 days, possibly attributed to the COVID-19 pandemic.

Table III-9: Total Acute Care Average Length of Stay
Hospitals Serving the Eastern Shore, CY 2017 – 2022

Average Length of Stay						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Anne Arundel Med Ctr	4.02	4.09	4.03	4.68	4.99	5.27
Atlantic General Hospital	3.62	3.46	3.39	4.16	4.66	4.54
ChristianaCare, Union Hospital	3.73	3.98	4.28	4.56	5.32	5.02
Peninsula Regional Med Ctr	4.60	4.63	4.59	5.01	5.36	5.23
UM - Upper Chesapeake Med Ctr	3.99	4.08	4.24	4.57	5.31	5.12
UM SMC Chestertown	3.99	3.93	3.90	4.05	4.00	4.40
UM SMC Dorchester (Cambridge)	4.32	4.34	4.36	4.06	4.09	
UM SMC Easton	4.26	4.25	4.31	4.84	5.20	5.92
Edward W. McCready Memorial Hospital(TidalHealth McCready Pavilion)	3.10	3.30	3.30	3.30		
Total for Hospitals Serving Eastern Shore	3.95	4.52	4.56	4.92	5.56	5.07
Total for State of Maryland	4.43	4.87	4.95	5.16	5.44	5.57

Source: HSCRC Discharge Database.

A. Summary

The Eastern Shore is served by seven acute care hospitals located in Talbot, Worcester, Wicomico, Kent, Cecil, Harford, and Anne Arundel counties. The population projections for UM SMC Easton's primary service area indicate overall growth by 2040, with notable increases in the 75+ age group. Racially, the region is predominately white and economic diversity varies among the counties. There has been a decline in the overall number of licensed acute care beds in the hospitals serving the Eastern Shore, similar to that seen statewide. Further, hospital utilization trends show a reduction in acute care discharges between 2017 and 2022, particularly in Anne Arundel Medical Center and UM SMC Chestertown, though it is worth noting that other hospitals serving the Eastern Shore region are experiencing an increase. The number of patient days rose between 2017 and 2022, with the ALOS for facilities serving the Eastern Shore spiking to 5.6 days in 2021. Such trends are most likely attributed to the increased care demands required during the COVID-19 pandemic.

Overall, population trends and demographic shifts on the Eastern Shore, as well as increases in ALOS and total patient days support the need for a facility that can handle the increased demand for coordinated healthcare services.

IV. STAFF REVIEW AND ANALYSIS

A. The State Health Plan

COMAR 10.24.01.08G(3)(a) — State Health Plan.

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

The relevant State Health Plan Chapters that will be considered in the review of this project are:

- COMAR 10.24.10, Acute Care Hospital Services;
- COMAR 10.24.11, General Surgical Services;
- COMAR 10.24.12, Acute Hospital Inpatient Obstetric Services;
- COMAR 10.24.09, Specialized Health Care Services - Acute Inpatient Rehabilitation Services; and
- COMAR 10.24.21 Acute Psychiatric Services.

COMAR 10.24.10 - State Health Plan for Facilities and Services: Acute Care Hospital Services

COMAR 10.24.10.04A — General Standards.

(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's Response

UM SMC Easton submitted a written policy to provide financial information regarding hospital services and charges to the public. (DI #3, Exh. 5). The policy requires a representative list of services and charges to be made available to the public in written form at the hospital(s) and on its website, https://www.umms.org/shore/patients-visitors/for-patients/financial-assistance-billing/hospital-charges.[13] The policy also states that "individuals or their payor representative may make a request for an estimate of charges for any scheduled or non-scheduled diagnostic test or service." The policy specifies that the Patient Financial Services department is responsible for ensuring that appropriate training and orientation is provided to its staff related to charge estimates. (DI #3, Exh. 5, page 2).

Staff Analysis

This standard is to ensure that information regarding the average cost for common inpatient and outpatient procedures is readily available to the public and that policies are in place and employees are trained to address charge-related inquiries. Staff reviewed the applicant's policy and the list of charges on their website and concluded that the policy included all the required provisions. Staff concludes that the applicant complies with this standard.

(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

[13] Accessed October 26, 2023.

the 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 hospitals, 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's Response

The applicant stated that UM SMC Easton provides care to all patients regardless of their ability to pay. The applicant provided a copy of the *Financial Assistance Policy* which stated that a preliminary determination of eligibility for financial assistance would be made within 2 business days. (DI #3, Exhibit 7). According to the applicant, each patient or patient representative is advised of the hospital's charity care policy at the time of registration and financial counselors are available to assist if applying for charity care is needed. (DI #3, p. 33). The applicant also provided a copy of the *Notice of the Availability of Charity Care* at the hospital which it states is posted at the Emergency Department and in the Admissions and Business offices. (DI #3, Exhibit 8). The applicant also provided a copy of the annual notices that are published in local newspapers (DI #3, Exhibit 9).

The applicant states that the most recent available community benefit report from HSCRC in 2020, states that UM SMC Easton provided a total net community benefit of 1.34 percent of operating expenses – ranking the hospital in the 3rd quartile of all acute care general hospitals in Maryland.

Staff Analysis

Staff reviewed applicant's financial assistance policy, the *Notice of Availability of Charity Care* and newspaper notices. Additionally, staff reviewed the most recent FY 2022 HSCRC Maryland Hospital Community Benefit Report and found that the applicant provided a total net community benefit of 1.99 percent of operating expenses, ranking the hospital in the 2nd quartile of all general hospitals in Maryland for the provision of charity care. Staff concludes that the applicant complies with this standard.

(3) Quality of Care. An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(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 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's Response

UM SMC Easton is licensed, and in good standing with the Maryland Department of Health as well as Medicare and Medicaid certified. (DI #3, Exh.10). The applicant also states that the hospital is accredited by the Joint Commission. (DI #3, Exh. 11).

In addition, UM SHS states that UM SMC Easton has earned an "A" grade for the five most recent consecutive bi-annual reporting periods from fall 2020 through fall 2022, from the Leapfrog group.[14](DI #3, p.14). Additionally, in 2018, UM SMC Easton was ranked by *US News and World Report* as one of the top 10 best hospitals in Maryland. In 2022, for the 2022-2023 rankings by *U.S. News and World Report*, UM SMC Easton was among a national group of "high performing" hospitals for "Best Hospitals for Maternity Care."[15]

In responding to subpart (b), the applicant noted that, of the 76 applicable measures in the *Maryland Hospital Performance Evaluation Guide* (accessed Nov 3, 2022), UM SMC Easton scored "better than average" or "average" on 57. The hospital did not have sufficient data to report on 15 of the quality measures and scored "below average" on four measures. UM SHS has identified those four "below average" measures along with a corrective action plan for each. (DI #3, Exh. 12) These four measures, and the hospital's actions to improve these measures are shown in the table below.

Table IV-1 Quality Improvement Actions

Measure	Action
How often was the area around the patient's rooms kept quiet at night.	Minimizing overhead announcements, quiet hours, increasing awareness amongst staff, and replacing loud carts and wheels.
How do patients rate the hospital overall	Redesigning shifts change handoff, reinforcing back to basics behaviors, education focusing on communication, implementing "Get to Know Me Boards" setting a consistent definition of patient experience.
Would patients recommend the hospital to friends and family	Same as previous
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	Implementing a 24/7 inpatient hospitalist program, an inpatient 24/7 anesthesia service, an inpatient pediatric hospitalist program. The hiring of a full-time maternal-fetal medical physician in February 2023 will further allow UM SMC at Easton to offer these expanded services.

DI #3, Exh. 12.

[14] https://www.hospitalsafetygrade.org/

[15] https://health.usnews.com/best-hospitals/hospital-ratings/maternity

UM SHS states that they believe UM SMC Easton's below average ratings are influenced by the patients' less than positive impression of the aging infrastructure, space limitations, and lack of parking. The applicant expects that these perceptions will improve at the proposed new state-of-the-art facility. (DI #3, Exh. 12).

Staff Analysis

The applicant addressed UM SMC Easton's rankings in the most recent report in the MHCC's *Hospital Performance Evaluation Guide* and provided their quality improvement plan. Staff finds the applicant provided a satisfactory plan to address the "below average" measures.

Staff concludes the applicant complies with this standard.

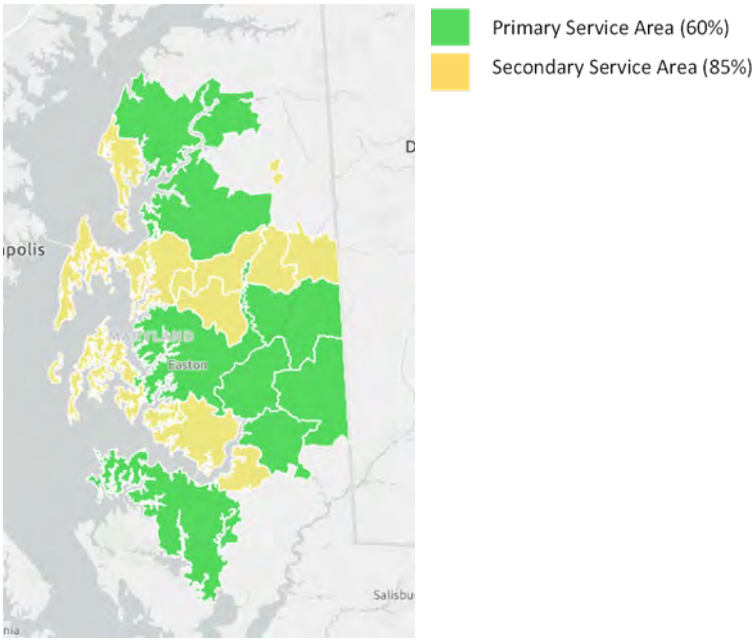
COMAR 10.24.10.04B — Project Review Standards

(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 population. 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 area.

Applicant's Response

UM SHS described the analysis used to measure travel times related to the proposed facility location, the existing facility, and two alternate sites from zip code areas within the projected service area to both its primary and secondary service areas. (DI #3, p.38).

Figure 1
UM SMC Easton's MSGA Service Area FY 2022



The applicant's methodology is described as follows:

1. The applicant identified eight ZIP codes as its primary service area and fifteen ZIP codes as its secondary service area.

Table IV-2 UM SMC Easton's Primary and Secondary MSGA Service Areas FY 2022

ZIP code	City	County	Discharges	Cumulative %
21601	Easton	Talbot	855	22.0%
21613	Cambridge	Dorchester	608	37.7%
21629	Denton	Caroline	276	44.8%
21620	Chestertown	Kent	153	48.7%
21643	Hurlock	Dorchester	144	52.4%
21655	Preston	Caroline	136	55.9%
21632	Federalsburg	Caroline	134	59.4%
21617	Centreville	Queen Anne's	132	62.8%
21663	Saint Michaels	Talbot	102	65.4%
21660	Ridgely	Caroline	96	67.9%
21639	Greensboro	Caroline	95	70.3%
21666	Stevensville	Queen Anne's	80	72.4%
21658	Queenstown	Queen Anne's	66	74.1%
21673	Trappe	Talbot	64	75.7%
21625	Cordova	Talbot	63	77.3%
21631	East New Market	Dorchester	63	78.9%
21638	Grasonville	Queen Anne's	55	80.4%
21654	Oxford	Talbot	45	81.5%
21619	Chester	Queen Anne's	42	82.6%
21661	Rock Hall	Kent	39	83.6%
21662	Royal Oak	Talbot	28	84.3%
21672	Wye Mills	Talbot	15	84.7%
21659	Queen Anne	Queen Anne's	11	85.0%
Total in service area			**3,302**	**85%**
Out of service area			583	15%
			3,885	**100%**

Source: (DI #3, p. 38).

2. Using Google Maps, the applicant determined the drive time to each facility from the Post Office in each of the listed ZIP codes.
3. The applicant then multiplied the drive timed by the 2029 population of each ZIP code, added the products together and divided by the total service area population. (DI #3, pp. 37-40).

Table IV:3 Weighted Drive Times for Projected 2029 Service Area Population

	219 South Washington St., Easton 21601 (Current Site)	Easton Bypass & Oxford Rd., Easton 21601 (Bypass at Oxford Road)	10028 Ocean Gateway Easton 21601 (Proposed Site)	Route 50 and 404, Wye Mill 21679 (Site in Northern Talbot County)
Average Drive Time (min)	26.1	25.1	23.5	22.7

Source: (DI #3, p. 40).

UM SHS concluded that the proposed site provides acute inpatient services at UM SMC Easton within 30 minutes for significantly more people than the current site as seen in Table IV-3. Using population estimates for 2029, the applicant determined that 135,802 Marylanders will live within a 30-minute drive of the new site versus the estimated 90,920 living within a 30-minute drive of the current site. This represents a 45,000 increase in the estimated population living within a 30-minute drive to the existing hospital.

Staff Analysis

This standard requires an evaluation of whether a proposed project is located to optimize accessibility in terms of travel time for its likely service area population and defines optimal travel time as being within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area. The applicant's methodology shows that on aggregate, the travel time to the new site is less than the travel time to the existing hospital for individuals living within the primary and secondary service areas.

Staff analysis found that four of the 23 ZIP codes in the service area are located outside of the required 30-minute drive. These include Chestertown (41 minutes), Federalsburg (32 minutes), East New Market (37 minutes), and Rock Hall (1 hour). The total population of these four ZIP codes is 11.7 percent of the service area for the new hospital location, resulting in 88.3% of the population in the likely service area residing within 30 minutes of the proposed location. While this falls slightly short of the 90% requirement, the new facility location is within a 30-minute commute for a larger segment of the population than the existing facility. UM SMC Easton will be the closest hospital for a majority of residents living in the Mid-Shore region and the new location is suitable to meet the needs of the vast majority of the service area.

Staff concludes that the applicant complies with this standard.

(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 bed capacity 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 bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that 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 Regulation .05 of this Chapter, as applied to the service area of the hospital.

Applicant's Response

UM SHS states that UM SMC Easton is currently licensed to operate 72 MSGA beds which falls below the most recently published MSGA bed need projection for Dorchester and Talbot Counties, that projects a gross need of 106 to 137 MSGA beds.[16] (DI#3, p. 42, Exhibit 13). Applicant's bed need calculation projects a need for 86 MSGA beds for the service area by 2032. (DI#3, p. 42).

Table IV-4 UM SMC MSGA Bed Need FY2019-FY2032

	Historical				Projected									
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Bed Need	89	74	70	75	76	77	78	79	80	81	82	84	85	86
% Change		-16.3	-5.7	7.0	1.5	1.1	1.1	1.1	1.1	1.6	1.6	1.7	1.7	1.7

Source DI #3, p. 50.

16 https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/shp_bed_need_msga_ped_projections_2025_%2020170120.pdf.

The Commission approved Exemptions from Certificate of Need Review for the conversion of UM SMC Dorchester from a hospital to a freestanding medical facility (FMF) and the consolidation of UM SMC Easton in April 2019.[17] The conversion included the cessation of inpatient services at UM SMC Dorchester, which were transferred to UM SMC Easton. The licensed acute care beds from UM SMC Dorchester were added to the licensed bed count at UM SMC Easton and now UM SMC Easton is the only provider of acute inpatient services within the service area. (DI #3, p. 42).

The applicant calculated bed need by defining the service area using the 23 ZIP Codes that comprise 85% of MSGA discharges from UM SMC Easton and from UM SMC Dorchester prior to the bed transfer. The service area spans Talbot, Caroline, Dorchester, Queen Anne's, and Kent counties and is represented in Figure 1, above. The applicant calculated the historical and projected discharge rates for residents in these ZIP codes to calculate the need. (DI#3, pp. 42-44).

The *Licensed Acute Care Beds by Hospital and Services: Maryland FY24* (effective July 1, 2023) for UM SMC Easton is represented in Table IV-5.

Table IV-5: Licensed Acute Care Beds by Hospital and Services: Maryland FY24 (effective July 1, 2023)

	MSGA	Obstetric	Pediatric	Psychiatric	Total
UM SMC Easton	72	13	3	10	98

Source: Licensed Acute Care Beds by Hospital and Service: Maryland, FY24 (Effective July 1, 2023). https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_acute_care_FY24%20Licensed%20Beds_20230717.pdf

Table IV-6 provides a comparison of the physical capacity and licensed capacity at UM SMC Easton before and after the construction and replacement of the existing hospital.

Table IV-6: UM SMC Easton – Physical and Licensed Bed Capacity – Current and Replacement Hospital

Bed Type	Current UM SMC Easton Physical Capacity	Current UM SMC Easton Licensed Capacity	Replacement Hospital - Licensed and Physical Capacity
MSGA	120	72	86
Obstetric	13	13	11
Pediatric	5	3	1
Psychiatric	12	10	12
Rehabilitation	15	20	12
Total	**165**	**118**	**122**

DI #11, Table 32, p. 10.

[17] *In the Matter of the Consolidation of the University of Maryland Shore Medical Center at Dorchester and the University of Maryland Shore Medical Center at Easton*, Dkt. No. 18-20-EX007 (April 18, 2019); *In the Matter of the Conversion of the University of Maryland Shore Medical Center at Dorchester to a Freestanding Medical Facility*, Dkt. 18-09-EX006 (April 18, 2019).

Table IV-6 indicates that the existing hospital has significant excess physical capacity compared to its licensed bed capacity, which the applicant states "creates operational and cost inefficiencies." (DI #3, p. 61). The applicant states that it has planned "to right-size the bed capacity of the replacement hospital based on the hospital's service area population's proposed bed needs." (DI #3, p. 61). The result is a licensed and physical capacity of 86 beds at the completion of the proposed project, which meets the applicant's projected acute care bed needs and design.

The following is the applicant's methodology to support the need to increase the number of licensed medical/surgical/gynecological/addiction (MSGA) beds from 72 to 86 beds.

MSGA Bed Need Analysis

Using the State Health Plan (SHP) bed need methodology, the applicant submitted a bed need analysis for MSGA beds for the previously defined service area. (DI #3, pp. 42 – 50). This service area is not expected to change after the move to the replacement hospital. Next, the applicant projected the growth in the primary and secondary service area's population for the age groups 15-64, 65-74, and 75 plus age cohorts. For FY 2023 through FY 2032, the applicant projected that the population in UM SMC Easton's service area would have a modest growth of 0.9 percent to 1.0 percent annually. Applicant projects the use rate for the MSGA beds that includes a modest annual increase of 0.6 percent annually for the same ten-year period.

Using these population projections and use rates, the applicant projected MSGA discharges for FY 2023 through FY 2032. During the COVID-19 pandemic, UM SMC Easton noted a decrease in the number of admissions from the emergency department from FY 2019 to FY 2022 because of an increase in MIEMSS Red and Yellow Alert diversions. (DI #3, pp. 47- 48 and DI #11, pp. 5 - 9). MIEMSS Red Alerts occur when there are no electrocardiogram (ECG) monitored beds available and Yellow alerts occur when there is a severe overload in the emergency room. Both Red and Yellow alerts result in ambulance diversion and rerouting to take patients to emergency departments at other hospitals. The rerouting resulted in a reduction of inpatient admissions to the MSGA beds at UM SMC Easton during the pandemic. The replacement hospital will have 72 ECG monitored beds, up from 38 ECG monitored beds in the existing facility. (DI #11, p. 5).

Based on the bed need methodology, and the assumption of an occupancy rate of 80 percent, the applicant calculated the need for 75 MSGA beds in FY 2022. The actual FY 2022 occupancy rate was lower than expected, leading to a FY 2023 licensed acute care bed designation of 72 MSGA beds. (DI #3, p.42)[18] UM SMC Easton projects the need for MSGA beds in the replacement hospital will increase to 86 beds by FY 2032. (DI#3, p.49). The projected increase is based on a decrease in red and yellow alerts, an increase in the number of residents over the age of 65 (DI #3, p. 45), and a more convenient location. (DI #3, p. 40). The applicant does not expect any changes in the hospital's market share or average length of stay from 2022 levels. (DI #3, pp.48-49).

[18] See Md. Code Ann., Health General, 19-307.2 and COMAR 10.24.01.03E(4).

Pediatric Bed Need Analysis

As shown in Table IV-6, UM SMC Easton is currently licensed to operate three pediatric beds following the conversion of UM SMC Dorchester to an FMF and the bed relocation to UM SMC Easton. Assuming 50 percent occupancy, applicant states the pediatric bed need methodology shows that UM SMC Easton has need for one pediatric bed for ages 0 through 14 years. (DI #3, p. 52). This need projection is not expected to change upon project completion and initiation of services at the replacement hospital through FY 2032.

UM SMC Easton is the only hospital within the five-county service area that has licensed pediatric beds. Applicant states that it needs a pediatric bed at the replacement hospital to ensure pediatric patients receive appropriate and tailored care; promote seamless transitions across the continuum of care for pediatric patients; minimize drive times in emergency situations; and promote physician recruitment in the Mid-Shore region. (DI #3, p. 53). The applicant projects that the pediatric population will remain constant in the service area, and that it will experience a steady demand for pediatric inpatient service capacity.

The applicant states that there will be no additional costs or inefficiencies associated with operating a one-bed pediatric unit. This bed will be located on the third floor adjacent to the Perinatal Labor and Delivery Unit and co-located with two medical-surgical beds to provide flex capacity should the hospital have to care for more than one pediatric patient at the same time. The hospital will have nurses with pediatric experience to care for the patients. (DI #3, p. 53). The proposed inpatient bed will provide a continuum of care as the patient moves from the emergency department to the inpatient unit to outpatient services. This will allow the hospital to retain patients and families in the local community instead of them traveling a significant distance to receive care.

Finally, a one-bed pediatric unit at UM SMC Easton will be commensurate with other community regional hospitals across the state. Of the 34 hospitals in Maryland with licensed pediatric beds, the applicant states that 18 are licensed with four or fewer beds for fiscal year 2023, with nine of those hospitals having only one or two licensed beds. (DI #3, p. 55). The applicant states that its one-bed pediatric unit would be typical of other pediatric units operated by Maryland hospitals. This pediatric unit would allow families in UM SMC Easton's five-county service area to have continued access to pediatric services in a local setting.

Staff Analysis

Staff has reviewed applicant's bed need methodology and concludes that the need for 75 MSGA beds by FY 2032 is supported. Assuming the modest population growth projections within UM SMC Easton's five-county service area, an increase in MSGA use rates due to an aging population, and a steady ALOS for patients at 5.6 days, staff agrees with the projection of need for 86 MSGA beds by FY 2032. Staff also concurs that an increase in the number of ECG monitored beds and a reduction in the number of COVID-19 related hospitalizations will lead to a decrease in Red and Yellow alert diversions from UM SMC Easton's emergency department. This will lead to an increase in admissions to the hospital, as most hospitalizations come through the ED.

In addition, staff agrees that the hospital has a need for one pediatric bed at the replacement hospital. Inpatient pediatric services on the Eastern Shore are scarce, with only two additional

hospitals, Christiana and Peninsula Regional with pediatric beds. Access would be an issue as both of these pediatric units are a significant distance from the primary service area and would place an undue burden on families with sick children. The establishment of a one bed pediatric unit will allow UM SMC Easton to provide local access of a needed continuum of pediatric services to the residents in the Mid-Shore region.

Staff concludes that the applicant complies with this standard.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit. An acute care 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 UM SMC Easton has an established pediatric unit. (DI #3, p.56)

Staff Analysis

Staff concurs that this standard is not applicable.

(4) Adverse Impact. A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or 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 Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average 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 objectives of the project.

Applicant Response

The applicant stated that it will request an increase in rates equal to approximately 50 percent of the increase in regulated capital costs (depreciation and interest) plus markup associated with the

proposed project. (DI#3, p. 56). UM SMC Easton will cover funding for the other 50 percent of capital costs. The applicant filed a full rate application with the HSCRC in the first quarter of fiscal year 2024 requesting a rate increase of $24 million in gross charges.

The projected total cost of the project is $539.6 million, of which $484.1 million is depreciable assets, $2.5 million is for the purchase of land, and $53.0 million represents gross interest during construction and $11 million in related financing fees. The applicant anticipates that proceeds from the issuance of tax-exempt bonds will be used to fund $333.3 million of depreciable assets and gross interest. (DI #3, pp. 56-57).

Table IV-7 UM SMC Easton Projected Total Capital Costs

Land Acquisition	$2,464,658
New Construction & Infrastructure	$278,183,562
Equipment, Furnishings, & IT	$169,091,591
Gross Interest During Construction	$49,999,000
Total Capital Costs	**$ 528,478,871**

Source: DI #11, Exh. 27, Table E.

UM SHS stated it anticipates that $21.8 million of the capital costs will be funded with an increase in UM SMC Easton's regulated revenue. The applicant states that it projects total regulated gross charges of $396.1 million in FY2029, which represents a 6.1 percent increase. (DI #3, p. 57).

The applicant questioned the peer group used in the HSCRC *Efficiency Methodology*, as it comprises all non-academic acute care hospitals in the State. This includes significantly larger hospitals than UM SMC Easton in terms of licensed beds and revenue. It also includes hospitals serving urban populations that differ greatly from the largely suburban and rural population served by UM SMC Easton. The applicant questioned the validity of the hospitals HSCRC included in the peer group and developed its own for comparison in the CON application.

Applicant suggested it would be more appropriate to compare UM SMC Easton to hospitals that are similar in size and location. To develop a comparison, the applicant included Calvert Memorial Hospital, Carroll Hospital Center, UM SMC Chestertown, Garrett County Memorial Hospital, Meritus Medical Center, UM SMC Dorchester, ChristianaCare Union Hospital, and Western Maryland Regional Medical Center.

The applicant compared the pro forma gross regulated charges at UM SMC Easton with its actual volumes and approved rates, by rate center, to the pro forma revenue at each of these other similarly sized hospitals calculated with UM SMC Easton volumes at the fiscal year 2022 approved rates for each of the other hospitals. The results show that UM SMC Easton's gross regulated charges are 1.8 percent below the average of these other hospitals. (DI #3, p. 57).

The applicant states that its pro forma revenue is greater than that of the other similarly sized hospitals. Because the capital-adjusted revenue for UM SMC Easton is greater than the pro forma revenue of the other similarly sized hospitals, the applicant calculated and compared the fiscal year

2021 debt-to-capitalization ratio and average age of plant ratio for UM SMC Easton to the average of the same ratios for the other hospitals.

UM SHS stated that, for financial reporting purposes, the debt and unrestricted net assets for UM SMC Easton and UM SMC Dorchester are considered a single entity. For the combined facilities, the applicant states that in fiscal year 2021, the debt to capitalization ratio of 38.1 percent for UM SHS was below the average of 40.5 percent for the other similarly sized hospitals. The applicant also found that, based on calculations performed using fiscal year 2021 audited financial statements, the average age of plant of 13.3 years for UM SHS exceeded the average of 7.1 years for the other similarly sized hospitals and health systems. (DI #3, pp. 56-60).

Table IV-8 Comparison of UM SMC Easton Charges to Those of Other Similarly Sized Hospitals ($ in thousands)

UM SMC at Easton FY2022 Pro-Forma Revenue			Approved Rates Compared to Peer Group		Capital-Adjusted Rates Compared to Peer Group	
FY2022 Pro-Forma Revenue [1]	FY2022 Revenue at Capital Adjusted Rates [2]	FY2022 Revenue at Peer Group Average Rates [3]	Over/(Under) Average Rates	Percent Variance	Over/(Under) Average Rates	Percent Variance
$ 261,507	$ 279,280	$ 266,191	(4,684)	-1.8%	$ 13,089	4.9%

Notes:

(1) Calculated as FY2022 HSCRC approved unit rates x FY2022 actual unit volume

(2) Capital-adjusted rates calculated by increasing FY2022 GBR by $24,039,922

(3) Calculated as average FY2022 peer group unit rates x UM SMC at Easton FY2022 actual unit volume. TPR Hospital peer group hospitals include: Meritus, UM SMC at Cambridge, Garrett Regional Medical Center, Western Maryland Regional Medical Center, ChristianaCare Union Hospital, Carroll Hospital Center, Calvert Memorial, and UM SMC at Chestertown

Source:

HSCRC FY2022 Statewide approved rates file

HSCRC FY2022 Final Experience Report

Source: DI #3, p. 58.

Staff Analysis

Staff has reviewed the applicant's response and believes that the project will not have an adverse impact on access and availability of services. The applicant has recently submitted a full rate application to the HSCRC requesting a rate increase of $24 million. The argument for this increase rests upon redefining the peer group to which the applicant will be compared. Staff agrees that due to its size, comparing UM SMC Easton to all non-academic acute care hospitals in the state may not be appropriate, yet questions applicant's inclusion of UM SMC Dorchester (now an FMF), UM SMC Chestertown (5 beds) and Garrett County Memorial Hospital (18 beds) as comparable peer hospitals. Removing these smaller hospitals would likely change this calculation, but staff believes that the rates may still fall below its peer institutions. Additionally, the debt to capitalization ratio falls below its peers (DI #3, p.59) and the current average age of the physical plant assets is greater than its peer institutions (DI #3, p.60).

The HSCRC's July 23, 2023 letter states that "preliminary review of the capital model implies that no material capital award would result, due to the relative inefficiency of the hospital's

service cost as compared to its peer group hospitals. The formula for a full rate application differs from these high-level tests. However, the projected award as included in the initial CON and the responses may be quite optimistic, and likely overstated." (DI #22, p.3).

Although the HSCRC has raised preliminary concerns, and the outcome of UM SMC Easton's full rate application to HSCRC is unknown, the applicant has shown that the debt to capitalization ratio of UM SMC Easton and the average age of its physical plant meet the requirements of this portion of the standard. Staff, therefore, concludes that the applicant complies with this standard.

(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

The applicant states that the replacement facility will have fewer physical beds than the existing facility, and that certain service lines will have fewer licensed beds. However, the applicant states that since the new facility is appropriately sized, based on the projected bed need of the service area population, the project does not reduce the availability or accessibility of any service. The applicant states that it will offer all existing inpatient and outpatient services currently provided at UM SMC Easton at the new hospital. It also states that none of the proposed project changes will impact access for indigent or uninsured patients, as UM SMC Easton will continue to care for patients regardless of their ability to pay.

The existing facility has significant excess physical capacity compared to its licensed bed capacity, much of which is used for observation patients spread throughout the hospital. The semi-private rooms in the existing hospital account for some of this excess in physical capacity, as often patients cannot share a room due to a patient's isolation status, gender, or acuity level. (DI #3, p. 61). This disparity between physical beds and licensed beds creates operational and cost inefficiencies.[19] The applicant states that it has optimized the replacement facility bed capacity based on the service area population's projected bed needs. Table IV-9 compares UM SMC Easton's existing physical and licensed bed capacity to the replacement facility's proposed physical and licensed bed capacity. (DI #3, pp. 60-62).

[19] Physical capacity denotes the total number of beds that could physically be set up in a space with available headwalls and gasses and without significant renovations.

Table IV-9 Bed Capacity of Current Facility Compared to Replacement Facility

Bed Type	Existing Facility Physical Capacity	Existing Facility Licensed Capacity	Replacement Facility – Licensed and Physical Capacity
MSGA	120	72	86
Obstetric	13	13	11
Pediatric	5	3	1
Psychiatric	12	10	12
Rehabilitation	15	20	12
Total	**165**	**118**	**122**

Source: DI #3, pp. 61.

Staff Analysis

Staff has reviewed the proposed changes in physical and licensed bed capacity. The applicant stated that the excess physical capacity creates operational and cost inefficiencies, and staff agrees that reducing the physical capacity in the replacement facility is warranted. Increased operational and cost efficiencies should be realized by consolidating observation beds in a dedicated observation unit, and by reducing room occupancy to all private rooms. The applicant is not reducing the availability or accessibility of any service, including services for indigent or uninsured.

HSCRC stated that its preliminary review of the capital model for the applicant's request for a $24 million rate hike is unlikely to result in the award of funds. (DI #22, p. 3). While this observation may not necessarily undermine the feasibility or viability of the project, it does mean that there will not be an unwarranted adverse impact on hospital charges resulting from this project. Staff concludes that the applicant complies with this standard.

(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 it 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, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it 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 sites located within a Priority Funding Area.

Applicant's Response

As required in paragraph (a), the applicant developed a regional service delivery model and facilities over a number of years and the planning for this development identified five priority objectives to best meet the identified needs. The objectives for the proposed project include: Flexibility to meet the long-term health care needs of its regional service area population; meeting the needs of an aging population; improving access to services; increasing physician recruitment; and improving the financial performance of the hospital. (DI #3, pp. 64-65, 73).

To satisfy paragraphs (a) and (c) UM SHS considered four options to meet the identified goals of this project. The two alternative approaches were evaluated as required in paragraph (a) include the redevelopment of the existing hospital and the proposed relocation of the hospital to a new site. Applicant evaluated three sites to satisfy paragraph (c). The evaluation contains the following options:

1. Redevelop the existing campus;
2. Relocate to the Bypass at Oxford Road;
3. Relocate to the Northern Talbot County;
4. Relocate to the Talbot County Community Center - proposed site

Each proposed option is summarized in Table IV-10, including the applicant's assessment of how well each alternative meets the project's objectives.

Table IV-10 UM SHS Overview of Project Option Considerations

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Alternative	Cost	Description
Redevelop the Existing Hospital Campus	$299,091,563	This option involves renovation of approximately 288,000 SF (the hospitals East and West towers) to create all private patient rooms. It also involved key upgrades to the hospital's infrastructure, the addition of a parking garage and new Central Utility Plant on the hospital's current surface parking lot. To minimize disruption to the existing hospital's operations and patient care, this alternative would have to be completed in a seven-year time frame.
Relocate to Bypass at Oxford Road Site	$518,374,490	UM SMC Easton owned a 60-acre parcel of land on the Easton Bypass (Route 322) at Oxford Road and considered relocating the hospital to this parcel. The hospital facility design in this alternative would be the same as the proposed project. There would be no land acquisition costs associated with this alternative, as the land had been donated to UM SHS. Because there were utility services available on Maryland Route 322, the applicant would not be responsible for extending water and electrical services to the site, as is the case in the proposed project. Access to municipal services such as fire and police on this site would be the same as the existing site.
Relocate to Northern Talbot County Site	$541,232,750	UM SMC Easton planned to acquire a 90-acre parcel of land on the southeast corner of the intersection of Maryland Routes 50 and 404. The cost of land acquisition was estimated at $7.15 million at that time. The hospital facility design in this alternative would be the same as the proposed project. There were no utilities available to serve this site. Electric service would have to be extended from Wye Mills and wells would have to be developed on the property to provide water. A sewage treatment plant to serve the new facility would also need to be developed on the property. There was no access to municipal services of fire and police at this site.
Relocate to Talbot County Community Center Site	$528,478,871	The proposed project site is a 235-acre parcel at the intersection of Longwoods Road and U.S. Route 50, just north of the Easton Municipal Airport. Talbot County conveyed the proposed project site to UM SHS in 2015 for $2.5 million. The site is predominantly a greenfield site, not all of which will be used for the hospital campus. The remainder of the parcel will be used for future development. As a greenfield site, utilities will have to be brought to the site lines, but the land has been annexed by the Town of Easton to provide utilities and services to the site. Access to municipal services of fire and police is the same as the existing site.

Source: DI #3, pp.65-66.

The applicant states that each option was evaluated with the following conclusions:

Option 1. The phased renovation plan of the current facility would cause disruptions to the daily operations of the hospital, which would negatively affect its market share and result in low consumer confidence. The creation of all private rooms in the constrained space of the current hospital would lead to insufficient bed capacity for current use and would preclude future growth and change. The applicant states that renovation of the existing hospital would leave the facility in

a congested residential area with poor access to major transportation routes. While this option is the least costly option, the anticipated loss of consumer confidence would lead to a projected operating loss by FY 2032. (DI #3, pp. 74-75).

Options 2-4. UM SHS states that all of the hospital relocation options offered the ability to expand at a later date, would result in a fully modernized facility, and would increase physician recruiting. The applicant pointed out that the difference between the options presented are how well the facility can be accessed by the population served and the capital cost of constructing the new building. The applicant provided weighted drive times to the proposed sites and found that the Northern Talbot site ranked slightly better than the Talbot County Community Center site at 22.7 min versus 23.5 minutes, respectively. The overall cost of constructing a replacement hospital was approximately $13 million more at the Northern Talbot County site. Additionally, the applicant stated that locating the project at Easton would result in the largest amount of philanthropic support. (DI #3, pp. 75-76).

Table IV –11 UM SHS Ranking of the Proposed Alternatives

Objective	Renovate Existing Hospital	Bypass at Oxford Road	North Talbot County	Talbot County Community Center (proposed site)
Modern Infection Prevention/Control	4	1	1	1
Private beds	2	1	1	1
Campus Adaptable/Expandable	4	1	1	1
Campus/Building Wayfinding	4	1	1	1
Aggregate Drive Times	4	3	1	2
Access to Municipal Fire/Police	4	2	4	1
Enhance Physician/Staff Recruitment	4	1	1	1
Projected Operating Income	4	1	3	2
Philanthropic Support	4	2	3	1
Ease of EMS Access	3	3	2	1
Lowest Capital Cost	1	2	4	3
Aggregate Score	**38**	**18**	**22**	**15**
Overall Ranking	**4**	**2**	**3**	**1**

DI #3 p. 74. 1-Best, 4-Worst

Staff Analysis

In its evaluation, the applicant compared each option to the project objectives of flexibility to meet the long-term health care needs of the service area population; the aging population needs; improving geographic access; increasing physician recruitment; and improving UM SMC Easton's financial performance. Applicant proposes to relocate a hospital with an aging physical plant from its current site to a new site. The cost-effectiveness analysis should consider whether it is more cost-effective to relocate UM SMC Easton or to modernize the existing facility at the current location.

While renovating UM SMC Easton resulted in the lowest capital cost, UM SHS dismissed that option because it would not allow expansion of the original footprint of the hospital or result in eliminating semi-private rooms. If the applicant implemented the proposed conversion to private rooms, the facility would not have sufficient bed capacity. Additionally, to minimize disruption to patients and the surrounding community, the project would have to be implemented in phases, over the course of seven years. Staff agrees that the disruptions caused by a renovation of this magnitude could adversely affect patients and the community and likely result in issues that could impact consumer confidence, thereby decreasing market share. Additionally, as hospitals in the state are moving towards all private rooms, a hospital with predominantly semi-private rooms would not be the first choice for many patients. Therefore, staff agrees that the first option is not the best choice to achieve the stated goals of the project.

The remaining three options all involve similar construction projects at different sites throughout the primary service area. The second option, while evaluated during the planning, is no longer viable as the applicant has sold the site. The remaining two options, the proposed site at the Talbot County Community Center and in Northern Talbot County remained viable possibilities.

The Northern Talbot County site had the shortest drive time for the priority population, but the difference between options three and four was only an average of 0.5 minutes. As for capital costs, the Northern Talbot County Site was estimated to have higher capital costs than the proposed project site based on the land purchase expense and the cost of bringing utilities to the site. Lastly, the Northern Talbot County site was ranked lowest for accessibility.

The Talbot Community Center Site, while ranking number three in capital costs, was found to be the most optimal in geographic accessibility and allowed the possibility for future expansion. Additionally, the choice of this site had the potential to attract the greatest amount of philanthropic support. Projections on future operating income showed this site to rank second highest, only after option two, which was no longer viable.

Because the proposed project involves the relocation of a facility which will provide more than a single service, paragraph (b) is not applicable.

Staff Analysis

Based on all the above considerations, staff concurs that the Talbot County Community Center Site is the most cost-effective option for the replacement hospital and that applicant complies with this standard.

(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

See the discussion under COMAR 10.24.01.08G(3)(b), the Need Criteria (infra, p.133).

Staff Analysis

Staff recommends that the Commission find that applicant complies with this standard.

(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 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 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.

Applicant's Response

UM SHS states that its Marshall Valuation Service (MVS) analysis of the cost of building the replacement hospital in Easton shows that the costs are reasonable and consistent with current industry standards experienced within the State of Maryland. The applicant further states that only costs applicable to the MVS definitions of construction cost for a standard acute care general hospital were included in this comparison. Thus, for MVS comparison purposes, project costs were adjusted to exclude construction costs not included in the MVS definitions, such as costs related to seeking and obtaining county approval, site development, the offsite utility connection fees, interest payments on debt during construction for equipment and other capital costs not included in the contract to construct the hospital building. In addition, UM SHS adjusted the project costs to exclude extraordinary costs that it considered not to be comparable to the MVS standard, including the costs related to the helipad, the pneumatic tube system, signage, and broadband internet. (DI #8, pp.19-20). According to the applicant, the adjusted project cost is $535.28 per square foot (SF), which is approximately eight percent below the MVS benchmark of $583.51 per SF, as calculated by the applicant. (DI #8, p. 23).

Staff Analysis

This standard requires a comparison of the project's estimated construction cost with an index cost derived from the MVS, which is based on the relevant construction characteristics of the proposed project. The MVS includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses, including hospitals. Separate base costs are specified for basements and mechanical penthouses. The MVS guide also includes a variety of adjustment factors, including adjustments of the base costs to the costs for the latest month, the locality of construction, as well as factors for the number of stories, height per story, building shape (such as relationship of floor size to perimeter), and departmental use of space. The standard provides that, if the projected cost per square foot exceeds the MVS 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 construction cost that exceeds the MVS benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

UM SHS's benchmark calculation used the MVS base cost for Class A, good quality construction, the current cost multiplier and a local multiplier for an uncertain date. The MVS current cost multiplier and the local multiplier are updated periodically, with the most recent update being October 2023.

Staff performed an independent MVS benchmark calculation using the most recent MVS multiplier updates and the project space and cost data submitted by the applicant in January 2023. Staff calculated base costs for the main hospital, the central utility plant (CUP), and the mechanical penthouse separately, as shown in Table IV-12.

Table IV-12: Calculation of Marshall Valuation Service Benchmark for UM SMC Easton

	Main Floors	CUP	Penthouse	Total
Construction Class/Quality	Class A/Good Quality	Class A/Good Quality		
Number of Stories	6	1	1	8
Square Feet	382,977	22,385	2,510	407,872
Average Floor Areas (square feet)	63,830	22,385	2,510	
Average Perimeter (ft.)	1,366	610	204	
Average Floor to Floor Height (feet)	15.3	20	21.83	
Base Cost per SF (June 2023)	**$485.00**	**$485.00**	**105.00**	
Elevator Add-on	Inc. above			
Adjusted Base Cost per SF	$485.00	$485.00	$105.00	
Adjustment for Dept. Cost Differences	1.05	0.70	1.0	
Gross Base Cost per SF	**$511.62**	**$331.41**	**$105.00**	
Multipliers				
Perimeter Multiplier	.9022	0.9197	1.0534	
Story Height Multiplier	1.076	1.184	1.226	
Multi-story Multiplier*	1.015	1.000	1.000	
Combined Multiplier	**0.985**	**1.0889**	**1.2915**	
Refined Cost per SF	**$503.95**	**$360.87**	**$135.61**	
Sprinkler Add-on	$3.09	$7.38		
Adjusted Refine Square Foot Cost	$507.04	$368.37	$135.61	
Update/Location Multipliers				
Current Cost Multiplier (Sept. 2015)	1.22	1.22	1.22	
Location Multiplier (Silver Spring, July 2015)	0.96	0.96	0.67	
Final Benchmark MVS Cost per SF	**$593.74**	**$$43**	**$158.80**	
Total Building SF	**382,977**	**22,385**	**2,510**	**407,872**
MVS Building Cost	**$227,388,764**	**$9,655,994**	**$398,588**	**$237,443,346**
Final MVS Cost Per SF				**$582.15**

Source: DI #8, pp. 12-24 and Marshall Valuation Service®, published by Marshall & Swift/Boeckh, LLC.

*Multi-story multiplier is .5% (.005) per floor for each floor more than three floors above the ground.

As detailed in Table IV-12, the MVS benchmark staff calculated for the hospital structure resulted in $582.15 per SF, which is $1.36 lower than applicant's calculation of $583.51 per SF. This nominal difference is due to changes in the cost multipliers in the recent MVS updates and rounding differences in the calculations.

Table IV-13: Comparison of UM SMC Easton Relocation Budget as Modified to Marshall Valuation Service Benchmark

Project Budget Item	Estimated Cost
Building	$170,364,261
Fixed Equipment	Include Above
Site Preparation	$649,215
Architectural Fees	$11,000,000
Permits	$6,135,000
Cap. Construction Int. & Finance Fees	$28,248,645
Total	**$188,048,476**
Loan Placement Fees	$2,024,675
Capitalized Construction Interest	$30,277,902
Adjusted Total for MVS Comparison	**$218,326,378**
Total Hospital Square Footage	**407,872**
Adjusted Hospital Cost Per SF	**$535,28**
MVS Benchmark Cost Per SF	$582.15
Total Over (Under) MVS Benchmark	**($46.87)**
Total Over (Under) MVS Total Cost	**($19,116,961)**

Source DI #11, pp. 12-23.

Staff's MVS benchmark calculation based on updated multipliers is detailed in Table IV-13. The calculated cost per square foot for the replacement hospital is $46.87 per SF less than the MVS benchmark. Therefore, there would not be any exclusion from a rate request submitted to the HSCRC related to excessive capital cost of the hospital construction portion of this project, or any associated contingency fees or inflation, as outlined in the standard. Staff concludes that the proposed cost of the project is reasonable and consistent with current industry cost experience in Maryland.

Staff was concerned, however, that the construction cost estimates of the replacement hospital were preliminary and based on estimates received in mid-2022 with no construction contracts signed. (DI#15, question 2). Recent large capital construction projects have had large cost overruns due to inflation and unforeseen project costs. (Docket No. 19-24-2438 and Docket No. 20-15-2443). As the CON review process was drawing to a close, staff asked applicant for an update and to confirm the project budget status based on the statement that bids will be solicited closer to the end of the CON process. (DI#15, question 2). The applicant confirmed that the November 2022 project budget remained valid. (DI #27).

Staff recommends that the Commission find that applicant complies with this standard.

(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's Response

UM SHS states that the project does not include construction of non-hospital space. (DI #4, p. 90)

Staff Analysis

The proposed project does not include any non-hospital space, staff concurs, this standard is not applicable.

(9) Inpatient Nursing Unit Space. Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of 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's Response

The applicant stated that the average square feet (SF) per bed of all of the nursing unit spaces was within 500 SF, but that the beds in both the ICU and behavioral health unit required additional space (Table IV-14). In the ICU, the applicant states that 630 SF per bed was required to accommodate specialized equipment, family and visitors in the room, and family/visitor lounge. In the behavioral health unit, 608 SF per bed additional space is required for specialized spaces including a day room, a group therapy room, locked visitor storage, a quiet room, and a seclusion room. See Table IV-14 for the average SF per bed in the proposed units.

Table IV-14 Average SF per Bed in Inpatient Nursing Units

Inpatient Unit	SF	# Beds	SF/Bed
Med/Surg Palliative/Peds	12,646	27	468
Med/Surg Telemetry	11,061	24	461
Med/Surg Adult	10,761	24	448
ICU	7,559	12	630
Behavioral Health	7,293	12	608
Total Area and Beds	**49,318**	**99**	
Average SF per bed			**498**

DI #3, p.92.

Staff Analysis

The standard provides that the cost for space built or renovated for inpatient nursing units that exceeds 500 square feet per bed be excluded from any rate increase related to the capital cost of the project. All units with the exception of the ICU and Behavioral Health units are less than 500 SF per bed, as is the average SF per bed of all the hospital units taken together. Staff consulted the 2022 FGI Guidelines for ICU units (Section 2.2-2.6.10) and Behavioral Health Units (Section 2.5-2.2.8) and found that the extra square feet designed by the applicant are required for those specialized units. Staff therefore concurs that the ICU and the behavioral health units require larger square footage as a result of the nature of the care they provide and in accordance with FGI guidelines.

Staff concludes that the proposed average square feet of all inpatient nursing units complies with the standard.

(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's Response

The applicant stated that this standard was not applicable based on a prior decision, in the CON review for *Washington Adventist Hospital*, Docket 13-15-2349, that the rate reduction agreements referenced in the standard have been replaced by the Global Budget revenue model. (DI #3, p.92).

Staff Analysis

Staff recommends that the Commission find this standard to be no longer applicable; rate

reduction agreements have been replaced by the Global Budget revenue model. In addition, this standard has been deleted from the pending COMAR 10.24.10 SHP update for which formal comments are due January 2, 2024.

(11) Efficiency. A hospital shall be designed to 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's Response

UM SHS states that it has already made a number of changes at the existing facility to improve efficiency, including a reduction of 113 FTEs during the consolidation of UM SMC Dorchester and UM SMC Easton. The applicant does not expect to improve additional efficiency in staffing through this project. The applicant expects to achieve increased efficiency in the proposed facility in the enumerated areas in Table IV-5.

Table IV-15 UM SMC Easton Changes to Improve Efficiency

Area	Expected Result
Bed Units	The replacement hospital will have standardized private rooms developed to optimize workflow for staff, patients, and family. Centralized support cores minimize footsteps for caregivers by 30%. Elevators between the units to improve transport, and ADA designed rooms closest to the elevators.
Imaging	Locating the department adjacent to the ED and close to patient/service elevators to reduce patient imaging times. The imaging department is designed with separate areas for inpatient and outpatient workflows.
Surgery	Centralized ORs with sterile supply located adjacent to the OR suite. Prep and recovery areas that can flex due to patient flow. Outpatient access is located less than 90 feet from the front entrance. There will be standardized ORs and central core for staging of case carts.
Observation Unit	A 25-bed observation unit is located adjacent to the ED. Allowing for transfer of patients out of the ED for observation without admitting to inpatient beds.
Emergency Department	Standardization of ED exam rooms, creation of a behavioral health holding area to promote better safety and security for patients, and space efficient bays for ambulatory patients.
Support Services	Materials management, lab, and pharmacy located to shorten distance for delivery of supplies, specimens, and medications. Pneumatic tube stations in each department with a dedicated route between lab and ED.

(DI #3 pp. 94-95).

UM SHS has designed the proposed new hospital in accordance with the latest code guidelines and standards. UM SMC Easton is a GBR hospital and pursuant to its agreement with the HSCRC, the hospital is incentivized to become more efficient. Applicant expects to lower utility expenses by 20 percent and repair costs by 40 percent compared to the existing hospital. The applicant expects that these efficiencies will have a net savings of $321,000 in 2029 dollars after an offset for the larger footprint of the new facility. (DI #3, p. 95).

Staff Analysis

Applicant states that it has already generated significant staffing efficiencies at the existing hospital as a result of the consolidation of UM SMC Dorchester and UM SMC Easton. (DI#3, p. 93). Staff agrees that the proposed staffing level at the replacement hospital is appropriate for the proposed bed capacity. The applicant provided an enumerated list of efficiencies in a variety of areas that have been included in the planning and design of the replacement hospital, along with the projected net savings of $321,000. In addition, staff finds that the proposed standardization of patient rooms, centralized support services, convenient imaging location, as well as appropriate placement of specialized services, combined with room design improvements in the replacement hospital are all factors that will improve the overall efficiency of operations. Staff concludes that the applicant has complied with this standard.

(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's Response

UM SHS states that the new facility is designed with patient and staff safety as a core design element and identified a number of design features and operational characteristics in the proposed project that will have a positive impact on patient safety. The key features that improve patient safety in the new hospital include: (1) all private rooms will decrease infection risk by eliminating the threat of cross contamination between patients sharing rooms; (2) Universal room design to accommodate patient lifts; (3) Centralized elevators with designated patient/trauma elevators; (4) Co-location of related support functions to maximize efficiency; (5) Upgrade to Americans with Disabilities Act/American National Standards Institute standards; (6) Reduced patient transfer distances in areas such as between surgery to short stay recovery, ED to ICU, ED to helipad, nursery/LDR to helipad, ED to Cath Lab, etc.; (7) Charting/observation at each patient room; (8) Medication safety zones located out of high traffic areas to support staff concentration and reduce errors; (9) Increased number of airborne infection isolation rooms with dedicated toilets; (10) Dedicated behavioral health holding suite within Emergency Department; (11) Specific provisions for patients of size, following current standards of care and guidelines; and (12) Staff break and respite spaces convenient to all diagnostic and inpatient units. (DI #3, pp.96-97, DI #11, p. 25).

The applicant notes that lessons learned from the COVID-19 pandemic have been integrated into the new facility campus design, specifically related to emergency event preparation such as mass decontamination and mass vaccination. The applicant has included increased numbers of isolation rooms in every department. (DI #3, p. 96).

Staff Analysis

The plans for the new facility were reviewed, and staff found patient, staff and visitor safety considerations from patient handling and movement design, diagnostic areas co-located with procedure rooms, intuitive wayfinding to acoustic privacy considerations. Staff concluded that the applicant has appropriately considered patient safety in the planning and design. The replacement hospital's design features reflect compliance with the most current hospital standards. Specifically, staff recognizes the patient room design improvements and the reduction of patient transfer distances as important steps in improving patient and staff safety. Staff also notes the efforts to improve safety for staff and visitors and recognizes the design features informed by lessons learned during the recent pandemic (i.e. the increased number of isolation rooms). Staff concludes that the applicant complies with the patient safety standard.

(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 area population of the hospital or State Health Plan need projections, if relevant;

Applicant Response

The applicant provided its Revenue and Expense Tables, stating that the UM SMC Easton utilization projection assumptions were based on historical trends in the utilization of these services by the service area population. The utilization projections reflect inpatient and outpatient utilization for UM SMC Easton, UM SMC Dorchester, and UM SMC Queenstown. (DI #11, Exh, 27). Included in applicant's assumptions is a $15 million dollar savings through 2027 attributed to performance improvements and increased efficiencies. (DI #15, Exh. 38, Table G). Additionally, applicant assumed a $24 million rate adjustment in 2029 for UM SMC Easton, equal to 50 percent of the depreciation and interest related to the project. (DI #11, Exh. 27, Tables G and H).

The bed need assumptions for UM SMC Easton include the historical shift of inpatient MSGA and psychiatric beds from UM SMC Dorchester to UM SMC Easton in fiscal year 2022. Applicant based future utilization projections on the new patient tower on estimated service area population growth. (DI #3, pp. 21-24 and p. 99).

In terms of staffing, the applicant projects a staffing reduction of 4.4 FTEs, for a total of 98.7 FTEs by 2029, specifically due to this project. (DI #15, Exhibit 38, Table L).

Staff Analysis

Staff reviewed the financial and utilization projections and found them to be optimistic, however, achievable due to the historic utilization trends of the hospital and the population projections for the primary and secondary service areas. Staff notes that the assumed $24 million rate adjustment has not yet been approved by the HSCRC. As stated in the HSCRC opinion letter, there are concerns about the current budget, which was based on cost estimates from 2022, not binding contracts. (DI #22, pp. 3-4). Recent large projects at Adventist Shady Grove Medical Center (Docket 20-15-2443) and University of Maryland Medical Center (Docket 19-24-2438) have seen large cost overruns due to inflation. While the budget currently contains an inflation allowance of $28 million, this may not be sufficient to cover the final costs of the project. (DI #15, Exh. 38, table E). Additionally, while the applicant continues to speak with state and local officials about project funding, UM SHS has no guarantee that they will realize the full $100 million budget request from the state for the replacement hospital. (DI #27). Staff also has some concern that the project would require more than $333 million in debt financing. Increased borrowing for the project could have a negative effect on feasibility.

Staff also considered whether the utilization projections were in line with historical trends and overall population projections for the service area. (supra pp. 8-11). Staff also considered the ALOS of 5.5 days by 2029 projected by the applicant and found it to be in line with current trends.

Staff concludes that the applicant provided the projections and assumptions required by Paragraph (a) of the standard, and that its utilization projections are aligned with historic trends, thereby complying with (b)(i) of the standard.

(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 hospital or, if a new hospital, the recent experience of other similar hospitals;

Applicant's Response

The applicant stated that the "projected revenue in Tables G and H reflect the utilization projections presented in Tables F and the budgeted 2023 regulated Global Budget Revenue (GBR) assumptions related to update factors, demographic adjustments, and uncompensated care. These assumptions, along with assumptions regarding unregulated revenue inflation, are included with the tables." (DI #15, Exh 38).

Staff Analysis

Staff reviewed the projected revenue in Tables G and H and found that it reflects the

utilization projections presented in Table F. An earlier version of the tables contained errors that were corrected with later submissions. (DI #15, Exh 38, Tables F, G and H). Staff notes that the expectation of an increase in Global Budget Revenue from the HSCRC may be optimistic, however, the HSCRC has stated that the project will be feasible if the applicant: maximizes the liquidation value of the current campus; realizes the greater efficiencies and performance improvements outlined in the report; minimizes potential cost overruns and maximizes public and private fund raising for the project. (DI #22, p. 6). Staff concludes that the applicant complies with (b)(ii) of the standard.

(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

Applicant Response

The applicant provided a staffing plan with cumulative staffing reductions of 98.7 FTE through 2029 (DI #11, pp. 63-64), most of which will occur in 2027 and are unrelated to the opening of the replacement hospital. The applicant projects a reduction of 4.4 FTEs as a result of merging the Joint Center and the Multispecialty Center once the facility opens, and the reduction is expected to result in a savings of $344,000 a year. (DI #11, p. 64).

Staff Analysis

Staff concludes that applicant's staffing plans are consistent with utilization projections and based on expenditure levels. Staff recommends that the Commission find that applicant complies with (b)(iii) of the standard.

(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 that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

Table IV-16 excerpts key actual and projected utilization and financial statistics from the application. Applicant submitted tables for UM SMC Easton (DI #11, Exh. 36) which has recently experienced a healthy bottom line. The margin is projected to be positive through CY 2029, though diminished after the project comes online.

Table IV-16: Utilization and Financial Statistics, CY 2023 to CY 2032

UM SMC Easton Selected Current and Projected Utilization and Financial Statistics, CY 2023 to CY 2032										
	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032
Discharges										
Acute	5,523	5,599	5,678	5,759	5,842	5,927	6,135	6,225	6,318	6,413
Acute Care Bed Occupancy	75.7%	74.4%	75.0%	75.4%	75.0%	75.2%	75.6%	75.3%	75.8%	74.7%
Revenue and Expense $000's										
Net Patient Revenue	$251,991	$252,971	$253,699	$254,110	$254,503	$254,284	$270,919	$270,680	$270,474	$270,267
Total Operating Expenses	$227,944	$220,000	$216,681	$214,549	$211,611	$212,293	$254,116	$255,048	$256,068	$257,080
Net Income	$46,589	$55,564	$59,611	$62,154	$65,435	$64,583	$39,396	$38,224	$36,998	$35,779

Source: DI #11, Exh. 36, Tables F and G
Note: financial projections are uninflated.

Staff Analysis

Staff reviewed the financial projections provided by the applicant and requested an opinion from HSCRC on the feasibility of the proposed project. The replacement hospital projects positive operating margins after project completion. According to HSCRC's analysis (DI #22, p.6), which took into account the finances of UM SHS, UM SMC at Easton and UMMS as a whole, the project may be financially feasible if the hospital realizes a number of objectives outlined in the feasibility section of this report (supra pp. 41-44). Staff concludes that the applicant complies with (b)(iv) and recommends that the Commission find that applicant complies with this standard.

(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 in the most recent edition of 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

UM SHS described UM SMC Easton's primary and secondary service areas as including 23 zip codes in Talbot, Dorchester, Caroline, Kent and Queen Anne's counties. The applicant provided the historic trends in emergency department (ED) utilization at UM SMC Easton by both individuals in the service area and those from outside the service area. The utilization numbers in Table IV-17 show a 29.2 percent decrease in UM SMC Easton's total ED visits from FY 2017-FY 2022, with 35,883 ED visits in FY 2017 and 25,393 visits in FY2022. UM SMC Easton's decrease in ED visits is greater than the 20.5 percent reduction in ED visits to all hospitals by residents of UM SMC Easton ED service area. (DI #3, p. 102).

Table IV-17 UM SMC Easton Historical Emergency Department Visits FY2017-2022

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY2022	Change
In service area	30,954	31,419	29,607	25,006	23,066	21,577	-30.4%
Outside service area	4,929	4,807	4,802	4,226	3,698	3,816	-22.6%
Total	**35,883**	**36.225**	**34,409**	**29,232**	**26,764**	**25,393**	**-29.2%**

DI #3, p. 104.

Beyond the overall decline in ED use in the state, the applicant stated that UM SMC Easton ED use was impacted by the opening of UM SHS urgent care centers in Chester, Easton, and Denton. These facilities diverted patients from UM SMC Easton ED to more appropriate care settings. (DI #3, p. 104). UM SHS also points out that the health systems network of primary care services were drivers of lower ED usage, by providing upstream preventative care for residents in each of the five counties of the service area. (DI #3, p.104, DI #3, Table 1).

UM SHS also attributes lower ED utilization with staffing shortages during the COVID-19 pandemic. From FY2019 to FY 2022, UM SMC Easton experienced a 3,754.2 percent increase in the number of hours on MIEMSS Red and Yellow alerts.[20] Potential UM SMC Easton ED

[20] Emergency Departments become too full to accommodate all patients arriving by ambulance. The high volume may be related to critical occupancy within the hospital. These conditions may result in a hospital requesting to be placed on Alert Status. The Alert Status enables the hospital time to resolve temporary operational delays and resume accepting ambulance patients. https://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/Reg1-Alert-Status-Policy-20190103.pdf?ver=2021-09-30-152925-023

patients were re-routed to other facilities in the region. (DI #3, p. 104). With the slowdown of COVID-19 related ED hospitalizations, and with staffing levels returning to pre-COVID-19 levels, the applicant expects that the usage numbers for the ED will rise to 27,854 per year by 2032.

UM SHS provided data on the percentage of individuals on Medicaid and uninsured individuals. (Table IV-18). The applicant stated that three out of five counties in the primary service area have a poverty rate greater than the State of Maryland as a whole and four of the five have higher percentages of individuals on Medicaid than the State as a whole. Four of five counties have a lower level of uninsured individuals. The applicant states that individuals on Medicaid are more likely to use the ED, while the uninsured are less likely to use the ED. (DI #11, pp. 32-33).

Table IV-18 Percentage of Individuals Receiving Medicaid or With No Insurance, UM SMC Easton Primary Service Area and Maryland for 2021

County	Medicaid	No Insurance
Caroline	32.4%	6.2%
Dorchester	32.1%	4.9%
Kent	21.9%	4.1%
Queen Anne's	14.7%	4.3%
Talbot	!8.4%	4.1%
Maryland	18.1%	5.9%

DI #11, p. 32

The applicant projects that starting in FY 2023, ED numbers at UM SMC Easton will begin to rebound and grow along with population growth. (DI #3, p. 107).

Table IV-19 UM SMC Easton Projected Emergency Department Visits and Population Growth

	Projected									
	2023	2024	2025	2026	2027	2028	2029	2030	2021	2032
ED Visits	25,610	25,833	26,062	26,297	26,539	26,788	27,043	27,306	27,576	27,854
Growth	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	1.0%	1.0%	1.0%

DI #3, p.107,

UM SHS is proposing a 21,890 SF ED in the new facility. (DI #3, Exh. 1, Table B). To calculate the number of ED treatment spaces, using the American College of Emergency Physicians (ACEP) guidelines for emergency room design, applicant asserts that the replacement hospital ED would fall into a high range ED,[21] based on patient population characteristics, patients expected length of stay, patient and family services, and test turnaround times. (DI #3, p. 106). ACEP guidelines for a facility of 30,000 visits per year call for a total of 25 treatment spaces, UM SHS states the new hospital will require 27 treatment spaces because of the projected increasing ALOS in the ED at the replacement hospital. (DI #3, p. 107). The applicant adds that 27 ED treatment spaces is less than the 32 ED treatment spaces at the existing hospital.

[21] ACEP Guidelines categorizes ED designs into low, mid, and high range using 16 factors, and the ranges are to provide preliminary benchmarks for sizing EDs. ACEP Guide at 109, 116-117. (DI#3, p.105).

Table IV-20 Applicant's Threshold Indicators for Proposed ED Size Based on ACEP Guidelines

Factor	Low	Medium	High	Future Hospital
% Admitted Patients	<8%	8-25%	>25%	Med
ALOS	<2.25 hours	2.5-3.75 Hrs.	>4 Hours	High
Private Rooms	Few	Majority	All	High
Waiting Areas	Available	Limited	Patients stay in bay	High
Location of Obs Beds	Outside ED	Limited	Inside ED	High
Boarding of Admitted. Patients	Stay <60 min.	Stay 90-120 min	Stay>150 min	High
Turnaround time Testing	< 45 min	60 min	>90 min	Medium
% Behavioral Health Patients	<3%	4-6%	>7%	Medium
% Nonurgent Patients	>45%	25-45%	<25%	High
Patient Age	<10% 65+	10-20% 65+	>20 65+	High
Imaging within ED	No	General and CT	Extensive	High
Family Amenities	None	Limited consult	Multiple Consult	High
Specialty Components Geriatric	None	Designated area	Module w support	High
Specialty Components Peds	None	Designated area	Module w support	Medium
Specialty Components Detention	None	Designated area	Module w support	Medium
Admin Teaching Space	Minimal	Moderate	Extensive	Medium

Source: DI #3, p. 106.

Staff Analysis

Staff accepts that the COVID-19 pandemic adversely affected many hospital emergency rooms and that a higher than normal MIEMSS red and yellow alerts at a facility would adversely affect the number of patients that present to the ED. The 3,754.2 percent increase in the number of hours on MIEMSS Red and Yellow alerts at the existing UM SMC Easton was similar to the numbers seen at EDs on the Eastern Shore. (DI #11, pp.6 - 9). Staff agree that the overall number of ED bypass alerts should drop with the decrease in COVID-19 ED visits and hospitalizations. S

This standard requires that the number of emergency department treatment spaces and departmental space proposed by an applicant 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*. Staff accepts the applicant's conclusion, based on ACEP Guide factors that the new hospital ED could be categorized as a "high range" ED and calculated using the gross SF and treatment space allowances using the high range estimates. To accommodate the projected 27,854 visits per year, staff calculates an ED size of approximately 25,000 SF with 23 treatment spaces. The proposed 21,890 SF ED falls within the accepted square feet range, however, the proposed ED includes four more treatment spaces than suggested by the ACEP Guidelines. Staff noted that the ED in the replacement hospital with 27 treatment spaces

has been downsized from the 32 treatment spaces in the current hospital.

Table IV-21 High and Low Range Estimated of Emergency Department Size and Treatment Spaces for Selected Visit Volumes

	Department Gross Square Feet		Treatment Spaces	
	Low Range	High Range	Low Range	High Range
25,000 ED Visits	18,563	21,875	18	20
30,000 ED Visits	21,000	27,344	21	25

Source: American College of Emergency Physicians, Emergency Department Design: A Practical Guide to Planning for the Future (April 2016).

While applicant's proposed ED treatment spaces slightly exceeds the high range of the ACEP guidelines, staff agrees with the applicant that ACEP guidelines are simply a tool to approximate treatment space. The number of ED treatment spaces are not excessive given the projected ED visit numbers. Staff recommends that the Commission find that applicant complies with this standard.

(15) Emergency Department Expansion. A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it 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. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, 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 of emergency department patients.

Applicant Response

Not applicable.

Staff Analysis

Staff concurs that this standard is not applicable.

(15) Shell Space

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the 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 present 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 for 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's Response

Not applicable, applicant does not propose to add any shell space in the proposed project.

Staff Analysis

The proposed project does not include any shell space, this standard is not applicable.

COMAR 10.24.12 State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services

COMAR 10.24.12.04 — Review Standards for Obstetric Services.

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. The burden of demonstrating the 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

The applicant states that it is currently licensed to operate 13 acute hospital inpatient obstetric beds. Of these beds, three are used to accommodate antepartum patients[22] and the remaining ten are labor-delivery-recovery-postpartum (LDRP) beds. Under this "LDRP model" a patient's labor, delivery, recovery, and postpartum stay all occur in the same room. (DI #3, p. 131).

The applicant states that the proposed replacement hospital will utilize a different model, which includes a combination of labor-delivery-recovery (LDR) rooms, and postpartum rooms. Under the "LDR model," the patient's labor through delivery and recovery occurs in an LDR room, and then the patient transfers to a postpartum room, or "obstetric bed" for the remainder of the

[22] Antepartum rooms are used to provide services to pregnant women experiencing health issues that are in need of treatment prior to delivery. This could include pregnant patients experiencing preeclampsia or ruptured membranes in need of observation, or patients needing intravenous antibiotics.

stay. (FGI Guidelines, pg. 173).[23] The applicant states that this model is the most common standard of care for facilities with 900 or more births per year, as the design provides for more efficient throughput, better accommodations, flexibility to handle seasonal volume swings, and improves patient experience. (DI #3, p. 132).

Using the obstetrics bed need methodology and assumptions described below, the applicant projects a need for 11 licensed obstetric beds at the replacement hospital. The 11 licensed obstetric beds will include eight postpartum beds to accommodate patients after delivery, two antepartum beds, and one LDRP bed to provide flexibility to handle surges in deliveries. (DI #3, pp. 132-138). While the applicant currently has 13 LDRP beds, and their requested 11 obstetric beds appears to be a decrease, the LDR model separates the birth from the postpartum stay which decreases the amount of time a patient spends in a "licensed bed." The LDR beds are not considered inpatient beds and therefore are not included in the "licensed obstetric bed count." The applicant indicates in Table F that projected obstetric discharges will increase from 1,012 in FY 2024 to 1,077 in FY 2032. (DI #15, Exh. 38, Table F).

The applicant states that vaginal and unplanned cesarean section deliveries typically start in an LDR or LDRP room. The applicant states that it reviewed industry standards on hospital utilization to determine the number of beds needed. It used a health design benchmark metric which assumes approximately 250 deliveries can be annually per LDR room. This benchmark is from data HKS, the health care architect firm used, which it has gathered through experience programming, designing, documenting, and analyzing obstetric units nationwide. (DI# 11, p. 55). Based on this metric, and the projected total births in the region, the applicant originally included three LDR rooms that are not considered "licensed beds" at the replacement hospital. However, as UM SMC Easton reviewed peak delivery data in response to staff comments, the applicant determined a need for a fourth LDR bed to ensure sufficient capacity to accommodate patients in labor. (DI#11, p. 1-2). The planned unit will have five total rooms, 4 LDR and one flex LDRP room. The applicant states that quantifying this need was difficult because data measures in the current model are based on when the patient is moved to inpatient status at the time of delivery. The applicant stated it manually collected data from patient charts to assess the number of patients in active labor, or in need of LDR or LDRP rooms. (DI #11, pp. 1-2, 55 and Exh. 28).

To allow for enhanced flexibility to accommodate the needs of laboring mothers at every stage of a routine birthing process, LDR/LDRP rooms are significantly larger, approximately 340-360 SF, than antepartum and postpartum rooms, which are approximately 200 SF. (DI #3, p. 132). The square footage saved in using an LDR-postpartum model also allows for appropriately sized family amenities and co-located triage and testing on the unit. Separate corridors for LDR and postpartum rooms also create a quieter experience for postpartum families. The LDR and postpartum corridors are immediately adjacent to one another which minimizes patient transfer distance and prevents transfers from being routed outside the locked unit, which promotes patient and infant safety.

The applicant states that the replacement hospital will also have two cesarean section rooms for patient safety and to support patients requiring emergency cesarean delivery. This is the same

[23] https://fgiguidelines.org/wp-content/uploads/2022/10/2018-HOSP-TOC.pdf

number of cesarean section rooms in the current hospital. The replacement hospital is designed with the obstetric unit connected directly to the emergency department, which has direct access to the surgical platform via a trauma elevator for emergent births. The applicant states that this availability of personnel and an operating theater for emergency cesarean delivery aligns with the standard of obstetric care.[24] (DI #3, p. 132).

The replacement hospital's 11 licensed bed obstetric wing will also have appropriate services for related care. For example, antepartum care includes two testing rooms, three triage rooms, and the availability of two medical-surgical inpatient rooms contiguous to the unit. The combination of two antepartum, eight postpartum rooms, and one LDRP for flexible use during peak demand, will allow the 11 beds in the obstetric unit of the replacement hospital to provide an optimal patient experience and to improve overall patient throughput to meet future demand (DI #3, p. 132).

Obstetrics Bed Need Calculation

To project the need for obstetric beds at the replacement hospital the applicant reviewed its most recent inpatient obstetric discharges from fiscal year 2022. The applicant ranked obstetrics discharges for the top 85 percent of resident ZIP Codes to determine its obstetrics service area. As shown in Table IV-22 below, UM SMC Easton's obstetrics service area includes 27 ZIP Codes that span five counties: Talbot, Dorchester, Caroline, Queen Anne's, and Kent on the eastern shore.

[24] The American College of Obstetricians and Gynecologists (ACOG) provides clinical practice guidelines. Source: www.acog.org/clinical/clinical-guidance/clinical-practice-guideline

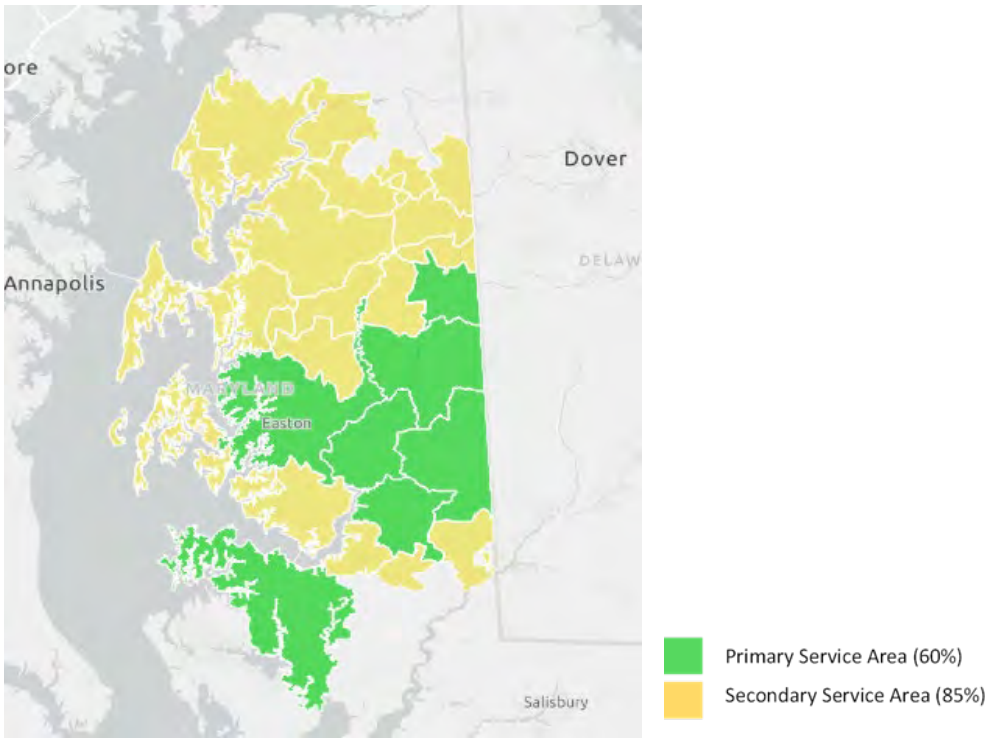
Table IV-22: UM SMC Easton's Obstetric Discharges by Zip Code Area
FY2022

ZIP	City	County	Discharges	Cumulative %
21613	Cambridge	Dorchester	182	18.2%
21601	Easton	Talbot	164	34.6%
21629	Denton	Caroline	72	41.8%
21632	Federalsburg	Caroline	61	47.9%
21643	Hurlock	Dorchester	49	52.9%
21655	Preston	Caroline	41	57.0%
21639	Greensboro	Caroline	36	60.6%
21649	Marydel	Caroline	33	63.9%
21673	Trappe	Talbot	24	66.3%
21660	Ridgely	Caroline	24	68.7%
21620	Chestertown	Kent	23	71.0%
21640	Henderson	Caroline	17	72.7%
21663	Saint Michaels	Talbot	16	74.3%
21658	Queenstown	Queen Anne's	14	75.7%
21636	Goldsboro	Caroline	13	77.0%
21625	Cordova	Talbot	12	78.2%
21623	Church Hill	Queen Anne's	12	79.4%
21617	Centreville	Queen Anne's	10	80.4%
21666	Stevensville	Queen Anne's	9	81.3%
21631	East New Market	Dorchester	8	82.1%
21659	Rhodes dale	Dorchester	7	82.8%
21638	Grasonville	Queen Anne's	5	83.3%
21619	Chester	Queen Anne's	5	83.8%
21661	Rock Hall	Kent	4	84.2%
21672	Wye Mills	Talbot	3	84.5%
21659	Queen Anne	Queen Anne's	2	84.7%
21612	Bozman	Tabot	2	84.9%
Total in service area			**848**	**84.9%**
Out of service area			151	15.1%
Total			**999**	**100%**

Source: DI #3, p. 133, based on hMetrix's analysis of HSCRC's statewide non-confidential hospital data tapes.

Figure 2 shows UM SMC Easton's primary and secondary obstetrics service area.

Figure 2 UM SMC Easton's OB Service Area FY2022



DI #3, p.134

Service Area Population Trends and Utilization Forecast

For the ZIP codes included in the service area for UM SMC Easton, the applicant obtained population projections for females in the 15-44 age cohort through 2027 from Environics Spotlight (formerly Nielsen Claritas). (DI#3, p. 134). Environics Analytics provides data combined with predictive modeling, demographic trends, and behavioral analytics to support informed decisions and provide a better standard of healthcare.[25]

The applicant used information from Environics Spotlight and extrapolated the population through 2032 by applying the annual growth rates from FY2022 to FY2027. The population of females in the 15-44 age cohort is expected to increase annually by 0.8 percent from FY 2022 to FY 2032, as shown in Table IV- 23.

[25] Source: www.environicsanalytics.com/en-ca/industries/health-care

IV-23: UM SMC Easton Historical and Projected Obstetric Service Area Population, Use Rate and Projected Discharges FY 2019 – FY 2032

Historical				
Age Group	2019	2020	2021	2022
15-44	26,703	26,685	26,668	26,650
Percent Change		-0.1%	-0.1%	-0.1%
Use Rate	62.4	60.1	59.6	63.9
Discharges	1,082	1,059	1,080	999

Projected										
Age Group	2023	2024	2025	2026	2027	2028	2029	2030	203 1	2032
15-44	26,859	27,071	27,283	27,498	27,714	27,932	28,151	28,373	28,596	28,820
Percent Change	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
Use Rate	63.9	63.9	63.9	63.9	63.9	63.9	63.9	63.9	63.9	63.9
Discharges	1,004	1,012	1,020	1,028	1,036	1,044	1,052	1,060	1,069	1,077

Source: DI #3, pp. 135-137.

The applicant calculated the use rate per 1,000 population of obstetrics discharges in UM SMC Easton's defined obstetrics service area. The applicant found the service area use rate decreased from FY 2019 to FY 2021, which was attributed to the pandemic. The use rate returned to pre-pandemic levels of 63.9 in FY 2022, after a drop to 59.6 in 2021. The applicant's projections through 2032 are based on the use rate of 63.9/1,000 women in the 15-44 age cohort. The combination of a constant use rate and low population growth results in a slow but steady growth in the number of obstetric discharges by FY 2032.

Table IV-24: UM SMC Easton Historical and Projected Market Share and Out-of-Service Area Population and Use Rate FY 2019 – FY 2032

Historical				
	2019	2020	2021	2022
Market Share from Service Area	55.2%	56.6%	55.3%	49.9%
Percent From Outside Service Area	17.5%	16.6%	17.0%%	17.0%

Projected										
	2023	2024	2025	2026	2027	2028	2029	2030	203 1	2032
Market Share from Service Area	49.9%	49.9%	49.9%	49.9%	49.9%	49.9%	49.9%	49.9%	49.9%	49.9%
Percent From Outside Service Area	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%

Source: DI #3, p. 135.

Of these total market obstetrics discharges, the applicant then applied its market share percentage to determine the likely volume it would continue to achieve, if the market share held steady. The market share is 49.9 percent of all births in the defined service area, and the applicant did not project a market share increase in future years, even with a new facility. The volume is

augmented by 17 percent market share of births at UM SMC Easton that occur to women from outside of the defined five county service area. Given the anticipated population growth rate, the applicant predicts obstetric discharges will increase slightly from 999 discharges in fiscal year 2022 to 1,077 discharges in fiscal year 2032 (DI #3, p.136).

The applicant states that based on historical experience, it projects that 79% of obstetric discharges will be normal vaginal deliveries and 21% will be by cesarean section. This historical experience was used to project the number of rooms needed for cesarean births vs normal vaginal deliveries. (DI #3, pp. 136-137).

Similar to the State Health Plan chapter for acute care services, which provides a 70 percent occupancy standard for services that experience an average daily census (ADC) of 0 to 49 patients, applicant projects demand for obstetric beds using a 70 percent occupancy rate assumption. Dividing the ADC by the occupancy standard results in a need for 8.0 postpartum beds at the replacement hospital in 2032. (DI #3, p. 137).

The applicant states that "using this need methodology based on HSCRC data alone [which only captures a patient's postpartum stay] and a 70% occupancy assumption does not fully account for UM SMC at Easton's OB bed need because it does not capture patients' time spent in beds on the OB unit prior to delivery, nor beds needed at the replacement hospital to accommodate peak census on the unit." (DI #3, p. 138).

When a patient occupies a bed in the obstetric unit prior to delivery it is not captured in the HSCRC ALOS data because a patient has not been admitted, which occurs at the time of delivery. Because of the limitations of the HSCRC data, the applicant presented additional data regarding the need for antepartum and LDR beds to provide a more realistic picture of its OB bed need. (DI #11, p. 50). The applicant states that the postpartum bed need analysis does not adequately capture antepartum patients that require pre-delivery testing, monitoring and observation for high risk patients. To account for these patients, the applicant provided the data to further support the bed need in Table IV-25.

Table IV-25: UM SMC Easton's Historical and Projected Baseline Obstetric Bed Need FY2019 – FY2032

Actual				
	2019	**2020**	**2021**	**2022**
OB Bed Need				
Postpartum Bed Need	9.7	8.2	7.3	7.4
AntePartum % of PostPartum Length of Stay	20%	20%	20%	20%
AntePartum Bed Need	1.9	1.6	1.5	1.5
Need for 1 LDRP Bed	1.0	1.0	1.0	1.0
Total Bed Need	12.6	10.8	9.8	9.9
Total Requested Beds	13.0	11.0	10.0	10.0

Projected										
	2023	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
OB Bed Need										
Postpartum Bed Need	7.4	7.5	7.6	7.6	7.7	7.7	7.8	7.9	7.9	8.0
AntePartum % of PostPartum Length of Stay	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
AntePartum Bed Need	1.5	1.5	1.5	1.5	1.5	1.5	1.6	1.6	1.6	1.6
Need for 1 LDRP Bed	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Total Bed Need	9.9	10.0	10.1	10.1	10.2	10.3	10.4	10.4	10.5	10.6
Total Requested Beds	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	11.0	11.0

Source: DI #3, p. 139.

The applicant states that health design benchmarks assume a need for antepartum rooms equivalent to 20 percent of the unit's postpartum rooms.[26] To address the need for antepartum services, the applicant plans to include two antepartum beds at the replacement facility (DI #3, pp. 137-139 (DI #11, pp. 49).

The applicant also addressed the need to account for peak demand in obstetric cases. The applicant states that the differences in staffing competencies and equipment needs creates issues with overflow obstetric patients that are difficult to place in other medical/surgical inpatient units. The applicant states that the obstetrics unit size must accommodate periods of peak census. To be conservative, and in recognition that the need projection should not account for extraordinary surges in volume, applicant adjusted its peak daily census by multiplying it by 80%. After applying this adjustment, the ratio of ADC to 80% of peak daily census was 190% for FY 2022 Table IV-26 reflects the peak census to ADC ratios the applicant used to develop the total bed need calculation. (DI #11, pg. 53).

The applicant states that the proposed need for 11 total licensed obstetric beds at UM SMC Easton, while it does not include capacity for 100 percent of peak daily census, the inclusion of four LDR rooms, two cesarean section rooms (special purpose ORs), triage and antepartum spaces

[26] The reference to annual birth threshold guiding obstetrical program model and facility design is in reference to throughput per room. This is based on HKS' (the project architect's) benchmarking gathered through experience programming, designing, documenting, and analyzing obstetric units nationwide. There is no industry-wide fixed standard for adoption of the LDR versus LDRP model. (DI #11, pg. 49).

will provide flexibility to accommodate surges in capacity. (DI #3, pp. 140-141).

Table IV-26 UM SMC Easton's Obstetric Average and Peak Census in FY2022

	Average Daily Census	Peak Daily Census	80% of Peak Daily Census
July	6.2	12.0	9.6
August	6.0	14.0	11.2
September	6.2	15.0	12.0
October	5.8	13.0	10.4
November	5.7	12.0	9.6
December	5.2	12.0	9.6
January	4.7	13.0	10.4
February	5.0	12.0	9.6
March	5.0	11.0	8.8
April	4.5	12.0	9.6
May	3.7	11.0	8.8
June	4.5	11.0	8.8
Average	5.2	12.3	9.9
Peak % of ADC		**237%**	**190%**

Source: Shore Internal Data

Source: DI #11, p. 53.

Preserving Access to Obstetric Patient Care in the Eastern Shore Region

There are additional reasons and information applicant provided regarding the need for obstetric services in the service area. The applicant states that UM SMC Easton is the only facility within its service area that offers labor and delivery services where expectant mothers can deliver babies. It states it is critical that the replacement hospital's obstetric unit be appropriately sized, with sufficient surge capacity to ensure patients have timely access to labor and delivery services due to the emergent nature of obstetric services and the distance to the next closest OB providers.

The State Health Plan chapter for inpatient obstetrics services states that "[h]ospital obstetrics services should be no more than a 30-minute one-way average automobile travel time under normal driving conditions for at least 90 percent of the population."[27] (DI #3, p. 142). The applicant provided the average drive time from the most populous location within each county in the service area to other birthing centers and hospitals in the region. Table IV-27 shows the drive time between the five Mid-Shore counties in UM SMC Easton's service area and the next closest labor and delivery units in Maryland and Delaware. The estimated drive times from each service area county shows that the proposed site for the replacement hospital is the only hospital with obstetric services providing access within a 30-minute drive time for residents of the service area.

[27] See COMAR 10.24.12B(5), p. 14.

Table IV-27
Driving Time (in Minutes) from the Five Mid-Shore Counties
To the Nearest Maryland and Delaware OB Facilities

Hospital or Birthing Center	Location	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Average
UM SMC Easton Proposed Site-	Easton, MD	24	30	42	21	11	**25.6**
Anne Arundel Med Ctr	Annapolis, MD	48	68	58	34	49	**51.4**
Tidal Health Peninsula Regional	Salisbury, MD	59	38	100	80	56	**66.6**
Beebe Medical Center	Lewes, DE	66	99	96	86	92	**87.8**
Bayhealth Sussex Campus	Milford, DE	40	70	68	62	63	**60.6**
Bayhealth Hospital, Kent Campus	Dover, DE	44	103	58	52	66	**64.6**
Christiana Hospital	Newark, DE	75	98	52	59	80	**72.8**
Christiana Care, Wilmington	Wilmington, DE	78	127	61	69	88	**84.6**
St. Francis Hospital	Wilmington, DE	78	125	61	70	88	**84.4**
Tidal Health Nanticoke	Sanford, DE	34	40	79	59	46	**51.6**
The Birth Center	Newark, DE	69	114	51	59	79	**74.4**

Source: DI #3, p.143. Applicant determined source of travel time in Google Maps, using the shortest travel time between each county and each hospital. Measurements were taken between 1:00 and 2:00 pm. on Wednesday, October 12, 2022.

Staff Analysis

The applicant defined UM SMC Easton's service area, provided historic volume, discharge numbers, use rates, population growth projections, projected market share, historical and projected pre-delivery and postpartum ALOS, and HSCRC data to establish historical and identify projected obstetric bed need. Applicant's analysis was complicated by the need to manually review the data in the LDR care delivery model, compared to the information readily available in the existing LDRP model. Analyzing medical records and separating out the need for pre-delivery from solely postpartum care resulted in a change in the total number of LDR beds requested during the review process. The collective impact of applicant's submission to support the need for the 11 licensed obstetric beds has been demonstrated for UM SMC's defined service area at the new location. Obstetrics at UM SMC Easton is not a new service line but will be an enhanced service at the new hospital for an existing obstetrics program.

Based on the historical volumes from the current 13 LDRP beds, the applicant provided an overview of the existing and projected demographics, the projected use rate for obstetric services, and predicted future volumes. Applicant noted that birth rates dropped during the pandemic, and although a rebound is projected, the rate is still reduced in the models compared to pre-pandemic rates. The data, information and analysis provided in the application and summarized in this report are reasonable and credible. Applicant has demonstrated a need for 2 antepartum beds, 8

postpartum beds, and one LDRP bed for flexibility during peak demand. This results in a request for 11 licensed obstetric beds.

The applicant suggested that the change from an LDRP model to an LDR and separate postpartum unit will improve the quality of the patient experience, the flexibility in care delivery and the efficiency in the delivery process. Previous staff reports indicate that most hospitals in Maryland utilize the LDR model compared to the LDRP model.[28]

Given the rural nature of the counties in the service area and the driving distances to other facilities, there is a clear need in the Eastern Shore region for a hospital that will support the community for all routine obstetric care and deliveries. In fact, staff notes that the next closest average drive time by center is just over 51 minutes. For these reasons staff conclude that the hospital has unique needs to maintain access to quality obstetric providers, programs, and its birthing site.

Based on historic obstetric volumes, demographic projections in the current market area, additional information on antepartum bed need, the need to accommodate peak census volumes, and the demonstrated rural population needs, staff concludes that applicant complies with the standard.

(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

The applicant states that it has a Level I perinatal center, as will the proposed replacement hospital The applicant provided a self-assessment conducted in October 2022 that utilized the *2019 Maryland Perinatal System Standards of the Perinatal Clinical Advisory Committee* at the Maryland Department of Health. The self-assessment results show that the hospital meets all the essential perinatal standards for a Level I perinatal center. (DI #3, p. 143 and Exhibit 19). (Additional information is at: https://health.maryland.gov/phpa/mch/pages/perinatal_standards.aspx).

Staff Analysis

Staff has reviewed the submission for all essential Perinatal System Standards and concludes that applicant complies with the standard.

[28] Chartbook of Maryland General and Special Hospital Facilities and Services, FY2019, Page 33-34. www.mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/con_chartbook_md_gen_special_hospitals_20220930.pdf

(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

Applicant provided all required written charity care policies in response to COMAR 10.24.10.04A(2) Charity Care, (supra, pp. 15-16), and also states that UM SMC Easton provides care to all patients regardless of the ability to pay. (DI#3, p33). The historical and projected level of charity care is appropriate to the needs of its service area population. (DI #3, pp. 34-35).

Staff Analysis

The documents and information applicant provided in previous sections of this report demonstrated that applicant has a written charity care policy that provides a determination of probable eligibility within two business days and provides the required charity care notices. Staff concludes that the applicant complies with the standard.

(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 area

Applicant Response

The applicant states that it provides care to all individuals, regardless of ability to pay or source of payment. (DI#3, p. 144). Based on data from the Maryland Department of Health's Maryland Medicaid eHealth Statistics, applicant provided an estimate of the Medicaid eligible population in UM SMC Easton's service area counties in Table IV-28.

Table IV-28 Medicaid Eligible Population by County

	Caroline	Dorchester	Kent	Queen Anne's	Talbot
Medicaid Eligible	13,605	14,635	5,533	9,661	9,602

Source: DI #3, p. 144. https://md-medicaid.org/eligibility/index.cfm

(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

The applicant states that it currently has 16 obstetricians, seven pediatricians, and seven nurse-midwives with admitting privileges at UM SMC Easton. (DI #3, pp. 144-145). All obstetric and pediatric physicians with privileges at UM SMC Easton participate in the Maryland Medical Assistance program. Applicant also enumerated multiple local community partners UM SMC Easton works with to identify Medicaid enrollees, underserved, uninsured and indigent women in need. UM SMC Easton collaborates with local health departments who identify patients in need of prenatal care and to link them to a UM SMC Easton obstetrician. (DI#3, p. 144). Applicant highlights the success of community partner collaboration with data showing that UM SMC Easton's obstetric service area has a lower percentage of births that had "Late of No Prenatal Care" compared to the State of Maryland as a whole. (DI#3, p. 152-153).

Staff Analysis

UM SMC Easton's commitment to serving Maryland Medicaid patients is supported with the statement that all obstetric and pediatric physicians with privileges at UM SMC Easton participate in the Maryland Medical Assistance program. Further, UM SMC Easton's partnership with local partners and outreach programs have yielded positive outcomes and resulted in early prenatal care as demonstrated by data from the Maryland Vital Statistics Administration showing a lower percentage of births with no prenatal care in the service area. Staff concludes that the applicant complies with this standard.

(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

The applicant provided estimated staffing at the third year of projected volumes showing the FTEs and projected expenses. (DI#3, p. 145).

Title IV-29: UM SMC Easton Proposed Obstetric Staffing at Third-Year Projected Volumes

Employee Category	Year 3 FTE	FTE Replacement Factor	Total Estimated Expense	Comments
Staff Nurse (RN)	31.5	13%	$3,497,490	All RNs are cross trained to L&D, Nursery, Postpartum, operating room, and outpatient testing/triage.
Per Diem RN				Per Diem Rate Varies. Included in total.
Clinical Coordinators	2.4			None
Surgical Technician (CNA/sec/tech)	7.2	12.5%	$438,970	All surgical technicians are cross trained to unit secretary functions.
Per Diem ST (CAN/sec/tech)				Per Diem Rate Varies. Included in total.
Nurse Manager	1.0		$115,606	Responsible for OB and Women & Children's (former Pediatrics) Units.
Relief Unit Secretary (US)	0		Variable	These are relief unit secretaries that fill in for the unit secretary role as needed.
Lactation Consultant	1.0		$93,891	None
Midwife*	5		Contractual	*Not a part of the nursing staff. Credentialed through the Medical staff office and hired through UM SMG-Women's Health
Physicians	3+			3 physicians with UM SMG-Women's Health Several physicians with OB Hospitalist (Laborist) program providing 24/7 in-hospital coverage
Overtime			$49,377	OT FTEs incl. in Employee Category for all employee categories.
On-Call				All employee categories.
TOTAL	**43.08**	**13%**	**$4,195,334**	*Midwives not included in total.*

(DI #3. pg. 145).

Table IV-29 shows that the staffing expense for the new program will create an expense of $4.1 million.

Staff Analysis

In addition to the table above, the applicant provided revised Workforce Table L (DI #11, Table L) which shows 42.0 FTEs are needed in the Obstetrics category for the proposed project. This is a slight reduction, which the applicant had stated is due to reductions in agency employees. (DI #11, pg. 63).

Staff concludes that the applicant complies with the standard.

(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

The applicant states that the replacement hospital will be configured to consolidate and centralize resources, minimize staff travel distances, and improve continuous patient visibility, while controlling noise in the units. It also states that the new building and the investment in technology will promote patient safety and quality by including the following features listed below.

- Co-location of related support functions to maximize efficiency
- Universal patient room design
- Charting/observation at each patient room
- Automation of technology and patient records
- Inclusion of lactation services and support spaces
- Appropriate number of triage rooms with dedicated bathrooms
- Dedicated trauma and obstetric unit elevator for patient transfers in emergency situations
- Reduced patient transfer time (surgery to short stay recovery, emergency department to ICU, emergency department to helipad, nursery/LDRP to helipad, etc.)
- Appropriate number of prep/recovery bays
- Special operating room lights in all triage rooms
- Direct access from C-section to nursery
- Continuing Care Nursery with accommodations for opioid addicted neonates or other special care needs
- Newborn / Baby Holding Nursery separated from Continuing Care Nursery to minimize noise and disruption in Newborn Nursery
- Increased telemetry capability on the unit
- Storage alcoves on the obstetric unit for wheelchairs and stretchers
- Upgrade to ADA/ANSI standards
- Require all traffic flow into building (main entrance) to pasts security
- Locked unit with an infant security system
- Increased family amenities located centrally with daylight access
- Dedicated medication/clean supply room

(DI #3, pp. 147-148).

Staff Analysis

Staff reviewed the planned new construction and recognized that many features will improve patient safety and quality of care. Key elements of the design include co-location of patient prep, procedure rooms and recovery; consolidation and centralization of supplies,

resources, and support functions to improve efficiency; public and staff corridors to improve staff efficiency and patient privacy; and design features to minimize patient transport distances. These are a few of the highlights that will contribute to improve efficiencies to the benefit patients and improve outcomes and overall quality of care. Staff concludes that applicant complies with the standard.

(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

This standard is not applicable. Applicant has an established perinatal service.

Staff Analysis

Staff agrees that this standard is not applicable.

(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:

- **(a) 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,**
- **(b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and;**
- **(c) information on the structure, staffing, and funding of the Plan;**
- **(d) 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;**
- **(e) an implementation scheme, the Community Benefit Plan.**
- **(f) 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.**
- **(g) 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

This standard is not applicable. Applicant has an established obstetric and perinatal service.

Staff Analysis

Staff concurs that this standard is not applicable.

(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

This standard is not applicable. Applicant has an established obstetric service.

Staff Analysis

Staff concurs that this standard is not applicable.

(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

The applicant states that UM SMC Easton is not proposing to create a new obstetrics program but is simply relocating the existing program. Further, all obstetricians practicing at the current hospital have offices in Easton, which is within the primary service area of the replacement hospital. In 2022, UM SMC Easton began a new in-house, 24/7 laborist program. A laborist is similar to a hospitalist in that they only work on site at the hospital. The laborist program provides immediate, 24/7 access to obstetrical care at the hospital. Applicant states that they contract with OB Hospitalist Group (OBHG), a laborist company that supplies approximately eight FTE board-certified obstetrician gynecologists (OB/GYNs) at UM SMC Easton. The OBHG's laborists do not have offices in UM SMC Easton's primary service area, they are contracted to staff UM SMC at Easton's birthing center, but do not provide prenatal care to the service area patients. UM SRH employs three full-time OB/GYNs and five nurse midwives to provide prenatal care to the region. This team provides care both in the hospital's birthing center and through its outpatient clinics to meet patients' prenatal care needs." (DI #11, pg. 57).

Staff Analysis

This new laborist model offers hospital coverage for local obstetricians, which the applicant believes will assist in the recruitment of medical staff. While the laborists do not offer patient visits in the community, the three staff obstetricians and five nurse-midwives employed by the facility all have local offices within the primary service area and provide prenatal services in UM SMC Easton's birthing center clinic and the outpatient clinics in the surrounding area.

The applicant has demonstrated that physicians with admitting privileges to provide obstetric services have offices for patient visits within UM SMC Easton's primary service area. Staff concludes that applicant complies with the standard.

(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

This standard is not applicable. Applicant has an established obstetrics service.

Staff Analysis

Staff concurs that this standard is not applicable.

(12) Minimum Volumes.

(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

Applicant states and staff concurs that this standard does not apply, as it has an established obstetrics service.

(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 project 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

This standard is not applicable. Applicant has an established obstetrics and perinatal service.

Staff Analysis

Staff agrees that this standard is not applicable.

(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

This standard is not applicable. Applicant has an established obstetrics and perinatal service.

Staff Analysis

Staff agrees that this standard is not applicable.

(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

The applicant states that it works closely with many community partners, including local health centers, county health departments, community centers, local physicians, schools, social services agencies, and other organizations in the five counties that identify patients who need prenatal care, especially those who may be uninsured, under-insured, or indigent (DI #3, pg. 151).

The applicant's program accommodates OB/GYN referrals for the underserved in all five counties from any of these sources. In addition, the applicant offers dozens of classes in the community, free of charge, including:

- Planning for baby's arrival - Take A Childbirth Education Class
- Successful Breastfeeding
- Health and Wellness Classes
- Labor and Delivery Class
- Pregnancy and Infant Loss (this program is offered via partnership with Talbot Hospice)
- New Mom, New Baby, and Infant Safety
- Big Brother and Big Sister program
- Infant CPR
- Stroke Awareness
- Diabetes Support Group
- Palliative Care Education
- Prostate Cancer and Urological Conditions
- Classes and Support Groups Focus on Managing Diabetes
- Blood Pressure Screenings
- Breast Cancer Screenings
- Cancer Support Groups
- Stroke Survivor Support Group
- Look Good…Feel Better
- Shore Kids Camp (this program is temporarily on hold due to COVID-19 restrictions)
- Safe Sitter Class

(DI #3, pp. 150-151)

The applicant states that whenever a patient in need of prenatal medical care is identified by any outside agency, county health department, or other source, the woman is referred to the University of Maryland Shore Medical Group – Women's Health to initiate prenatal care. If any pregnancy-related or other medical needs are identified, the patient is referred to the appropriate local agency for additional assistance in obtaining the available and necessary resources.
If a patient presents for care at UM SMC Easton and does not have a prenatal provider, the hospital staff will work to assign the patient to an obstetrician. The applicant states that no patients are turned away. (DI #3, p. 151).

The applicant provided data from the Maryland Department of Vital Statistics comparing the rates of late or no prenatal care and rates of care in the first trimester from its five-county service area compared to the state. As Table IV-30 shows, the hospital's obstetric service area has a lower percentage of births that had "Late or No Prenatal Care" compared to the State of Maryland as a whole. In addition, the same area had a higher percentage of births that had "First Trimester Prenatal Care" than did the State as a whole.

Table IV-30 Births with "Late or No Prenatal Care" and "1st Trimester Prenatal Care"
Queen Anne's, Kent, Caroline, Talbot, and Dorchester Counties, CY 2020

Region	Total Births	Late or No Prenatal Care		1st Trimester Prenatal Care	
	#	#	%	#	%
Kent	148	17	11.5%	115	77.7%
Queen Anne's	478	26	5.4%	350	73.2%
Caroline	398	28	7.0%	283	71.1%
Talbot	377	11	2.9%	318	84.4%
Dorchester	377	14	3.9%	297	78.8%
Total Service Area	1,778	96	5.4%	1,336	76.7%
Maryland	68,546	4,303	6.3%	46,259	67.5%%

Source: DI #3, pp. 152-153.

Staff Analysis

The applicant has documented an outreach program for obstetric patients in its service area, without regard to the patient's financial background or resources. The community outreach programs address a wide variety of topics, including childbirth education, breastfeeding, labor and delivery, pregnancy and infant loss, and health and wellness classes to name a few, as required by the standard. In collaboration with community partners, Applicant strives to ensure that any patient who needs prenatal care, regardless of ability to pay, is able to access care and educational outreach programs at UM SMC Easton. Staff concludes that the applicant complies with the standard.

COMAR 10.24.11 - State Health Plan for Facilities and Services: General Surgical Services.

COMAR 10.24.11.05A — General Standards.

The following general standards reflect Commission expectations for the delivery of surgical services by all healthcare facilities in Maryland, as defined in Health-General §19-114(d). Each applicant that seeks a Certificate of Need for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

(1) Information Regarding Charges and Network Participation. Information regarding charges for surgical services shall be available to the public.

(a) Each ambulatory surgery center, ambulatory surgical facility, and hospital shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

(b) Each ambulatory surgery center, ambulatory surgical facility, and general hospital shall provide to the public, upon inquiry or as required by applicable regulations, the names of the health carrier networks in which it currently participates.

(c) Each ambulatory surgery center, ambulatory surgical facility, and general hospital shall provide to the public, upon inquiry, the names of the health carrier networks in which each surgeon and other health care practitioner that provides services at the facility currently participates.

(d) The Commission shall consider complaints to the Consumer Protection Division in the Office of the Attorney General of Maryland or to the Maryland Insurance Administration when evaluating an applicant's compliance with this standard in addition to evaluating other sources of information.

(e) Providing a patient with an estimate of out-of-pocket charges prior to arrival for surgery shall be a condition of any CON issued by the Commission.

Applicant Response

UM SHS submitted a written policy for public disclosure of financial information regarding hospital services and charges to the public in response to COMAR 10.24.10.04A(1) and cross references that response for this standard. *(*supra, pp. 14-15). Applicant states that a representative list of services and charges will be made available to the public in written form at the hospital and via the UM SMC Easton website. (DI #3, Exh. 5, p. 1). This policy includes: procedures on the maintenance of the Representative List of Services and Charges; procedures for responding to requests for information regarding current charges for specific services and procedures; and requirements for staff training on inquiries regarding charges for services. (DI #3, p. 32).

UM SHS states that the hospital "provides to the public, upon inquiry or as required by applicable law, the names of the health care carrier networks in which it currently participates." (DI #3, p. 113). Applicant also states that the hospital "provides to the public, upon inquiry, the

names of the health care carrier networks in which its employed surgeons and other health care practitioners that provide services at the facility currently participate." (DI #3, p. 113). The hospital will direct inquiries involving network participation of non-employed surgeons directly to the surgeon's office.

UM SHS indicates that it "is unaware of any complaints to the Consumer Protection Division in the Office of the Maryland Attorney General of Maryland or to the Maryland Insurance Administration alleging that it failed to provide information either upon request or as required by law, to the public concerning its charges for the full range of surgical services." (DI #3, pp. 113-114).

UM SHS acknowledges that providing a patient with an estimate of out-of-pocket charges prior to arrival for surgery shall be a condition of CON approval. (DI #3, p. 114).

Staff Analysis

Staff confirmed the response to COMAR 10.24.10.04A(1) and confirms that applicant has provided all the policies and information regarding charges and network participation as required by subparagraphs (a) through (e) of this standard. Additionally, the Consumer Protection Division in the Office of the Maryland Attorney General of Maryland and to the Maryland Insurance Administration websites were reviewed. Staff recommends the Commission find the applicant complies with this standard.

In accordance with the requirements of Paragraph (e), staff recommends that any project approval include the following condition:

> The University of Maryland Shore Medical Center at Easton shall provide to the patient, upon inquiry or as required by applicable regulations or law, information concerning an estimate of out-of-pocket charges prior to arrival for surgery.

Staff concludes that the applicant complies with this standard.

(2) Information Regarding Procedure Volume. Each hospital, ambulatory surgical facility, and ambulatory surgery center shall provide to the public upon inquiry information concerning the volume of specific surgical procedures performed at the location. A hospital, ambulatory surgical facility, or ASC shall provide the requested information on surgical procedure volume for the most recent 12 months available, updated at least annually.

Applicant Response

UM SHS states that upon request UM SMC Easton will provide the public information concerning the volume of specific surgical procedures performed at UM SMC Easton for the most recent 12 months available and will update this information at least annually. (DI #3, p. 114).

Staff Analysis

Applicant has stated their commitment to provide surgical procedure volumes to the public, upon request. Staff concludes that the applicant complies with this standard.

(3) Charity Care and Financial Assistance Policy. Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care and financial assistance regarding free and reduced-cost care to uninsured, underinsured, or indigent patients and shall provide ambulatory surgical services on a charitable basis to qualified persons consistent with the policy. The policy shall include, as applicable below, at a minimum:

(a) ***Determination of Eligibility for Charity Care or Financial Assistance.*** **Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital or ambulatory surgical facility shall make a determination of probable eligibility and notify the patient of that determination.**

(b) ***Notice of Charity Care and Financial Assistance Policy.*** **Public notice and information regarding the hospital or ambulatory surgical facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. This notice shall include general information about who qualifies and how to obtain a copy of the policy or may include a posted copy of the policy. Prior to a patient's arrival for surgery, the facility shall address any financial concerns of the patient, and individual notice regarding the facility's charity care policy shall be provided.**

(c) ***Criteria for Eligibility.*** **A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ambulatory surgical facilities described in these regulations. An ambulatory surgical facility, at a minimum, shall include the following eligibility criteria in its charity care policies:**

(i) Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge; and

(ii) Persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands.

(d) 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 reported in the

most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(e) A hospital shall be able to demonstrate that its historic level of charity care or its projected level of charity care is appropriate to the needs of its actual or projected service area population. This demonstration shall include an analysis of the socio-economic conditions of the hospital's actual or projected service area population, a comparison of those conditions with those of Maryland's overall socio-economic indicators, and a comparative analysis of charity care provision by the applicant hospital and other hospitals in Maryland. The socio-economic indicators evaluated shall include median income and type of insurance by zip code area, when available. The analysis provided may also include an analysis of the social determinants of care affecting use of health care facilities and services and the health status of the actual or projected hospital service area population.

(f) An applicant submitting a proposal to establish or expand an ambulatory surgical facility for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ambulatory surgical facilities in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

- **(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment;**
- **(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed; and**
- **(iii) If an existing ambulatory surgical facility has not met the expected level of charity care for the two most recent years reported to the Commission, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of its service area population.**

(g) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall make a commitment to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ambulatory surgical facilities, measured as a percentage of total ambulatory surgical facility expenses, in the most recent year reported. The applicant shall demonstrate that:

- **(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and**
- **(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.**
- **(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the**

applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant's Response

UM SHS provided a copy of the Financial Assistance Policy which states that "Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS must make a determination of probable eligibility." The determination of probable eligibility is subject to change, based on the receipt of supporting documentation. (DI #11, p. 3 and Exh. 30). Applicant indicates that the Financial Assistance Policy is posted on UM SMC Easton's website at https://www.umms.org/patients-visitors/umms-financial-assistance/policy-and-form. (accessed on 11/30/2023).

Applicant states that a copy of this policy is posted in its Emergency Department and the Admissions and Business Offices. (DI #3, p. 33). The hospital publishes annual notification of this policy in the following newspapers: *The Star Democrat (Talbot County), The Caroline County Times-Record, Kent County News, Dorchester Star, and The Bay Times and Record Observer (Queen Anne's County).* (DI #3, Exh. 9). The policy states that financial assistance is provided "to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their financial situation." (DI#11, Exh. 30). Financial counselors will assist individuals in the preparation and filing of documentation required to seek charity care at the hospital. (DI #3, p. 33).

UM SHS references the response to COMAR 10.24.10.04A(2), and states that the Financial Assistance Policy "complies with applicable state statutes and HSCRC regulations regarding charity care and financial assistance policies." (DI #3, p. 33). (supra, pp. 15-16). The policy indicates the hospital will utilize the following sliding scale for patients who meet the following financial criteria. (DI #11, Exh.30, p. 2).

I. Free Care – Those with income up to 200 percent of the income eligibility limits established by the Maryland Department of Health are eligible for free care.
II. Reduced Cost Care – Those between 200 percent and 300 percent of the income eligibility limits established by the Maryland Department of Health are eligible for discounts on a sliding fee scale.
III. Financial Hardship – Those who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom their medical debt incurred at all UMMS member organizations exceeds 25 percent of the Family Annual Household Income, are eligible for financial hardship assistance.

UM SHS also states that payment plans will be made available to all patients and if requested, modifications to the payment plan. (DI #11, Exh 30, p. 2).

The applicant reported that the HSCRC's FY 2020 Community Benefit Report indicates that UM SMC Easton fell within the third quartile of hospitals, providing 1.34 percent in charity care as compared to total operating expenses. (DI #3, pp. 33-35). A total of 45 hospitals were included in this report with the average charity care percentage of 1.94% for FY 2020, ranging from a high of 6.2% at Garrett County Memorial Hospital to a low of 0.0% at McCready

Foundation, Inc. The applicant's percentage of charity care does not fall in the fourth or bottom quartile for these 45 hospitals for FY 2020.

The applicant submitted an update with the FY 2022 HSCRC's Maryland Hospital Community Benefit Report for the current information on UM SMC Easton's charity care performance.[29] (DI #31, pp. 4-5.). For this year, the applicant's percentage of charity care compared to total operating expenses has increased to 1.89%. While UM SMC Easton remained in the third quartile, based on 45 hospitals who are included in this report, the increase in charity care percentage moved the applicant to first in this quartile. The average percentage for these 45 hospitals in FY 2022 was 1.99%, ranging from a high of 6.26% at Holy Cross Hospital to a low of 0.39% at Grace Medical Center.

In addressing the socio-economic conditions of its service area population, applicant provided information on the percentage of persons living in poverty and the percentage of the population who are Medicaid recipients or have no insurance in its five-county service area compared to the Maryland average. (DI #31, pp. 1-2). Regarding the percentage of persons living in poverty, the applicant stated that the level of poverty was slightly higher for residents in Dorchester (15.0%), Caroline (13.5%), and Kent (12.0%) Counties as compared to the Maryland average of 10.3%.[30] Conversely, the percentage of poverty was slightly lower in Talbot (9.4%) and Queen Anne's (8.0%) Counties.

As for the percentage of the population who are Medicaid recipients, the applicant stated that four of the five counties in its service area, which it identified as Caroline (32.4%), Dorchester (32.1%), Kent (21.9%), and Talbot (18.4%) had a higher percentage of recipients enrolled in Medicaid compared to the Maryland average (18.1%), with Queen Anne's the only jurisdiction that was lower (at 14.7%).[31] (DI #31, Table 112, p. 2). As for residents with no insurance, UM SMC Easton indicated that Caroline County had 6.2% with no insurance compared to the Maryland average of 5.9%, with the residents in Dorchester, Kent, Queen Anne's, and Talbot Counties at levels that fall below the state average, ranging from 4.1% to 4.9%. (DI #31, Table 112, p. 2).

Applicant states that UM SMC Easton five county service area faces a significant number of health disparities that include geographic isolation, lower socio-economic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. (DI #31, pp. 2-3). These health disparities are compounded by such factors as limited public transportation options and fewer choices to acquire healthy food.

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[29] Available at: https://hscrc.maryland.gov/Documents/CommBen/FY%202022%20Final%20State%20Reports/HCB%20FY22%20Statewide%20Report%20Final%209-27-23.pdf (Accessed December 20, 2023).

[30] Source: DI #31, Table 111, p. 2, from U.S. Census Bureau, available at: https://www.census.gov/quickfacts/fact/table/US.

[31] Source: DI #31, Table 112, p. 2, from TownCharts, available at: https://www.towncharts.com/Maryland/Maryland-state-Healthcare-data.html, Data quoted from Figure 13 on the page for each county and Maryland.

Applicant states that the unique socio-economic needs of its rural service area population are addressed by identifying high priority community health needs and offering outreach programs designed to target such needs. (DI #31, pp. 3-4). The applicant indicates that it works in partnership with public sector agencies, health care providers, and community-based partners on a variety of community activities that promote health equity in the community it serves and that it seeks to increase the trust in communities that may have been marginalized in the past and may have long-standing distrust of the health care delivery system. The applicant states that it collaborates with local health departments, behavioral health agencies, Opioid Tasks Force, Chambers of Commerce, and faith-based organizations that work to improve the quality of life for the residents of the Eastern Shore. (DI #31, pp. 3-4).

Staff Analysis

UM SHS shows that the hospital's historical and projected level of charity care is appropriate to the needs of its service area population as demonstrated in its response to COMAR 10.24.01.04A(2)(b). (DI #3, pp. 34-35). The FY 2020 HSCRC Community Benefit Report indicated that UM SMC Easton provided 1.34 percent charity care (about $2,913,105) of total operating expenses, which was in the third quartile of all Maryland hospitals reported. (DI #3, Table 3, p. 34). The other health care institutions reported in the third quartile included such institutions as Frederick Memorial Hospital (1.63%), Suburban Hospital (1.53%), Meritus Medical Center (1.32%) and University of Maryland institutions such as UM Upper Chesapeake Medical Center (1.44%), UM Shore Regional Health Chester River (1.43%), and University of Maryland Medical Center (1.26%).

UM SMC Easton reviewed the FY 2022 HSCRC Community Benefit Report[32] as an update on the applicant's performance in providing charity care at levels that comply with this standard and found that UM SMC Easton has increased the amount of charity care from FY 2020 to 1.89% (about $4,379,000) in FY 2022. When compared with the eleven hospitals in the University of Maryland Medical System, the FY 2022 report indicates UM SMC Easton ranked third behind the University of Maryland Capital Region Health at 2.85% and University of Maryland Shore Medical Center at Chestertown at 2.43%; the report also indicates the University of Maryland Shore Medical Center at Dorchester provided 1.37% charity care.

Table IV-31 below is an analysis of a number of socio-economic factors that compares the State of Maryland with the population that reside in UM SMC Easton's five county service area. Using the 2018-2022 American Community Survey (ACS) 5-year estimates from the Maryland Department of Planning's Maryland State Data Center, staff compared a number of factors which included the total number of residents, their employment status, median and mean household income, health insurance coverage, and the percentage of families and people whose income is below the poverty level.

[32] Available at:chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://hscrc.maryland.gov/Documents/CommBen/FY%202022%20Final%20State%20Reports/HCB%20FY22%20Statewide%20Report%20Final%209-27-23.pdf. (accessed on December 20, 2023).

Table IV-31: UM SMC Easton Socio-Economic Analysis - Health Service Area

	Maryland	UM SMC Five County Service Area					
		Caroline	Dorchester	Kent	Queen Anne's	Talbot	Total
Total Population	**6,161,707**	**33,320**	**32,557**	**19,289**	**50,316**	**37,663**	**173,145**
Male	3,002,896	16,414	15,261	9,215	25,045	18,023	83,958
Female	3,158,811	16,906	17,296	10,074	25,271	19,640	89,187
Employment Status							
Population 16 years and over	4,957,297	26,411	26,687	16,670	40,905	31,651	142,324
In Labor Force	3,331,958	16,808	15,877	9,679	27,224	17,654	87,242
Income and Benefits (in 2022 Inflation-Adjusted Dollars)							
Total households	2,318,124	12,013	13,216	8,375	19,351	16,270	69,225
Median household income ($)	$98,461	$65,326	$57,490	$71,635	$108,332	$81,667	$76,890
Mean household income ($)	$129,642	$90,691	$80,396	$98,025	$134,896	$119,018	$104,605
Health Insurance Coverage							
Civilian non-institutionalized population 19 to 64 years	6,070,969	32,946	32,203	18,878	49,925	37,264	171,216
With health insurance coverage	5,710,484	30,701	30,513	18,070	47,404	35,640	162,328
With private health insurance	4,478,259	19,087	18,641	13,631	38,352	26,349	116,060
With public coverage	2,061,645	16,383	17,681	8,420	17,463	17,877	77,824
No health insurance coverage	360,485	2,245	1,690	808	2,521	1,624	8,888
Percentage of Families and People whose Income in the past 12 months is below the Poverty Level							
All Families	6.20%	9.80%	8.70%	5.10%	3.70%	6.30%	6.72%
All People	9.30%	12.90%	15.40%	9.50%	6.90%	9.30%	10.80%

Source: U.S. Census Bureau, 2018-2022 American Community Survey 5-year Estimates
Available at: Maryland Department of Planning, Maryland State Data Center, at: https://planning.maryland.gov/MSDC/Pages/american_community_survey/2018-2022ACS.aspx (Accessed 12/21/2023).

The population in the applicant's five county service area (173,145) represents about 2.8% of Maryland's total population. About 82.2% of the population age 16 years and over in the applicant's service area are employed, compared to only 80.5% for Maryland. Conversely, the median household income ($98,461) and mean household income ($129,642) for Maryland residents is higher when compared to UM SMC's service area ($76,890 and $104,605 respectively), though the residents of Queen Anne's County are outliers and are comparably higher than the State.

The ACS 5-year estimates indicate with regard to the civilian population age 19 to 64 years, that approximately 5.2% of residents in the applicant's service area (8,888 people) do not have health insurance coverage, which is a lower percentage when compared to the 5.9% of residents of Maryland (360,485). Finally, the table indicates that with regard to the population who reside in the applicant's service area. that the percentage of families and people whose income is below the poverty level is a little higher when compared to Maryland residents.

Overall, the ACS estimates indicate that the residents of the applicant's service area have higher employment rates compared to the State as a whole, and as a result of their employment, have access to health insurance at a rate that is higher than Maryland residents. In contrast, the median and mean household incomes are significantly higher for Maryland residents as a whole, with the exception of Queen Anne's County residents, compared to the residents in the applicant's service area. The poverty levels of 6.7% for families and 10.80% for the overall population who reside in the applicant's service area indicate that UM SMC Easton has higher rates of poverty compared to the state as a whole and would need higher rates of charity care.

As previously discussed, the percentage of charity care provided by UM SMC Easton in FY 2022 was 1.9%, which placed the hospital within the third quartile of 45 hospitals reported on HSCRC's Hospital Community Benefit report. The applicant has increased the percentage and dollar amount of charity care provided to the people who reside in its five-county service area. These residents have median and mean household incomes that are lower, and there is a higher number of families and people who fall below the poverty level in the applicant's service area as compared with the State of Maryland.

Based on UM SHS's response to Paragraphs (a) through (e), UM SMC Easton has increased the amount of charity care provided from $2.9 million in FY 2020 to $4.4 million in FY 2022, an increase of about 51.7%. The applicant has submitted documentation of its Financial Assistance Policy including its sliding fee scale and evidence of its efforts to provide a level of charity care that is appropriate to the needs of its service area population. Staff finds that UM SMC Easton has improved and meets the level of charity care for the population who reside in its five-county service area.

Staff concludes that subparts (f) and (g) are not applicable and that the applicant complies with this standard.

(4) Quality of Care. A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health.

(b) A hospital shall document that it is accredited by the Joint Commission or other accreditation organization recognized by the Centers for Medicare and Medicaid and the Maryland Department of Health as acceptable for obtaining Medicare certification and Maryland licensure.

Applicant Response

Applicant referenced the response to COMAR 10.24.10.04A(3)(a) - Quality of Care standard. (supra, p. 16-18). UM SMC Easton is licensed by the Maryland Department of Health and accredited by the Joint Commission. (DI #3, Exh. 10 and 11).

(c) An existing ambulatory surgical facility or ASC shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs;

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation organization recognized by the Centers for Medicare and Medicaid Services as acceptable for obtaining Medicare certification; and

(iii) A provider of quality services, as demonstrated by its performance on publicly reported performance measures, including quality measures adopted by the Centers for Medicare and Medicaid Services. The applicant shall explain how its ambulatory surgical facility or each ASC, as applicable, compares on these quality measures to other facilities that provide the same type of specialized services in Maryland.

(d) An applicant seeking to establish an ambulatory surgical facility shall:

(i) Demonstrate that the proposed facility will meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment;

(ii) Agree that, within two years of initiating service at the facility, it will obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities or another accreditation organization recognized by the Centers for Medicare and Medicaid Services as acceptable for obtaining Medicare certification and approved by the State of Maryland; and

(iii) Acknowledge in writing that, if the facility fails to obtain the accreditation in subparagraph (ii) on a timely basis, it shall voluntarily suspend operation of the facility.

(e) An applicant or a related entity that currently or previously has operated or owned one or more ASCs or ambulatory surgical facilities in or outside of Maryland in the five years prior to the applicant's filing of an application to establish an ambulatory surgical facility, shall provide details regarding the quality of care provided at each such ASC or ambulatory surgical facility including information on licensure, accreditation, performance metrics, and other relevant information.

Applicant's Response

UM SMC Easton is not an ambulatory surgical facility, subparagraphs (c) through (e) of this standard is not applicable.

Staff Analysis

Staff has reviewed documentation submitted for (a) and (b) that shows UM SMC Easton's license is in good standing and it has achieved Joint Commission accreditation. Staff concludes subparts (c) through (e) are not applicable and that applicant complies with this standard.

(5) Transfer Agreements.

(a) Each hospital shall have arrangements for transfer of surgical patients to another hospital that comply with the requirements of Health-General Article §19-308.2.

Applicant's Response

Applicant submitted a number of patient transfer agreements with other acute care hospitals. UM SHS transfer agreements are with the following hospitals: University of Maryland Medical Center (Baltimore); Peninsula Regional Medical Center (Salisbury); and Alfred I. DuPont Hospital for Children of the Nemours Foundation (Wilmington, DE). (DI #3, Exhibit 17).

(b) Each ambulatory surgical facility shall have a process for assuring the emergency transfer of surgical patients to a hospital that complies with the requirements of COMAR 10.05.05.09.

Applicant's Response

UM SMC Easton is not an ambulatory surgical facility, subpart (b) of this standard is not applicable.

Staff Analysis

Staff reviewed the submitted transfer agreements and concluded that applicant complies with subpart (a) of the standard, and subpart (b) is not applicable.

COMAR 10.24.11.05A — Project Review Standards.

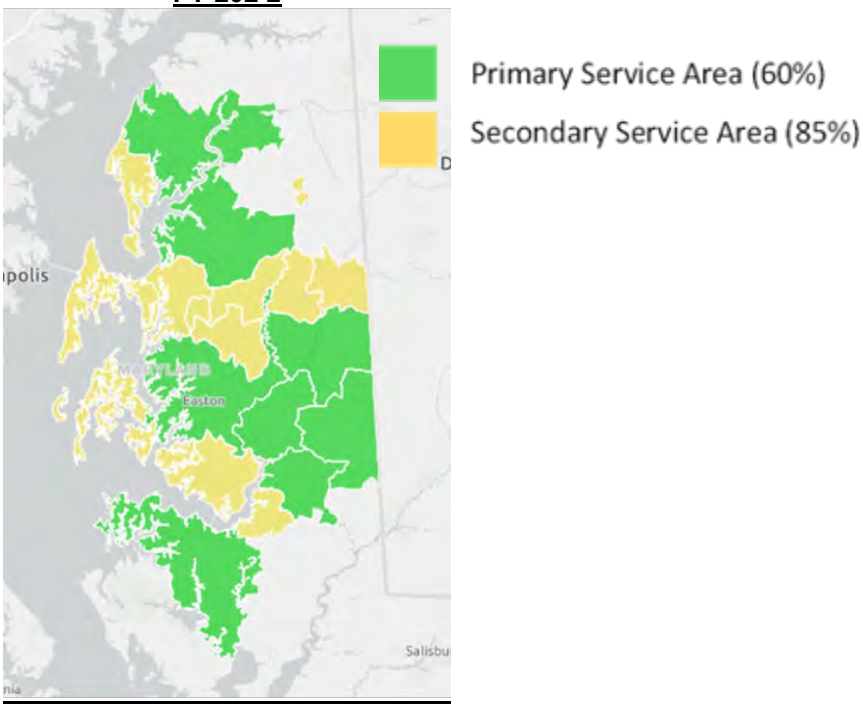
The standards in this regulation govern reviews of Certificate of Need applications involving surgical facilities and services. An applicant for a Certificate of Need shall demonstrate consistency with all applicable review standards.

(1) Service Area. An applicant proposing to establish a hospital providing surgical services or an 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's Response

UM SHS states that UM SMC Easton's surgical service area is defined based on the zip codes from which 85 percent of the surgical cases performed at UM SMC Easton and UM SMC Dorchester originated in FY 2022. This service area includes zip codes in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. (DI #3, pp. 122-123). A map of UM SMC Easton's primary and secondary surgical service areas is included below.

Figure 3 UM SMC Easton's Primary &Secondary Surgical Service Areas FY 202 2



Source: DI #3, Figure 5, p. 123.

The applicant states that it "does not anticipate that the relocation of the hospital will change its surgical service area." (DI #3, p. 122).

Staff Analysis

The applicant's defined service area for UM SMC Easton surgical services includes zip codes in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. The applicant bases this service area on where 85 percent of the surgical cases performed at UM SMC Easton originated in FY 2022. The applicant does not expect that this five-county service area will change with the hospital relocation. Staff concludes that the applicant complies with this standard.

(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 .06 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 .06 of this Chapter.

(c) An applicant proposing to establish or replace a hospital shall submit a needs assessment that includes:

(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 the relocation.

(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's Response

Applicant states that UM SMC Easton currently operates with six (6) mixed-use, general purpose operating rooms and is proposing seven mixed use, general purpose ORs at the new

facility.[33] UM SHS indicates that the surgical suites at UM SMC Easton are too small to accommodate complex surgical procedures and equipment and are in need of replacement. (DI #3, p. 121). Applicant states that while the six existing ORs meet the minimum FGI standards required for operating rooms of 400 SF per room, the actual usable space is far less. The shape of two of the existing ORs reduces the amount of usable space.[34]

The applicant further states that most surgeries performed laparoscopically are now performed with the use of surgical robots, which require a significant amount of space within the OR. The existing hospital ORs are insufficient to accommodate the volume of surgeries using robotic equipment. While UM SHS Easton renovated two existing ORs to accommodate the large robotic equipment, the applicant states that the increased volume of robotic surgical procedures in specialties such as urology, general surgery, gynecology, neurosurgery, and orthopedics has created scheduling problems and limits the hospital's flexibility for all ORs. (DI #3, p 121). Historically, all ORs could accommodate any type of surgery, but advancement of surgical techniques that increasingly rely on robotic equipment limits which ORs can be used to perform certain surgical cases.

UM SHS states that the proposed new hospital is designed to accommodate seven (7) new mixed-use, general purpose ORs. The applicant states that "each of the ORs in the replacement hospital will be sized appropriately to accommodate the needs of modern surgical delivery and current industry standards." (DI #3, p. 121). Each of the proposed ORs will meet the FGI minimum size standard for ORs of 600 SF minimum clear floor area to accommodate surgical procedures that utilize robotic equipment.[35] (DI #16, p. 3). Applicant anticipates the newly designed ORs will provide versatility to accommodate robotic cases and will minimize scheduling and functional limitations as robotic surgery continues to expand.

Operating Room Need Assessment – Historical Utilization

Table IV-30 provides the historical surgical volumes from FY 2019 to FY 2022 at UM SMC Easton and UM SMC Dorchester (Cambridge) before Dorchester's October 2021 conversion to an FMF. (DI #11, p. 40). The applicant used the historical inpatient and outpatient surgical cases and minutes from the data reported in UM SHS Easton's electronic health records (EHR) system in this assessment.

In calculating the need for operating rooms, COMAR 10.24.11.06A(2)(a) states that "when reliable information on average room turnaround time is not available from an applicant, it is assumed that an average room turnaround time of 25 minutes can be achieved." Applicant states

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[33] UM SMC Dorchester had four mixed-use, general purpose operating rooms before converting to a freestanding medical facility (FMF) in October 2021, at which time the inpatient surgical cases were transitioned to UM SMC Easton. (Approved on April 18, 2019, Docket No. 18-19-EX006).

[34] Facility Guideline Institute (FGI) Guidelines for Design and Construction of Hospitals states "Each operating room shall have a minimum clear floor area of 400 square feet (sf)." Cited at Part 2.2-3.4.3.2(1) Operating Room space requirements, pp. 206-207, 2022 Edition.

[35] Id., "Operating rooms for image-guided surgery using portable imaging equipment or surgical procedures that require additional personnel and/or large equipment…have a minimum clear floor area of 600 sf with a minimum clear dimensions of 20 feet. Cited at Part 2.2-3.4.3.2(2).

that UM SMC Easton tracks its surgical turnaround times (TATs) through its EHR system and uses a 37-minute TAT assumption based on actual experience. The applicant used the historical turnaround times reported for FY 2019 through FY 2022 in assessing the number of ORs at optimal capacity for this four-year period. The applicant explains that the increase in UM SMC Easton's average TATs is a result of robotic surgery, which requires additional TAT to prepare the robotic equipment and protocols for the particular case. In addition, the applicant states there is significant processing time between cases for cleaning the robotic instruments. (DI #16, p. 3).

With the use of actual turnaround times ranging from 39 minutes in FY 2019 to 37 minutes in FY 2022, Table IV-32 shows UM SMC Easton's utilization based on optimal capacity was over 6.0 ORs for this time period. The applicant notes that UM SMC Easton experienced a decrease in the volume of surgical cases in FY 2020 and FY 2021 due to the impact of the COVID-19 pandemic. (DI #11, p. 38).

Table IV-32: UM SMC Easton and UM SMC Dorchester (Cambridge)
Historical Surgical Case Volume FY 2019 - FY 2022

Key	FY	2019	2020	2021	2022
	Operating Room Cases				
A1	Inpatient	1,494	1,204	1,085	957
A2	Outpatient	4,580	3,879	4,523	4,411
A	Total	6,074	5,083	5,608	5,368
	Operating Room Minutes per Case				
B1	Inpatient	121	118	130	123
B2	Outpatient	71	83	88	86
	Operating Room Minutes				
C1=A1 times B1	Inpatient	181,443	142,570	141,490	117,238
C2=A2 times B2	Outpatient	325,573	323,177	399,488	380,379
C	Total	507,016	465,747	540,978	497,617
	Turnaround Time (TAT) per Case (Minutes)				
D		39	38	36	37
	Total Turnaround Time (TAT) Minutes				
E=A times D	Total	236,886	193,154	201,888	198,616
	Total Operating Room Minutes plus TAT				
F=C plus E	Total	743,902	658,901	742,866	696,233
	Optimal minutes per OR				
G*		114,000	114,000	114,000	114,000
	Operating Rooms Needed at Optimal Capacity				
H=F/G	Total	6.5	5.8**	6.5**	6.1

Source: DI #11, Table 117, p. 39.
Historic surgical utilization volumes based on actual surgical cases and minutes reported from the hospital's Electronic Health Record system. (DI #11, pp. 38-39).
*COMAR 10.24.11.06A(1)(a), Assumption for mixed-use general purpose operating room optimal capacity is 1,900 hours per year (or 114,000 minutes per year).
** UM SHS states that the surgical utilization decreased in FY 2020 and FY 2021 due to the impact of the COVID-19 pandemic. (DI #11, p. 38).

UM SMC Easton has six ORs in service Monday through Friday from 7:45 am through 3:30 pm. During these normal hours, the hospital states that elective, urgent, semi-urgent, and emergent add-on cases are scheduled in the surgical suites. When necessary, the hospital offers extended operating hours from 3:30 pm to 7:00 pm in a reduced number of ORs to accommodate a patient or surgeon's schedule. The applicant also states surgeons have performed surgery during the weekends when they are not able to schedule cases during normal hours. (DI #11, pp. 42-43).

Operating Room Need Assessment – Projected Utilization

Tables IV-33 shows UM SMC Easton projected utilization during construction and Table IV-34 the first three years after completion, for FY 2023 through FY 2032. For the projected OR need assessment, applicant used a TAT time assumption of 37 minutes, which is based on the actual TAT time for FY 2022. (DI #11, p. 38). The applicant projects that the growth in UM SMC Easton surgical cases from FY 2023 through FY 2032 will be based on an annual population increase of 0.9 percent to 1.0 percent in UM SMC Easton's primary service area of Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. The applicant also includes the additional surgical case volumes that were formerly performed at UM SMC Dorchester in its projections. (DI #11, p. 40).

UM SHS states that the six mixed use general purpose ORs currently in use are highly utilized and often have had to extend their normal hours of operation to include extended weekdays and weekends to accommodate elective and urgent/emergent cases. (DI #11, p. 43). With the completion of construction and initiation of services, the applicant projects a need for seven ORs by the first year of operation in the replacement hospital. Applicant states the addition of a seventh OR at UM SMC Easton would provide sufficient surgical capacity to serve the physicians and population need for surgical services in its service area. The seven ORs will serve 41 surgeons, which include five general surgeons, one neurosurgeon, 15 obstetricians/gynecologists, two plastic surgeons, one podiatrist, one transplant surgeon, four urologists, and five vascular surgeons. (DI #11, Table 120, pp. 46-48).

Table IV-33: UM SMC Easton Projected Operating Room Need During Construction
FY 2023 - FY 2029

Key	FY	2023	2024	2025	2026	2027	2028	2029
	Operating Room Cases							
A1	Inpatient	965	974	982	991	1,000	1,010	1,019
A2	Outpatient	4,448	4,487	4,527	4,568	4,610	4,653	4,697
A	Total	5,414	5,461	5,509	5,559	5,610	5,663	5,717
	Operating Room Minutes per Case							
B1	Inpatient	123	123	123	123	123	123	123
B2	Outpatient	86	86	86	86	86	86	86
	Operating Room Minutes							
C1=A1*B1	Inpatient	118,239	119,268	120,326	121,412	122,529	123,676	124,856
C2=A2*B2	Outpatient	383,606	386,945	390,375	393,900	397,523	401,246	405,074
C	Total	501,844	506,213	510,701	515,312	520,052	524,923	529,930
	Turnaround Time (TAT) per Case (Minutes)							
D		37	37	37	37	37	37	37
	Total Turnaround Time (TAT) Minutes							
E=A*D	Total	200,303	202,046	203,838	205,678	207,570	209,514	211,512
	Total Operating Room Minutes plus TAT							
F=C + E	Total	702,147	708,259	714,538	720,991	727,621	734,436	741,422
	Optimal minutes per OR							
G*		114,000	114,000	114,000	114,000	114,000	114,000	114,000
	Operating Rooms Needed at Optimal Capacity							
H=F/G	**Total**	**6.2**	**6.2**	**6.3**	**6.3**	**6.4**	**6.4**	**6.5**

DI #11, Table 117, p. 39.

*COMAR 10.24.11.06A(1)(a), Assumption for mixed-use general purpose operating room optimal capacity is 1,900 hours per year (or 114,000 minutes per year).

Table IV-34: UM SMC Easton Projected Operating Room Need First Three Years after Project Completion FY 2030 - FY 2032

Key	FY	2030	2031	2032
	Operating Room Cases			
A1	Inpatient	1,029	1,039	1,050
A2	Outpatient	4,743	4,790	4,838
A	Total	5,772	5,829	5,888
	Operating Room Minutes per Case			
B1	Inpatient	123	123	123
B2	Outpatient	86	86	86
	Operating Room Minutes			
C1=A1*B1	Inpatient	126,069	127,316	128,599
C2=A2*B2	Outpatient	409,009	413,055	417,216
C	Total	535,078	540,371	545,815
	Turnaround Time (TAT) per Case (Minutes)			
D		37	37	37
	Total Turnaround Time (TAT) Minutes			
E=A*D	Total	213,567	215,680	217,853
	Total Operating Room Minutes plus TAT			
F=C + E	Total	748,645	756,051	763,668
	Optimal minutes per OR			
G*		114,000	114,000	114,000
	Operating Rooms Needed at Optimal Capacity			
H=F/G	**Total**	**6.6**	**6.6**	**6.7**

DI #11, Table 117, p. 39.

*COMAR 10.24.11.06A(1)(a), Assumption for mixed-use general purpose operating room optimal capacity is 1,900 hours per year (or 114,000 minutes per year).

Special Purpose Operating Room

The State Health Plan for General Surgical Services defines a "special-purpose operating room," as:

> "...a sterile operating room that is dedicated for a specific purpose or surgical specialty such as a caesarian-section operating room and in which space, equipment, or other factors limit its use to a narrow range of surgical procedures. [COMAR 10.24.11.07B(34)].

Currently, UM SMC Easton has two cesarean (C-section) operating rooms, however, one of the ORs is not operational because of an issue with medical gases that has not been addressed because of the expense of the repair. (DI# 31, p. 6). As a result of not being able to use the OR, UM SMC Easton has only reported having a single special purpose OR, which is used as a C-

section operating room.[36] The applicant proposes two special purpose ORs at the replacement hospital upon project completion.

To support the need for two C-section ORs, applicant states that a second C-section OR is necessary as a backup, so that one OR is always immediately available for an emergency cesarean delivery. (DI #29, p. 2). Applicant cites the American College of Obstetricians and Gynecologists (ACOG) that generally recommends a facility have the capacity to initiate emergency C-sections with a decision-to-incision time of 30 minutes or less.[37]

Applicant also references the SHP language that states "Optimal capacity for a special purpose operating room is best determined on a case-by-case basis, using information from an applicant regarding:

(i) The population or facility need for each special purpose operating room or both;
(ii) The documented demand for each special purpose operating room; and
(iii) Any unique operational requirements related to the special purpose for which the operating room will be used." [COMAR 10.24.11.06A(c)].

Unlike the need assessment used for mixed-use, general purpose ORs, there is no minimum volume capacity threshold for special purpose ORs. Applicant states that the need for having a second C-section OR at the replacement hospital is to improve patient safety and outcomes for patients who need an emergency C-section.

Historically, the applicant states that UM SMC Easton has had approximately 1,000 deliveries per year, which equates to approximately three to four deliveries per day on average. (DI #31, pp. 6-9). The clinical leadership at UM SMC at Easton and UMMS has determined that if the hospital delivered only 500 deliveries per year, that one C-section OR would be sufficient, however, with the historical 1,000 deliveries per year, one C-section OR would be inadequate to safeguard patient safety.

The applicant has documented experience of needing to perform more than one C-section within a four-hour period. From FY 2020 through FY 2022, UM SMC Easton documented the need to perform two or more C-sections on 24 occasions in FY 2020, and 17 occasions each in FY 2021 and FY 2022. (DI #29, p. 2). The applicant states that approximately one to two times per month, C-sections occur within hours of each other and that a second C-section OR is needed to minimize delay in accessing care and to prevent harm to patients. (DI #31, p. 8).

Further, the applicant states that the average time from provider decision to "in-room" for C-section cases performed in the main surgical services department OR was 37 minutes. The decision to OR time took 22 minutes longer than the same decision time for a C-section performed in the Labor and Delivery unit's C-section OR. (DI #29, pp. 3-4). In emergent cases such as uterine

[36]Chartbook of Maryland General and Special Hospital Facilities and Services Fiscal Year 2019, Table 17 Dedicated Cesarean Section Operating Rooms and Procedure Rooms by Hospital: Maryland Hospitals, June 1, 2019, p. 29: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/con_chartbook_md_gen_special_hospitals_20220930.pdf.
[37]Guidelines for Perinatal Care, Chapter 7 Intrapartum Care of the Mother, p. 267.

rupture, placental abruption, placenta previa, umbilical cord prolapse, and maternal cardiac arrest, the proximity of the C-section OR and timeliness of initiation of surgery is correlated with better infant and maternal outcomes. (DI #31, p. 7). The applicant states that a 22-minute delay could make a difference between a favorable and unfavorable outcome. The consensus in the Guidelines for Perinatal Care is that a C-section should be performed within 30 minutes of the decision. (DI #31, p. 7).

Applicant states the replacement hospital will locate the general surgical ORs on the second floor, while the Labor & Delivery Unit will be located on the third floor. The proximity of the C-section ORs to the Labor & Delivery Unit at UM SMC Easton is pivotal, since "the additional prep and transport time to await for an elevator and move the inpatient between floors to initiate an emergency C-section critically extends the time frame to initiate the procedure beyond the 30-minute or less recommended window." (DI #31, p. 8).

Applicant provided the historical utilization for UM SMC Easton's C-section OR in Table IV-35. While UM SMC Easton currently operates with one special purpose, C-section OR, the situation has not been ideal. Applicant states that UM SMC has had to manage the timing of patients' labor, and in some instances delaying induction and labor to navigate the availability of a single C-section OR. (DI #31, p. 8). The applicant states that it must take these steps to manage labor so that only a single patient needs the C-section OR at a time. UM SMC Easton does not intend to continue operations with the current limitations at the proposed replacement hospital, as it is not ideal for patient safety.

Table IV-35: UM SMC Easton
Historical C-Section OR Surgical Case Volume
FY 2019 - FY 2022

Key		2019[38]	2020	2021	2022
A	C-Section OR Cases	263	210	205	208
B	OR Minutes per Case	68	67	68	82
C = A * B	OR Minutes per Case	17,884	14,070	13,940	17,056
D	Turnaround time (AT) per Case (minutes	35	45	45	45
E = A * D	Total TAT Minutes	9,205	9,405	9,225	9,300
F = C + E	Total OR & TAT Minutes	27,089	23,520	23,165	26,416
G	**C-section Operating Room Need**	**2.0**	**2.0**	**2.0**	**2.0**

Source: DI #29, p. 3, Table 48.

As the only acute care provider in the five-county service area that performs C-sections, the applicant underscores the need for UM SMC Easton to have immediate availability of a C-section OR for emergencies. The applicant indicates that there must be adequate capacity at UM SMC Easton to serve the population and to meet the needs of mothers who require emergent C-sections to protect their own lives and that of their babies. (DI #31, p. 8).

Applicant projects C-section OR need from FY 2023 through FY 2029 in Table IV-36, and for the first three years after project completion for FY 2030 through FY 2032 in Table IV-37.

[38] MHCC's Chartbook of Maryland General and Special Hospital Facilities and Services Fiscal Year 2019 states that UM SMC Dorchester did not operate with a C-section OR at this hospital in 2019. Chartbook of Maryland General and Special Hospital Facilities and Services Fiscal Year 2019, Table 17 Dedicated Cesarean Section Operating Rooms and Procedure Rooms by Hospital: Maryland Hospitals, June 1, 2019, p. 29: Available at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/con_chartbook_md_gen_special_hospitals_20220930.pdf.

Table IV-36: UM SMC Easton
Projected C-Section Surgical Case Volume During Construction
FY 2023 - FY 2029

Key		2023	2024	2025	2026	2027	2028	2029
	Growth in C-Sections	0.5%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
A	C-Section OR Cases	209	211	212	214	216	217	219
B	OR Minutes per Case	82	82	82	82	82	82	82
C = A * B	OR Minutes per Case	17,139	17,274	17,410	17,547	17,685	17,824	17,964
D	Turnaround time (AT) per Case (minutes	45	45	45	45	45	45	45
E = A * D	Total TAT Minutes	9,406	9,480	9,554	9,629	9,706	9,781	9,858
F = C + E	Total OR & TAT Minutes	26,545	26,754	26,964	27,176	27,390	27,605	27,822
G	**C-section Operating Room Need**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**	**2.0**

Source: DI #29, p. 3., Table 48.

Table IV-37: UM SMC Easton C-Section Need Based on Projected Surgical Case Volume
First Three Years after Project Completion FY 2030 - FY 2032

Key		2030	2031	2032
	Growth in C-Sections	0.8%	0.8%	0.8%
A	C-Section OR Cases	221	223	224
B	OR Minutes per Case	82	82	82
C = A * B	OR Minutes per Case	18,105	18,247	18,391
D	Turnaround time (AT) per Case (minutes	45	45	45
E = A * D	Total TAT Minutes	9,936	10,014	10,092
F = C + E	Total OR & TAT Minutes	28,041	28,261	28,483
G	**C-section Operating Room Need**	**2.0**	**2.0**	**2.0**

Source: DI #29, p. 3, Table 48.

Staff Analysis

For FY 2023 through FY 2032, the applicant projects that the average number of surgical minutes and the TATs will remain constant. The OR need assessment shows an annual increase of approximately 1.0 percent in surgical case volume during this ten-year period. If the mixed-use general purpose ORs operate at optimal capacity, Shore's need assessment supports 6.6 ORs by FY 2030, with utilization increasing to 6.7 ORs by FY 2032, and seven ORs upon project completion.

Staff reviewed applicant's data to support the need for UM SMC Easton to have two special purpose ORs for C-sections at the replacement hospital and believes it is reasonable. For the period FY 2029 through FY 2032, the applicant projects that the average number of surgical minutes and for TATs will remain constant. The applicant projects a small annual increase in C-section volumes. Applicant's rationale for having a second C-section OR available aligns with ACOG recommendations that a facility have the capacity to initiate emergency C-sections with a decision-to-incision time of 30 minutes or less to improve patient safety and outcomes for both the infant and the mother. The physical location of the two C-section ORs in the Labor and Delivery unit will also contribute to improved patient outcomes.

The projected utilization supports the need for two C-section ORs. Staff assessment is that UM SHS has demonstrated the need for seven ORs in the relocated surgical services department and for two special purpose, C-section ORs in the Labor & Delivery Unit. Staff concludes that the applicant complies with this standard.

(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 .06 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 .06 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's Response

UM SHS states the standard is not applicable, UM SMC Easton is not proposing to expand the number of operating rooms at an existing facility.

Staff Analysis

Staff concludes that this standard is not applicable.

(4) Design Requirements. Floor plans submitted by an applicant must be consistent with the current FGI Guidelines:

(a) A hospital shall meet the requirements in current Section 2.2 of the FGI Guidelines.

(b) An ambulatory surgical facility shall meet the requirements in current Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ambulatory surgical facility 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's Response

UM SHS submitted a letter from Emily Dickinson, AIA, from the architectural firm HKS confirming that the architectural design of the operating rooms suite at UM SMC Easton complies with Section 2.2 of the FGI Guideline. (DI #3, Exh. 18).

Staff Analysis

Staff concludes that the applicant complies with this standard.

(5) Support Services. Each applicant seeking to establish or expand an ambulatory surgical facility shall provide or agree to provide laboratory, radiology, and pathology services as needed, either directly or through contractual agreements, in compliance with COMAR 10.05.05.

Applicant's Response

This standard is not applicable, the applicant does not propose to establish or expand an ambulatory surgical facility.

Staff Analysis

Staff concludes that this standard is not applicable.

(6) Patient Safety. The design of proposed 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's Response

UM SHS references the response to COMAR 10.24.10.04B(12) - Patient Safety, (supra, pp. 40-41) and adds that patient safety has been a central focus of many design decisions in the surgical department, from the operating rooms, perioperative to the support spaces. (DI #11, p. 48). Applicant states the following considerations went into the design of the surgical services department:

> A critical early decision was to create space to accommodate flexibility in equipment and technology to support safe patient movement and care. The ORs are approximately sized to allow for safe movement of the care team and equipment around the patient. The ORs are designed to be standardized and oriented in the same way to reduce errors. Anesthesia support spaces are integrated within the surgical suite to enable quick response times and staff teaming areas near care delivery zones (to) encourage communication. ORs will have American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE)-compliant ventilation, filtration, and environmental control. Ceilings will be a pre-manufactured specialized OR air system. All ORs will have resinous floors to reduce damage to the flooring material and reduce infection risk. All ORs will have patient lifts for safe transfer of patients. Additional airborne infection isolation rooms in perioperative areas provide safe accommodation for infectious patients. Updated equipment and electrical infrastructure facilitates appropriate lighting, audio-visual integration, and power supply for equipment to deliver care in complex cases in an effective manner. Attention will be paid to finishes and acoustic design to reduce noise-related stressors for patients and staff.

For the two special purpose ORs, the applicant states that the Chair of the OB/GYN Department, Manager of the Labor and Delivery Unit, Chief Nursing Officer, and the Director of Surgical Services were included in the design and planning for these two rooms. (DI #29, p. 5-6). The applicant states:

> The two cesarean ORs are designed to meet standards as outlined in American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Guidelines for Perinatal Care, 8th Edition, as well as Guidelines for Design and Construction of Hospitals by The Facility Guidelines Institute (FGI). The operating suite is located within the Women's wing, allowing for immediate access for emergency cesarean deliveries from the labor & delivery

rooms, as well as immediately adjacent to a trauma elevator with direct connection to the Emergency Department (ED) for patients presenting at the ED. Within the suite, the two ORs are supported with dedicated prep/recovery bays and support spaces to create a self-sufficient suite fully supportive of anesthesia, nursing, and physicians. Prep/recovery bays are located with nursing support space for direct observation of patients preparing for planned surgeries and recoveries of both planned and emergent surgeries. Support alcoves in the controlled zone of the suite allow for quick access to hemorrhage medications, sterile supplies, and specialty equipment such as a difficult airway cart. Provisions for family support in both prep/recovery and the OR allow for direct communication between the care team, patient, and birthing partner as well as provide safe and dedicated location(s) for the birthing partner in the OR.

UM SMC Easton states that the location of the two cesarean ORs within the Labor and Delivery unit at the replacement hospital will allow for immediate and timely access and the safe transfer from recovery bays to a postpartum room. (DI #29, p. 5).

Staff Analysis

UM SHS has considered patient safety in the design for the seven ORs in the general surgical services department and for the two special purpose ORs in the Labor and Delivery unit for both the patients and medical staff. Key design features, such as standardized spaces, co-location of necessary support spaces and supplies for quick access and response, as well as provisions for family support are all features that address patient safety. Staff concludes that patient and surgical staff safety was a priority in the design and concludes that applicant complies with this standard.

(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 adjustment of the hospital's global budget revenue authorized for 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.

Applicant Response

UM SHS references the response to COMAR 10.24.10.04B(7) – Construction Cost of Hospital Space in the Acute Care Chapter of the State Health Plan. (supra, pp. 34-37).

Staff Analysis

Staff concludes that the applicant complies with this standard.

(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 25% 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's Response

This standard is not applicable, UM SMC Easton is an existing hospital and does not operate as an ambulatory surgery facility.

Staff Analysis

Staff concludes that this standard is not applicable.

(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 hospital or ambulatory surgical facility will generate excess revenues over total expenses for the specific services affected by the project (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

UM SHS references the response to COMAR 10.24.10.04B(13) – Financial Feasibility in the Acute Care Chapter of the State Health Plan. (supra, pp. 41-44).

Staff Analysis

Staff concludes that the applicant complies with this standard.

(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 other practitioner;

(ii) A minimum of two years of historic surgical case volume data for each physician or other 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 other practitioners; 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 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 that hospital, 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 .06A of this Chapter and the operating room inventory rules in Regulation .06C of this Chapter shall be used in the impact assessment.

Applicant's Response

This standard is not applicable, UM SMC Easton is an existing hospital, does not operate as an ambulatory surgery facility and applicant does not seek to establish an ambulatory surgical facility. Further, the projected surgical cases and volumes will be performed by physicians with privileges at UM SMC Easton. The replacement hospital will not have an adverse impact on other hospital(s) within the defined service area of Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties.

Staff Analysis

Staff concludes that this standard is not applicable.

COMAR 10.24.09 - Specialized Health Care Services: Acute Inpatient Rehabilitation Services

COMAR 10.24.09.04A — General Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy.

(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 reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response

UM SHS references the response to COMAR 10.24.10.04A(2) – Charity Care Policy in the Acute Care Chapter of the State Health Plan. (supra, pp. 15-16). Applicant's Financial Assistance Policy applies to both acute care and rehabilitation services. (DI #3, p. 154).

Staff Analysis

Staff concludes that the applicant complies with this standard.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

Applicant Response

UM SHS stated that this subpart to the standard is not applicable, UM SMC is subject to HSCRC regulations.

Staff Analysis

Staff concludes that this subpart to the standard is not applicable.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported.

Applicant Response

UM SHS stated that this subpart to the standard is not applicable, UM SMC is not an HMO.

Staff Analysis

Staff concludes that this subpart to the standard is not applicable.

(2) Quality of Care. A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

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

Applicant Response

UM SHS references the response to COMAR 10.24.10.04A(3) – Charity Care Policy in the Acute Care Chapter of the State Health Plan. (supra, pp. 15-16). The applicant states that the Requard Center for Acute Rehabilitation (the Requard Center) is UM SMC Easton's acute inpatient rehabilitation, and it complies with all applicable accreditation and certification standards. The Requard Center also in compliance with the conditions of participation for Medicare and Medicaid programs. The applicant included copies of its license and of the most recent Commission for Accreditation of Rehabilitation Facilities (CARF) accreditation certificate. (DI #3, Exh 10, Exh. 20 and Exh. 31).

Staff Analysis

Staff concludes that the applicant provided documentation that complies with this standard.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

Applicant's Response

The applicant referenced its response to COMAR 10.24.10.04A(3)(b) – Quality of Care which discusses UM SMC Easton's performance on the Hospital Guide for Maryland Health Care Quality Report measures. (supra, pp. 16-18 and DI #11, p.58). The four quality measures requiring corrective action plans did not relate specifically to acute inpatient rehabilitation services.

In addition, the applicant states that the Requard Center is CARF accredited and attached the accreditation report. (DI #11, Exh. 31). The applicant states that CARF determined the Requard Center "…is recognized for providing quality services," and that it "demonstrates a commitment to ongoing quality improvement." (DI #11, Exh. 31, p. 4).

Staff Analysis

Staff reviewed exhibit 12 of the application and found the four quality measures requiring

corrective action did not relate to acute inpatient rehabilitation care. (DI #3, Exh. 12). Staff concludes the applicant complies with this standard.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

Applicant's Response

The applicant states that this subpart is not applicable. UM SMC Easton's Requard Center is an existing provider of inpatient rehabilitation services.

Staff Analysis

The applicant is an existing provider of inpatient rehabilitation services and staff concludes subpart (c) of the standard is not applicable.

COMAR 10.24.09.04B — Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

Applicant Response

The applicant referenced COMAR 10.24.10.04B(1) – Geographic Accessibility discussed

in the Acute Hospital Services SHP for this standard. (supra, pp. 18-20).

Staff Analysis

Applicant demonstrated that UM SMC Easton is the only acute hospital providing inpatient rehabilitation services to the residents of the service area, and that without the proposed 12 beds, planning region patients would lack sufficient access to necessary post-acute care. The applicant notes that the next closest inpatient rehabilitation facilities are Encompass Health Rehabilitation Hospital of Middletown, DE, which is located approximately 54 miles from the proposed project, and Encompass Health Rehabilitation of Salisbury, located approximately 58 miles away.

Staff reviewed applicant's response to COMAR 10.24.10.04B(1) and concludes applicant complies with the standard.

(2) Need. A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) **The project credibly addresses identified barriers to access; and**

(ii) **The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and**

(iii) **The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.**

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Applicant's Response

The applicant stated that UM SMC Easton is currently licensed to operate 20 special hospital rehabilitation beds in fiscal year 2023. However, UM SMC Easton's rehabilitation unit was reduced to 15 physical beds with the consolidation of UM SMC Dorchester. The applicant proposes to reduce the number of rehabilitation beds at UM SMC Easton to 12 beds. (DI#3, p. 158).

Table IV-38 shows the current licensed bed capacity on the Eastern Shore for acute rehabilitation beds of 84 beds. The projected 2026 gross acute rehabilitation bed need range for the Eastern Shore is 35 to 76 beds and the net need is -49 to -8. (DI#3, p. 158). The 12 acute rehabilitation beds planned for at the replacement hospital, combined with 64 beds at Encompass Health Rehabilitation Hospital of Salisbury (Encompass Salisbury) will result in a total of 76 licensed rehabilitation beds on the Eastern Shore. The 12 beds included in the proposed project will continue to provide access to inpatient rehabilitation services for Eastern Shore residents, while reducing the total number of licensed beds in the region by eight beds. The proposed project will result in a net decrease of eight licensed beds in the Eastern Shore planning region, which falls within the current regional need projection and will not exceed the most recent annual calculation of bed capacity seen in Table IV-38.

Table IV-38 MHCC 2026 Bed Need Projections for Acute Rehabilitation Beds Eastern Shore

Hospital	Current Licensed Bed Capacity	Gross Bed Need		2026 Net Bed Need	
		Minimum	Maximum	Minimum	Maximum
Shore	20	-	-	-	-
Encompass Salisbury	64	-	-	-	-
TOTAL	**84**	**35**	**76**	**-49**	**-8**

Source: Maryland Register, Volume 49, Issue 14, July 1, 2022.

The applicant states that it is necessary to maintain the proposed 12 acute inpatient rehabilitation beds to provide access to care for patients in UM SMC Easton's service area. UM SMC Easton is the only acute hospital providing inpatient rehabilitation services to the residents of the five counties comprising UM SMC Easton's rehabilitation service area. The only other rehabilitation beds serving the Eastern Shore are located at Encompass Health Rehabilitation Hospital of Middletown, DE approximately 54 miles away from the proposed project, and Encompass Salisbury, approximately 58 miles away. (DI # 3, pp. 166-7).

The applicant provided its acute rehabilitation bed need methodology and assumptions to support the need for 12 rehabilitation beds at the proposed replacement facility. The applicant defined UM SMC Easton's service area using rehabilitation discharges sorted by Zip Code. Applicant ranked the 21 Zip Codes from highest to lowest number of discharges to identify 85% of UM SMC Easton's rehabilitation discharges that spanned Talbot, Dorchester, Caroline, Queen Anne's and Kent counties. (DI#3, p. 159).

For the 21 ZIP Codes that comprise UM SMC Easton's service area, the applicant obtained population projections through 2027 from Environics Spotlight and used the information to extrapolate population growth through 2032. (DI#3, p. 161). All age cohorts are projected to increase with the largest increase in the older age cohorts, age 65 and above. The historical rehabilitation services use rates show decreases for multiple age cohorts, however the applicant attributes those decreases to the impact of the COVID-19 pandemic and related staffing shortages. The staffing issues limited the number of patients that could be admitted to the rehabilitation unit. (DI#3, p. 162). The applicant projects that its market share would remain constant at FY2022 levels by age cohort, and that as a result of the aging population that its market share would increase slightly, in aggregate, from FY2022 to 2032 (DI #3, p. 162, Table 74).

While the Applicant stated the assumptions resulted in a significant increase in rehabilitation discharges by over 46 percent from FY2022 to FY2032, the result is an average of an additional 8.8 patients per year in the 12-bed unit in this time period. (DI #3, pg. 163-164, DI #11, Table F). The applicant notes, however, the projected total result in FY2032 is still below the pre-pandemic volumes experienced between FY2019 and FY2021. The applicant stated that the pandemic led to unprecedented staffing challenges, which were particularly acute in FY 2021 and FY 2022, resulting in UM SMC Easton limiting unit admissions to no more than six patients per day. This led to the decline in admissions, average daily census, and average length of stay. (DI #3, pp. 163-165).

Staff Analysis

COMAR 10.24.09.03, the State Health Plan for Facilities and Services: Specialized Health Care Services — Acute Inpatient Rehabilitation Services policy section states:

> Due to recent and anticipated changes that may significantly alter the capacity required for acute inpatient utilization,[39] a need projection based on historic patterns should not be the sole factor used to determine whether additional acute inpatient rehabilitation capacity is required. In addition, the wide variation in the use of acute rehabilitation beds among HPRs [health planning regions] in Maryland suggests that there could be access barriers for some residents. Therefore, the possibility that access barriers are negatively affecting some Maryland residents should be considered as part of evaluating changes in the delivery system for acute inpatient rehabilitation.

[39]United States. Centers for Medicare and Medicaid Services. (2013, May 8). Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal year 2014; Proposed Rule. <http://www.gpo.gov/fdsys/pkg/FR-2013-05-08/html/2013-10755.htm>

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The applicant provided a need analysis based on historic utilization and demonstrated an access issue without the rehabilitation unit.

UM SMC Easton is licensed for 20 beds, but operationally reduced to 15 beds as a result of the consolidation with UM SMC Dorchester. (DI#3, p. 158). Applicant noted significant staffing issues during Covid-19 that limited UM SMC Easton's ability to accept patients. During that time period, the rehabilitation unit patient census was limited to 6 patients. However, applicant provided data that demonstrated staffing improvements that could handle increased patient volumes.

Applicant's proposed reduction in rehabilitation beds at the replacement hospital to 12 beds places the Eastern Shore health planning region within the Commission bed need projections. Table IV-32 shows a need for 76 total rehabilitation beds in the region. While the Eastern Shore HPR currently is an excess of inpatient rehabilitation beds at 84, the planned decrease to 12 beds will correct the oversupply. The applicant has also shown that maintaining beds at UM SMC Easton will ensure access for patients in its primary service area, who otherwise would be required to travel over 50 miles to the next nearest facility offering rehabilitation services.

Staff concludes that the applicant complies with the applicable portions of the standard and that subparts (d), (e) and (f) are not applicable.

(3) Impact. A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

Applicant's Response

UM SHS states that it is not proposing to add additional rehabilitation beds but will be reducing the number of physical rehabilitation beds by eight. The applicant states its need projections for rehabilitation services assume that patient volume will increase consistent with population growth, and that UM SMC Easton will maintain and slightly increase market share as a result of the aging demographics. (DI#3, p. 170). With fewer rehabilitation beds in the health

planning region, and higher use rates projected because of the aging population, the impact at other acute inpatient rehabilitation providers on patient volume, average length of stay, or case mix will be minimal or nonexistent. (DI#3, p. 170).

The applicant also states the project will not result in the reduction of the availability or accessibility of rehabilitation services. While the number of licensed beds at the replacement hospital will be less than are currently at UM SMC Easton, the reduction is based on the need projections from actual utilization of rehabilitation services in the service area. The applicant states that this project will right-size the number of beds needed in the service area. Additional detail is provided in COMAR 10.24.10.04B(4), applicant's response to the impact standard in the Acute Hospital Services SHP Chapter. (supra, pp. 25-29).

As an existing provider of rehabilitation services, the applicant's proposed project aligns bed capacity with the Commission's 2026 regional need projections. The applicant states that there should not be any reduction in the quality of care at other providers or any reduction in the ability of other providers to maintain its staffing levels.

Staff Analysis

Because the applicant is reducing the number of beds, the applicant estimates the impact of the proposed project on the patient volume, average length of stay, and case mix at other acute inpatient rehabilitation providers will be minimal or non-existent. Services will be maintained at an appropriate level for the service area and the project should not have an adverse impact on patient access, including for the uninsured, indigent or patients eligible for charity care. The applicant's charity care policy meets the requirements of the State Health Plan.

The minimal increase of seven FTEs for the rehabilitation unit should not have a major impact on other providers' ability to maintain their specialized staff needed to provide acute inpatient rehabilitation services. The closest alternate acute rehabilitation providers are approximately an hour away, and the replacement hospital is only maintaining the services it currently offers.

Staff concludes the applicant has provided sufficient information and supporting documents to show that it complies with this standard.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project 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. 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 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.

Applicant Response

The applicant referenced the response to COMAR 10.24.10.04B(7) - Construction Cost of Hospital Space in the Acute Care SHP in its response to this standard.

Staff Analysis

Staff concludes applicant complies with this standard.

(5) Safety. The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

Applicant Response

The applicant states that the acute rehabilitation unit design meets all safety related standards of The Joint Commission and CARF and will be consistent with requirements of ADA design. (DI#3, p. 171). Further, applicant states that environment of care/safety self-inspection rounds are performed on a semi-annual basis, and that these rounds will continue, per CARF requirements. Annual inspections by external authorities are also completed and will be continued. (DI#3, p. 171).

The applicant states that the replacement hospital will follow the design and safety features discussed in response to COMAR 10.24.10.04B(12) – Patient Safety of the Acute Care Hospital standards. (DI #3, p. 171). (supra, pp. 40-41).

Staff Analysis

As previously noted in the Acute Care Hospital Standards section, in addition to meeting the CARF requirements (DI #11 pg. 59), the applicant stated that the acute rehabilitation unit will include the following features:

- The private room and bathroom design reduces noise and chance of infection.
- One room on the unit is tailored to meet standards for individuals of size to provide an appropriate and safe environment of care for that patient population.
- The unit includes decentralized nursing stations to increase patient visibility.
- Rooms are also equipped for bedside documentation to increase nursing staffs' time with patients.
- Rooms include provisions for family space, to encourage and support both patient and family involvement in care.
- At the replacement hospital the activities of daily living (ADL) lab and gym will

be incorporated on-unit.

Staff concludes the applicant complies with the standard.

(6) 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 CON application must be accompanied by a statement containing each assumption used to develop the projections.

(a) Financial projections filed as part of a hospital CON 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 the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;**

(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 hospital or, if 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 expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.**

Applicant Response

The applicant referenced the response to COMAR 10.24.10.04B (13) – Financial Feasibility in the Acute Care SHP Chapter, (supra, pp. 41-44) in its response to this standard.

Staff Analysis

The applicant provided utilization, revenue estimates, and staffing projections as well as revenue and expense projections for the replacement hospital. The projections were reasonable, based on population and utilization projections across UM SMC Easton Shore, UM SMC Dorchester, and UM SMC Queenstown. As discussed in the HSCRC memo to the Commission,

the applicant's rationale for financial feasibility includes their $15 million efficiency goal savings by 2027 and a $24 million rate adjustment in 2029. In terms of staffing, the applicant projects a reduction of 98.7 FTEs by 2029 for the entire project. However, the rehabilitation service line is projected to have a 7.0 increase in FTEs by FY2032 due to the aging of the population and growth in patient volume. (DI #3, pg. 170).

Staff reviewed the financial projections provided by the applicant and requested an opinion by HSCRC on the feasibility of the proposed project. The replacement hospital projects positive operating margins after project completion. HSCRC's analysis (DI #22, p.6), which took into account the finances of UM SHS, UM SMC at Easton and UMMS as a whole, stated the project may be financially feasible if the hospital realizes a number of objectives outlined in the feasibility section of this report.

Staff concludes that the applicant complies with the standard.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

Applicant's Response

The new hospital's rehabilitation unit will have 12 beds, which is above 10 required in the standard. The State Health Plan chapter for acute inpatient rehabilitation services, COMAR 10.24.09.05D(5)(a) requires a minimum occupancy of 75 percent for facilities with an ADC of 0-49 patients. The applicant projects an average daily census of 8.8 patients at UM SHS Easton, which will meet the 75 percent minimum occupancy percentage in fiscal year 2029, and in the following years. (DI #3, p. 172, and DI #3, Exhibit 1, Table F).

Staff Analysis

Staff concludes that the applicant meets subpart (a) of the standard, and subpart (b) does not apply, UM SMC Easton is not a standalone inpatient rehabilitation specialty hospital.

(8) Transfer and Referral Agreements. Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

Applicant's Response

UM SHS states it has established written transfer agreements with other health care facilities to ensure the continuum of care for patients requiring transfer to another facility or entity due to the level of care required. Examples of patient transfer agreements with other facilities can be found in Exhibit 21 of the application. (DI #3, Exh. 21).

The applicant states that transfers of patients who exceed the unit's level of care capabilities fall into two categories: (1) patients whose acute care needs necessitate transfer to an acute care service; and (2) patients whose rehabilitation needs exceed the unit's level of care capabilities and so must be transferred to another rehabilitation facility. This would be for patient care such as new acute traumatic brain injury, new quadriplegics, new paraplegics, or multiple traumas with weight bearing limitations. The acute care hospitals to which such cases are transferred include University of Maryland Medical Center, and Johns Hopkins Hospital. There is also an acute rehabilitation hospital in the medical system to which patients are transferred for more intense rehabilitation, University of Maryland Rehabilitation and Orthopedic Institute (the former Kernan Hospital). The number of transfers based on the level of care provided in fiscal years 2017– 2022 are shown below in the table below.

Table IV-39 Patient Transfers Due to Exceeding the Care Capabilities at UM SMC Easton FY 2017–2022

Types of Cases	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Acute Care Transfers (Discharged from Rehab)	31	24	33	24	20	17
Specialized Rehab/Care (Admitted to Rehab then Transferred)	0	0	2	0	1	1

Source: DI #3, p. 173.

Staff Analysis

Staff has reviewed the written transfer agreements and concludes that the applicant complies with the standard.

(9) Preference in Comparative Reviews. In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

Applicant Response

This standard is not applicable.

Staff Analysis

This is not applicable, there are no other applicants and this is not a comparative review.

COMAR 10.24.21 - State Health Plan for Facilities and Services: Acute Psychiatric Services Standards

COMAR 10.24.21.04A — Procedural Rules - Docketing.

(1) The Commission shall not docket an application involving establishment of a special psychiatric hospital or changes to an existing special psychiatric hospital or psychiatric unit of a general hospital unless the applicant provides an affirmation, under penalties of perjury, that, within the last ten years:

- **(a) No current or former owner or senior manager of the hospital or of the hospital operator, or of any related or affiliated entity:**
  - **(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony; or**
  - **(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; and**
- **(b) Neither the hospital, its operator, nor a current or former related or affiliated entity:**
  - **(i) Has been convicted of a felony or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony;**
  - **(ii) Has received a determination of exclusion from participation in Medicare or State health care programs, with respect to a criminal conviction or civil finding of Medicare or Medicaid fraud or abuse; or**
  - **(iii) Has paid fines, penalties, or entered a monetary settlement that exceeds$10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charges or investigation relating to allegations of Medicare or Medicaid fraud or abuse.**
- **(c) The applicant may show evidence as to why this rule should not be applied if each individual involved in the allegations of fraud or abuse that resulted in the monetary settlement, fines, or penalties is no longer associated with the entity, or any of the related or affiliated entities, and each entity has fully complied with each applicable plan of correction and, if applicable, with each condition of the imposition of a civil penalty, monetary settlement, or agreed disposition.**

Applicant Response

The applicant provided the signed affirmation of Kenneth Kozel, MBA, FACHE, the President and Chief Executive Officer of Shore Regional Health, the sole corporate member of UM SHS. (DI#3. Exhibit 22).

Staff Analysis

The affirmation included all the requirements and staff concludes the applicant complies with the standard.

COMAR 10.24.21.04B — Procedural Rules - Acquisition.

Commission staff shall apply the following rules to a person or legal entity seeking to acquire a special psychiatric hospital pursuant to Health-General §19-120. If Commission staff finds non-compliance with these rules, it shall not approve the acquisition.

(1) Notice of Acquisition. A person or legal entity seeking to acquire a special psychiatric hospital shall provide the Commission with the notice required by COMAR 10.24.01.03A. The notice shall include:
  (a) The identity of each person with an ownership interest in the acquiring entity or a related or affiliated entity;
  (b) The percentage of ownership interest of each such person; and
  (c) The history of each such person's experience in ownership or operation of health care facilities.

(2) Information and Disclosures Required. A person or entity seeking to acquire a special psychiatric hospital shall:
  (a) Affirm that the services provided will not change as a result of the proposed acquisition;
  (b) Affirm that the commitment to Medicaid participation will not change as a result of the proposed acquisition and shall provide information on corporate structure and affiliations of the purchaser, purchase price, source of funds, and other relevant data as requested;
  (c) Affirm, consistent with Regulation .04A(1) of this Chapter, under penalties of perjury, that within the last ten years neither the acquiring entity, a related or affiliated entity, nor an owner or former owner, or member of senior management or management organization, or a current or former owner or senior manager of any related or affiliated entity has been convicted of felony or crime, or pleaded guilty, nolo contendere, entered a best interest plea of guilty, received a diversionary disposition regarding a felony or crime, and that neither the acquiring entity or a related or affiliated entity has paid a civil penalty or monetary settlement in excess of $10,000,000 that relates to an investigation regarding the ownership or management of a health care facility.

(3) Disqualification for Acquisition. Commission staff may deny an acquisition of a special psychiatric hospital if the acquiring entity, a related or affiliated entity, or an owner or former owner, or member of senior management or management organization, an

owner or member of senior management of a related or affiliated entity has, within the preceding ten years, been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, received a diversionary disposition regarding a felony or crime, or paid fines, penalties, or entered a monetary settlement that exceeds $10,000,000 with or without an admission or finding of guilt with respect to any criminal or civil charge or investigation relating to allegations of Medicare or Medicaid fraud or abuse, if staff concludes that that the proposed acquiring entity has not shown sufficient evidence why the acquisition should go forward, consistent with Regulation .04A(1)(c) of this Chapter and the public interest.

Applicant Response

This standard is not applicable; the applicant is not acquiring a Special Psychiatric Hospital.

Staff Analysis

Staff concludes the standard is not applicable.

COMAR 10.24.21.05A — General Standards.

An applicant for a Certificate of Need to establish acute psychiatric services shall address and meet the applicable general standards in COMAR 10.24.10.04A, in addition to the applicable standards in this Chapter.

Applicant response

The applicant responded to the applicable general standards in its response to COMAR 10.24.10.04(A). (supra, pp. 14-16).

Staff Analysis

Staff concludes the applicant complies with this standard.

COMAR 10.24.21.05B — Project Review Standards.

The standards in this section shall apply to Certificate of Need applications and exemption requests involving acute psychiatric services. An applicant for a Certificate of Need must address, and its proposed project shall be evaluated for compliance with all applicable review standards. An applicant for an exemption from Certificate of Need review must address, and its proposed project shall be evaluated for consistency with all applicable review standards.

(1) Geographic Accessibility. A site proposed for a new psychiatric hospital or relocation

of a psychiatric hospital shall optimize accessibility through minimizing travel time for the likely population to be served.

(a) Optimal travel time for adult acute psychiatric services is within 30 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region where the facility is located or will be located, has, or will have as a result of the proposed project, optimal travel time to acute psychiatric services or if the Commission determines that access will be substantially improved for the population in the applicant's likely service area through a reduction in travel time.

(b) Optimal travel time for adolescent and child acute psychiatric services is within 45 minutes under normal driving conditions. The geographic accessibility standard is met if 90 percent of the population in the health planning region where the facility is located, or will be located, has or will have as a result of the proposed project, optimal travel time to acute psychiatric services or if the Commission determines that access will be substantially improved for the population in the applicant's likely service area through a reduction in travel time.

Applicant Response

The applicant responded to this standard under COMAR 10.24.10.04(B)(1) – Geographic Accessibility. This standard requires an evaluation of whether a proposed project is located to optimize accessibility in terms of travel time for its likely service area population and defines optimal travel time as being within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area. The applicant defines its primary and secondary service area as Dorchester, Talbot, Caroline, Kent, and Queen Anne's counties. The calculation of the service area is based on adult psychiatric discharges and the service area is slightly different between acute care and psychiatric care. The applicant's methodology in the acute care standard on Geographic Accessibility shows that on aggregate, the travel time to the new site is less than the travel time to the existing hospital for individuals living within the primary and secondary service areas. (supra, pp. 18-20).

The applicant also discussed the psychiatric service area in the need standard that follows, and in Table IV-40. The applicant used the top 80 percent of 2022 discharges by ZIP code. The ZIP codes span Dorchester, Talbot, Caroline, Kent, and Queen Anne's counties. (DI #3, pp. 179-180). Of the 349 total discharges in 2022, Table IV-40 shows 280 discharges in the service area and 69 outside the service area. The applicant also looked at the geographic accessibility compared to other acute psychiatric inpatient options in the area in Table IV-6. (infra, p. 122).

Staff Analysis

The applicable subpart is (a) because the psychiatric program will only serve adults. Staff concludes that although the applicant's calculations show that 19.7% of the psychiatric discharges are outside the service area, this is an improvement to the travel times for the existing hospital as discussed in COMAR 10.24.10.04(B)(1) – Geographic Accessibility. Staff also concludes that for the majority of the service area the psychiatric program at UM SMC Easton is the closest inpatient option. Staff concludes that the applicant complies with the standard.

(2) Need for Acute Psychiatric Services.

(a) The Commission shall publish, at least every two years, regional projections for adults, children, adolescents, and the geriatric population using the methodology in Regulation .06 of this Chapter.

(b) The Commission shall publish at least every two years a needs determination for historically underserved populations for acute psychiatric services by region.

(i) The needs determination for historically underserved populations will be developed based on consideration of factors that include trends in acute psychiatric discharges, trends in hospital emergency department boarding, and needs assessments developed by local behavioral health authorities and State agencies that identify gaps in the mental health system.

(ii) Commission staff shall publish on its website a draft needs determination for historically underserved populations that includes the sources and assumptions used to develop the determination and request public comment regarding the draft determination. Staff shall also send the notice to each acute general hospital and special psychiatric hospital in Maryland. The Commission shall consider the comments and the Commission's staff's recommendations at a public meeting before establishing a needs determination for historically underserved populations that shall apply to a Certificate of Need review and to a request for exemption from Certificate of Need review for a project that involves acute psychiatric services.

(c) The Commission shall use the regional acute psychiatric hospital utilization projections and the needs determination for historically underserved populations to evaluate the need for a proposed new psychiatric hospital, the proposed introduction of psychiatric services by a general hospital, the relocation of a special psychiatric hospital or a general hospital providing psychiatric inpatient services, and other projects that involve acute psychiatric services. An applicant shall address the need for its proposed project within the context of the regional acute psychiatric hospital utilization projections and the needs determination for historically underserved populations in effect when a Certificate of Need application or request for an exemption from Certificate of Need review is filed and shall explain the basis for any inconsistency between the needs determination for historically underserved populations and the bed capacity and patient populations it proposes to serve.

(i) When the needs determination for historically underserved populations indicates a level of regional utilization for a patient population with specialized needs that is sufficient to support four or more beds for one or more historically underserved populations, an applicant shall address how its proposed project will meet the needs of at least one of the historically underserved patient populations; or

(ii) If the applicant does not currently serve or propose to serve any of the historically underserved populations in need, as identified in the needs determination for historically underserved populations, the applicant shall demonstrate that developing bed capacity or programming to serve any of these patient populations would jeopardize the financial viability of the hospital or would jeopardize the ability of the hospital to meet the needs of the broader patient population it serves, or that the Commission, after considering evidence provided by the applicant, finds that the applicant will be unable to effectively meet the needs of any of the historically underserved populations.

(d) In addition to addressing the current needs determination for historically underserved populations, an applicant shall demonstrate in a service-area level needs assessment that the acute psychiatric hospital bed capacity proposed is needed. The applicant's service-area level needs assessment shall include a forecast of demand for acute psychiatric hospital beds by the population in its projected service area and a zip-code area level analysis of the market share that the applicant expects to capture within the projected service area. The applicant shall demonstrate the reasonableness of its assumptions in:

(i) Defining the service area of the proposed project;
(ii) Projecting acute psychiatric discharge rates for its service area population;
(iii) Projecting the market share of applicable acute psychiatric discharges within the project's service area; and
(iv) Projecting the average length of stay in proposed psychiatric beds.

Applicant Response

The Commission has not published regional need projections for psychiatric services described in subparts (a) through (c), therefore the applicant responded to subpart (d) providing a service-level needs assessment that the proposed acute psychiatric hospital bed capacity is needed.

Historically, UM SMC Dorchester was licensed to operate 16 adult inpatient psychiatric beds prior to its conversion to a freestanding medical facility (FMF) in October of 2021. As a result of the approved conversion to an FMF, UM SMC Dorchester relocated 12 inpatient psychiatric beds to UM SMC Easton, which previously had no inpatient psychiatric beds. The applicant projects the continued need for 12 inpatient psychiatric beds for the replacement hospital through 2032.

To address the need standard, the applicant used the top 80 percent of FY2022 discharges for the adult psychiatric cohort by ZIP code to determine the replacement hospital service area. The ZIP Codes span Dorchester, Talbot, Caroline, Kent, and Queen Anne's counties. (DI #3, pp. 179-180). Of the 349 total discharges in FY2022, Table IV-40 shows 280 discharges in the service area and 69 outside the service area.

Table IV-40: UM SMC Easton Adult Psychiatric Service Area FY 2022

ZIP	City	County	Discharges	Cumulative %
21601	Easton	Talbot	61	17.5%
21613	Cambridge	Dorchester	58	34.1%
21629	Denton	Caroline	21	40.1%
21620	Chestertown	Kent	20	45.8%
21617	Centreville	Queen Anne's	15	50.1%
21643	Hurlock	Dorchester	15	54.4%
21660	Ridgely	Caroline	14	58.5%
21632	Federalsburg	Caroline	13	62.2%
21639	Greensboro	Caroline	11	65.3%
21663	Saint Michaels	Talbot	8	65.8%
21655	Preston	Caroline	7	69.6%
21673	Trappe	Talbot	7	75.7%
21625	Cordova	Talbot	5	77.3%
21638	Grasonville	Queen Anne's	5	74.5%
21662	Royal Oak	Talbot	4	75.6%
21631	East New Market	Dorchester	4	78.9%
21622	Church Creek	Dorchester	4	77.9%
21665	Sherwood	Talbot	3	78.8%
21659	Queen Anne	Queen Anne's	2	79.4%
21658	Queenstown	Queen Anne's	1	79.7%
21623	Church Hill	Queen Anne's	1	79.9%
21672	Wye Mills	Talbot	1	80.2%
Total in service area			**280**	**80.2%**
Out of service area			69	19.8%
			349	**100%**

hMetrix's analysis of HSCRC's statewide non-confidential hospital data tapes. Source: (DI #3, p. 180).

In Table IV-41, the applicant provided annual population projections of the psychiatric service area through 2027. The projections show a 0.9 percent total change in population between 2010 and 2027, with the largest growth in population for the age cohort of 65-74.

Table IV-41: UM SMC Easton Historical and Projected Adult Psychiatric Service Area Population FY 2010 – 2027

	Service Area Population						CAGR % Change in Population
	2010		2022		2027		
Age Cohort	Pop	% of Total	Pop	% of Total	Pop	% of Total	2022-27
15-64	79,301	77.8%	76,766	71.6%	77,358	69.1%	0.2%
65-74	12,309	12.1%	17,001	15.9%	20,143	18.0%	3.4%
75+	10,332	10.1%	13,396	12.5%	14,382	12.9%	1.4%
Total	**101,942**	**100.0%**	**107,163**	**100.0%**	**111,883**	**100.0%**	**0.9%**

Source: Environics SPOTLIGHT Pop-Facts Demographics by Age Race Sex. (DI #3, p.181).

Applicant then used the annual growth rate, by age cohort from 2022 to 2027, to project the service area population through 2032. For fiscal years 2022 to 2032, the total service area population is expected to grow by 0.8 percent to 1.0 percent per year for an aggregate growth of 9.4 percent. (DI #3, p.181).

Since relocation of the adult inpatient psychiatric unit from UM SMC Dorchester to UM SMC Easton in September 2021, the applicant states that physical capacity and staffing constraints have required UM SMC Easton to limit its psychiatric patient census. The UM SMC Dorchester inpatient psychiatric unit consisted of all private rooms, whereas the unit at UM SMC Easton has four private rooms, and four semi-private, double occupancy rooms. After the relocation, UM SMC Easton faced issues with the patient rooms that affected room availability. UM SMC Easton's seclusion room could not accommodate a restraint bed therefore, one of the four private rooms was required to be converted and used as a restraint room. In addition, the semi-private rooms were limited based on patient gender, acuity level, and managing infection control during the pandemic, and as a result, the semi-private rooms were limited to single occupancy. (DI #3, p.182).

The applicant explains further that in addition to space constraints, there were pandemic related staffing shortages. Because of inadequate staffing, many patients needing psychiatric admission were held in the emergency department awaiting a bed or to be transferred to another hospital. The applicant states that although there have been some staffing improvements, the physical space and staffing challenges resulted in a decline in utilization at UM SMC Easton. In July 2022, the average daily census (ADC) was only 4.74 out of 12 beds, a 40 percent occupancy rate. The ADC increased to 6.93 out of 12 beds, a 58 percent occupancy by November 2022. However, because the replacement hospital will have all private rooms, many of the prior issues will be alleviated. The applicant has projected that it will be able to sustain a 70 percent occupancy for its inpatient adult psychiatric beds. (DI #3, p.183).

The capacity constraints and staffing limitations UM SMC Easton experienced in FY 2022 resulted in 121 patients being referred to hospitals in Delaware. Applicant states that the recapture of referral volumes and population projections support its need projections. Applicant states that UM SMC Easton projects it will recapture this volume beginning in FY2029 given that the patients originally chose UM SMC Easton for care. (DI #3, p.183).

The historical use rates for the adult psychiatric service area population declined from 4.9 in FY2019 to 4.0 in FY2021, and declined again by 16.2 percent in FY2022 to 3.3 in conjunction with the move from UM SMC Dorchester to UM SMC at Easton.This drop is attributed to capacity and staffing issues at UM SMC Easton. Applicant projects that by 2029, with the opening of the replacement hospital, the referrals previously sent out of the service area are expected to be recaptured, added into the use rate, then held constant. The applicant projects that the adult psychiatric use rates will increase by 26.2 percent over the next ten years. (DI #3, p.185, Table 88).

The applicant states that market share was calculated based on UM SMC Easton's FY2022 adult psychiatric discharges and its acute psychiatric services market share decreased two percent from 2019 to 2022 for a 78.2 percent market share in FY22 as a result of space and staffing constraints at UM SMC Easton. (DI #3, p.186). In the projections, the applicant expects its acute psychiatric services market share will remain constant by age cohort. In 2029, when the replacement hospital opens the applicant states that it will be able to admit patients previously referred to Delaware hospitals, increasing market share by 6.9 percent leading to 83.5 percent market share. The applicant projects no market share shift from any Maryland psychiatric hospitals, and that volumes will remain constant through applicant's projections to FY2032. (DI #3, p.186).

The applicant states that the average length of stay (ALOS) of adult psychiatric patients increased from 7.2 days in 2017 to 8.4 days in 2021. The increase in ALOS was a result of increased pandemic restrictions at other area psychiatric programs where UM SMC Easton usually discharged patients. In FY2021 the ALOS of 8.4 days decreased to 5.7 days in FY2022 because of transfers to other providers related to staffing and capacity constraints. The applicant projects that the ALOS will reach 6 days in 2029 and remain constant at 6 days through 2032. (DI #3, p.188).

The applicant states that the proposed 12 beds will provide geographic access to behavioral health services which is a barrier to care for rural counties in Maryland. The applicant cites the *Geographic Access Policy* of the Psychiatric State Health Plan which states that acute psychiatric services shall be financially and geographically accessible to all who need them, including the underserved, indigent, underinsured, and uninsured, and that optimal travel time for services should be within 30 minutes for 90 percent of the population. (DI#3, p. 190). Table IV-42 below shows the drive time between the service area counties and the next closest inpatient psychiatric units in Maryland and Delaware. UM SMC Easton has the shortest drive times.

Table IV-42: Drive Time in Minutes from the Five Mid-Shore Counties to Area Psychiatric Inpatient Units

	UM SMC Easton	AAMC	CUH	Tidal PR	CW	DPC	MWBH	Rockford	Dover	Sun
Caroline	24	48	74	59	78	69	60	71	44	44
Dorchester	30	68	116	38	127	112	103	100	103	70
Kent	42	58	50	100	61	53	49	54	58	88
Queen Anne's	21	34	65	80	69	63	55	61	52	66
Talbot	11	49	84	56	88	84	74	84	66	64

Source: DI #3, p.190
Key: Anne Arundel Medical Center (AAMC), Christiana Care Union Hospital Elkton (CUH), Tidal Health Peninsula Regional (Tidal PR), Christiana Care Wilmington (CW), Delaware Psychiatric Center (DPC), Meadow Wood Behavioral Health (MWBH), Rockford Center (Rockford), Dover Behavioral Health System (Dover) and SUN Behavioral Health (Sun).
Source of travel time is Google Maps, using the shortest travel time between each county and each hospital. Measurements were taken between 2:00 and 3:00 pm on Wednesday, October 12, 2022.

Staff Analysis

Staff concurs with the applicant that it is appropriate to address the need for acute psychiatric services by assessing service area level needs. In the need analysis the applicant provided a credible assessment of the challenges it faced with the relocation of the adult psychiatric beds from Dorchester County to Talbot County. The relocation of the inpatient psychiatric beds, combined with pandemic staffing shortages has resulted in UM SMC Easton utilization metrics, such as use rates and market share, suffering. The applicant has, however, provided a reasonable

and credible strategic plan for recapturing market share and overcoming past issues. The plan for all private rooms will address the prior space limitations and allow for the bed capacity to increase because there will not be barriers imposed by infection control or gender matching. There is also estimated to be a 0.9% increase in population by the time the new hospital opens in 2029. The applicant's need analysis assessed service area, utilization, discharges, market share ALOS, and drive times. Staff concludes the applicant's need analysis is credible and complies with the standard. The applicant's analysis demonstrates a need for 12 adult inpatient psychiatric beds at the replacement hospital, consistent with the current bed capacity at the existing hospital.

(3) Patient Rooms.

(a) All new patient rooms in a special psychiatric hospital or in a psychiatric unit of a general hospital will be private rooms designed for single occupancy. Semi-private patient rooms, which are designed for double-occupancy, shall only be permitted if the applicant provides evidence demonstrating that, under the specified circumstances presented by the proposed project, semi-private patient rooms are appropriate.

Applicant Response

The applicant states that all psychiatric inpatient rooms in the replacement hospital will be private. (DI #3, p. 190).

Staff Analysis

The inpatient psychiatric unit will have all private rooms, and staff concludes that the applicant complies with this standard.

(b) Projects in a special psychiatric hospital or in a psychiatric unit of a general hospital that involve renovation or replacement of patient rooms will, to the maximum extent possible, replace semi-private rooms with private rooms. Renovation or replacement of patient rooms that retain semi-private rooms shall only be permitted if the applicant provides evidence demonstrating that, under the specified circumstances presented by the proposed project, semi-private patient rooms are appropriate.

Applicant Response

The applicant states that this subpart of the standard is not applicable because the project does not involve renovation or replacement of patient rooms; the new hospital has been designed with all private rooms. (DI #3, p.191).

Staff Analysis

The inpatient psychiatric unit will have all private rooms, and staff concludes that the applicant complies with this standard.

(4) Other Program Requirements. An applicant proposing to provide acute psychiatric services for two or more age groups shall provide physical separation and programmatic distinctions between the patient groups consistent with Maryland Department of Health requirements.

Applicant Response

The State Health Plan distinguishes between four different age groups: children (under 13); adolescents (13 to 17); adults (18 and over); and geriatric (65 and over). COMAR 10.24.21.06C. The applicant proposes to provide acute psychiatric services to adult and geriatric populations at the replacement hospital. The applicant provided information on its policies and programs specific for geriatric psychiatric services. The applicant states that psychiatric admissions are reviewed with an assessment of the patient's ability to participate in and benefit from treatment. Although UM SMC Easton routinely treats older adults with depression, bi-polar and schizophrenia disorders, it does not admit older adults with neurocognitive deficits based on acuity and safety concerns. Applicant states that instead, the patient is referred out to an appropriate placement. (DI #11, p.59). The applicant also states that it is in the process of implementing a policy with specific provisions for the geriatric population: *Special Behavioral Health Population Treatment Protocols,* which was in place at UM SMC Dorchester and addresses special protocols for geriatric patients. The policy states the geriatric population can be admitted if they can participate in, and benefit from treatment and recommends consultation with a hospitalist and a fall risk assessment for geriatric patients. (DI #11, p.59, Exhibit 32).

Staff Analysis

Staff agrees there should be policies in place that address the needs of the 65 and older cohort and reviewed the applicant's policy for *Special Behavioral Health Population Treatment Protocols.* Staff concludes the policy, which the applicant plans to implement at the replacement hospital, addresses the needs of older adults receiving psychiatric services. The applicant's decision not to admit older adults with neurocognitive deficit based on acuity and safety concerns is an operational decision and does not impact compliance with the standard. Staff concludes that the applicant complies with the standard.

(5) Support for the Project. Certificate of Need applications and requests for exemption from Certificate of Need review involving acute psychiatric services shall document support for the project from entities that serve the population in the applicant's service area, including:

(a) Local health departments;
(b) Local community mental health centers;
(c) Each local mental health advisory council or agency; and
(d) Behavioral health service providers.

Applicant Response

The applicant provided multiple letters of support for the project from local businesses, colleges, state/local government, community mental health centers, mental health advisory council/agencies, and behavioral health service providers (Marshy Hope Family Services, LLC, Community Behavioral Health, Eastern Shore Crisis Response, Channel Marker, Inc., Mid-Shore Behavioral Health, Corsica River Behavioral Health, and For All Seasons). The application also included letters of support from Health Officers in Queen Anne's, Dorchester, Talbot, Caroline, and Kent counties; the Mayors of Chestertown, Cambridge, and Easton; County Commissioners in Caroline, Kent, and Queen Anne's counties; and the County Councils in Dorchester, Talbot, and Caroline counties. (DI #3, Exhibit 23, p.191).

Staff Analysis

Staff reviewed the 47 letters of support for the project included in the application. (DI#3, Exhibit 23). A detailed list of all letters is included in the Procedural History, (supra, pp. 6-7). There were no interested parties in this review. Staff concludes that the applicant complies with this standard.

(6) Emergency Services. General hospitals with acute psychiatric services shall have the ability to provide services on an emergency basis at all times, including the capability to perform evaluations of persons believed to have a mental disorder and brought to the hospital on emergency petition, unless otherwise exempted by the Maryland Department of Health as provided in Health-General §10-620(d)(2). Each such hospital shall also have emergency-holding bed capabilities and at least one seclusion room.

Applicant Response

The applicant states that UM SMC Easton is a 24/7 acute care general hospital and that the adult psychiatric services follow written procedures currently in place for providing emergency inpatient psychiatric care. The applicant also states that the replacement hospital will have a 27-bay emergency department, which includes two psychiatric-appropriate exam rooms. In addition, the emergency department will also have three rooms designated as behavioral health/psychiatric holding areas for patients awaiting admission decisions and a seclusion room located on the sixth floor inpatient psychiatric unit. (DI #28, p.1). UM SMC Easton is designated by the Maryland

Department of Health to perform mental health evaluations of persons brought to the hospital on an emergency petition. (DI #3, p.192).

Staff Analysis

The hospital website states "We are available 24/7 to provide emergency evaluations, both in person and remotely, for patients who may be experiencing a mental health crisis."[40] The applicant will provide 24/7 emergency services, emergency-holding bed capabilities, a seclusion room and emergency evaluations of persons with mental disorders. Staff concludes the applicant has demonstrated the ability to provide emergency psychiatric services and complies with this standard.

(7) Involuntary Admissions.

(a) Each special psychiatric hospital and psychiatric unit operated by a general hospital shall admit involuntary patients, unless otherwise exempted by the Commission. The factors the Commission will consider in determining whether to exempt a hospital from the requirement to admit involuntary patients include the following:

(i) Number of psychiatric beds;

(ii) Access to hospitals that admit involuntary patients for the population to be served; and

(iii) Comments from interested parties or other stakeholders.

(b) A special psychiatric hospital or hospital with a psychiatric unit may not discontinue admissions of involuntary patients without written approval from the Commission.

Applicant Response

The applicant states that UM SMC Easton is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to the hospital on emergency petition and will admit involuntary patients. (DI #3, p.192). The applicant states that subpart (b) is not applicable, UM SMC will not discontinue admissions of involuntary patients. (DI #3, p.193).

Staff Analysis

UM SMC Easton is a general hospital that will have 12 inpatient psychiatric beds and is the only hospital offering inpatient psychiatric services in the five-county service area. Applicant affirmatively states that UM SMC Easton will admit involuntary patients and it will not discontinue involuntary admissions. Staff concludes the applicant complies with this standard.

[40] https://www.umms.org/shore/health-services/emergency, Accessed 12/11/23 to ascertain provision of emergency evaluations.

(8) Access to Acute Psychiatric Services.

(a) A special psychiatric hospital or a psychiatric unit in a general hospital shall only deny admission if it is unable to provide the appropriate level of care for a patient and shall not deny admission due to:

(i) A patient's full or partial inability to pay for services; or

(ii) A patient's status as an involuntary patient unless the hospital has been issued an exemption by the Commission that permits it to serve only voluntary patients.

(b) A special psychiatric hospital and a general hospital with a psychiatric unit shall participate in the Medicare and Medicaid programs.

Applicant Response

The applicant states that UM SMC Easton does not and will not deny any admissions due to a patient's inability to pay or a patient's status as involuntary and meets subpart (a). (DI #3, p.193). Further, UM SMC Easton participates in Medicare and Medicaid programs and thus meets subpart (b) of the standard. (DI #3, p.193).

Staff Analysis

Staff concludes that the applicant has demonstrated its commitment to providing access to acute psychiatric services such as its treatment of involuntary admission, its participation in Medicare and Medicaid programs and caring for patients with no ability to pay. The applicant also states UM SMC Easton will not deny admissions based on inability to pay, or involuntary patient status and will accept Medicare and Medicaid. Staff recommends that the Commission find the applicant meets this standard.

(9) Adverse Impact.

(a) A project requiring action by the Commission involving acute psychiatric services shall not have an unwarranted adverse impact on the total cost of care, availability of acute psychiatric services, or access to acute psychiatric services. If the applicant is a Maryland general hospital seeking a capital-related adjustment in its global budget revenue, it shall demonstrate that:

(i) It is an efficient hospital both in terms of hospital cost per case and total cost of care, consistent with the Health Services Cost Review Commission's most recent efficiency policies;

(ii) It does not have excess capital costs in comparison to statewide peers, and does not have demonstrated excess capacity relative to its prior bed capacity, as reflected in the most recent Capital Policy Recommendation published by Health Services Cost Review Commission;

(iii)If the project involves replacement of a physical plant asset, the age of the physical plant asset being replaced exceeds the average age of plant for its

peer group or the hospital shall otherwise demonstrate why replacement of the physical plant asset is required to achieve the primary objectives of the project; and

(iv) If the project will likely reduce the availability or accessibility of acute psychiatric services by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish the availability of or access to acute psychiatric services: for the population within an optimal drive time, as defined in Regulation .05B(1) of this Chapter; for the population in the hospital's health planning region; or for the indigent, underinsured, and uninsured.

Applicant Response

For subparts (a)(i) and (ii), please see staff's analysis of the State Health Plan standard for Acute Care Hospitals 10.24.10.04B(10) Rate Reduction Agreement which discusses HSCRC's efficiency policies and excess capital costs. (supra, pp. 39-40). Subpart (iii) is discussed under COMAR 10.24.10.04B(5) Cost-Effective Alternatives and applicant has demonstrated the replacement of the physical plant is necessary. (supra, pp. 29-33).

For subpart (iv) the applicant states that in the transition to the replacement hospital, it is not reducing capacity from the 12 currently licensed inpatient adult psychiatric beds for its behavioral health unit. Subsequently the cost of care for all patients, including underserved, indigent, underinsured and uninsured, as well as the availability of services and access to care should not be impacted negatively. The replacement hospital is in an optimal geographic location and will improve access for the service area. In addition, the new hospital will have all private rooms, which will allow UM SMC Easton to accommodate more patients than in its existing physical plant in which there are shared rooms and inadequate space. (DI #3, p.194).

Staff Analysis

The proposed psychiatric unit in the new facility maintains the current bed capacity and includes patient care improvements such as private rooms, ED holding rooms and a separate seclusion room. (DI #28, p.1). Staff concludes there will be no adverse impact on the total cost of care, availability of acute psychiatric services, or access to acute psychiatric services. Staff agrees with the applicant that in order to reduce any adverse impact the replacement hospital must maintain the current capacity, a 12-bed inpatient psychiatric unit. Staff concludes that the applicant complies with this standard.

(10) Construction Cost.

(a) 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 good quality Class A hospital construction 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 capital-related adjustment of global budget revenue 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.

(b) An applicant shall provide the information necessary for Commission staff to calculate the construction cost per square foot based on the Marshall Valuation Service® guide.

(c) An applicant is permitted but not required to submit calculation of the construction cost per square foot based on the Marshall Valuation Service® guide, independent of Commission staff's analysis.

Applicant responded to this standard in response to Construction Cost of Hospital Space COMAR 10.24.10.04B(7), (supra, pp. 34-37*).* Staff concluded the applicant complied with this standard.

(11) Inpatient Nursing Unit Space. Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of 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 capital-related adjustment in global budget revenue 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 responded to this standard in response to Inpatient Nursing Unit Space COMAR 10.24.10.04B(9), (supra, pp. 37-38). The inpatient nursing unit spaces on average show that the average of all nursing unit space meets the ≤ 500 square feet per bed standard. Staff concludes that the applicant complies with this standard.

(12) 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 or a request for an exemption from Certificate of Need review must be accompanied by a statement containing each assumption used to develop the projections;

(b) An applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the acute psychiatric services, unless the applicant demonstrates why future utilization should not be expected to be consistent with observed historic trends for the likely population to be served by the applicant;

(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 hospital or, if 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, within five years or less of initiating operations, if utilization forecasts are achieved for the specific services affected by the project. An exception to this requirement is permitted if the hospital demonstrates or the Commission finds that overall, the hospital's financial performance will be positive; the hospital can support operating losses for the proposed services over the long-term; and the proposed services will benefit the hospital's service area population.

Applicant Response:

The applicant addressed financial feasibility in response to the Financial Feasibility standard at COMAR 10.24.10.04B(13*)*. (supra, p. 41-44)

Staff Analysis

The revenue and expense projections show a positive operating margin through 2032, although the margin is reduced significantly when the new facility is open in 2029. While this reduction is acknowledged, staff concludes that the overall financial feasibility of this project remains positive and that the applicant has met this standard.

Criteria for Review of Applications.

B. COMAR 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.

Applicant Response:

The applicant responded to the need analysis in each of the applicable chapters of the State

Health Plan, including Acute Hospital Services, Obstetric Services, General Surgical Services, Acute Inpatient Rehabilitation Services, and Psychiatric Services. The primary need for this project is to replace an aging and deficient hospital building, expand capacity for community programs and technology and increase observation beds to meet the needs of the community.

Replace the Existing Hospital Building

The applicant states that the existing facility comprises four components from different eras. A small portion of the building was built in 1915. The majority of the building, including most of the inpatient units, was constructed in phases between 1955 and 1975. A four-story inpatient addition was constructed in 1982, with a fifth floor added in 1990, and a one-story ambulatory and emergency wing built in 2006. With the majority of the building constructed between 1955 and 1982, UM SHS indicates that this facility is old and functionally obsolete for inpatient care. (DI # 3, p. 20).

UM SHS states that the existing hospital is located in a residential area that is surrounded by neighborhoods which prevents the hospital from expanding its current footprint. (DI #3, p. 197). Also, the location in downtown Easton makes the current hospital inconvenient for patients who live outside the city limits.

In 2012, the applicant identified numerous deficiencies and limitations in nearly every department in the hospital after engaging The Schachinger Group (TSG) and conducting departmental interviews. (DI #3, p. 197). In 2021, UM SMC Easton's mechanical engineer conducted a risk assessment of the hospital's mechanical, electrical, and plumbing infrastructure. Given the age and space limitations within the existing hospital, the study identified a number of issues, which the applicant summarized below: (DI #3, pp. 197-198).

- Location and accessibility of supplies are suboptimal. Hoarding of supplies is common. Inefficient supply placement results in an inordinate amount of staff time used for supply and inventory ordering, tracking, and maintenance. Par levels may be higher than necessary to mitigate supply chain problems.
- Inadequate storage throughout the hospital contributes to insufficient use of staff time and cluttered hallways. Patient rooms have been closed and repurposed as storage for beds, computer carts, blood pressure cuffs, and other necessary equipment.
- Elevators are too small for larger patient transports and inconveniently located both in terms of physical location and difficulty getting through the corridors. Elevator protocol results in prolonged wait times for some departments. Patients in transport are exposed to public spaces.
- The rooftop helipad is too small to accommodate the Maryland State Police helicopter transport, forcing the helicopter to land at the nearby airport and resulting in patient transfer via vehicle.
- The elevator providing access to the rooftop helipad and supply storage has experienced progressively increasing failures. Due to the age of the elevator, it is becoming difficult to find compatible replacement parts.
- Clean and soiled utility rooms are inappropriately sized for respective units, with existing soiled utility rooms considerably undersized.
- The structure and configuration of the facility makes wayfinding difficult.

- The existing building design and features, which includes a lack of private rooms or optimal airflow, are not ideal for patient safety and infection control.

Regarding the hospital's physical plant, the applicant indicates that the facility lacks a central storage area for its Bio-Med equipment and requires costly repairs and/or replacement of a deteriorating plumbing infrastructure; failing domestic water supply and sanitary sewage infrastructure; an aging air handling system; a leaking roof in the south building; an aging pneumatic tube system that is deemed obsolete and difficult to find replacement parts; and boilers and valves that are more than 20 years old. (DI #3, p. 202). The costs to repair these systems are expected to be significant as they age. As these systems age, obtaining replacement parts becomes increasingly difficult and challenging to purchase. (DI #3, p. 203).

Improvement in Community Space and Technology

The applicant identified a number of educational and community-based programs and strategies that contribute to improvements in health outcomes for its patient population. Some of these programs focus on diabetes prevention, high blood pressure, smoking cessation, healthy pregnancy and healthy baby, healthy eating, chronic disease self-management programs, mental illness and behavioral health, substance abuse, and nutrition. (DI #3, p. 204). However, the applicant states that its current facilities in Easton lack capacity to handle the programs.

To address their current limitations, the proposed replacement hospital will provide a state-of-the-art facility with space for these programs. The applicant indicates the new facility will allow the staff to promote cutting edge information in a more sophisticated electronic platform. In addition, relocating the hospital to a site about three miles north, close to the municipal airport and Talbot County Community Center will increase access. The replacement hospital will be located on a 200-acre greenfield site that will have more parking and be more accessible and convenient for the population in its service area. (DI #3, p. 204).

The applicant anticipates that constructing a new replacement hospital on the Eastern Shore will also aid UM SMC Easton in physician recruitment efforts. The applicant asserts that a facility constructed with the newest cutting-edge technology will attract more clinicians to this rural area. The proposed hospital "will be constructed in accordance with all modern building codes, FGI Guidelines, and will take into account the best practices for clinical care," which will include updated technology, larger treatment spaces, better storage capacity, and more efficient layouts. (DI #3, p. 204).

Need for Observation Beds

UM SMC states that the hospital opened a dedicated observation unit in 2018 before the COVID-19 pandemic. The number of observation beds grew from 13 beds in FY 2019 to 25 beds in FY 2022. From FY 2020 through FY 2022, the hospital repurposed the observation unit to treat COVID-19 patients specifically, which resulted in the hospital dispersing the observation patients throughout the hospital.

In projecting the utilization for the observation unit, UM SHS indicated the need to operate a dedicated 25 bed observation unit upon project completion. While the number of cases is

projected to increase by 1.0 percent annually from FY 2022 through FY 2032, the applicant anticipates utilization in the dedicated observation unit to be offset by a decrease in the average length of stay of 1.0 percent annually. From FY 2022 through FY 2032, the hospital assumes an occupancy rate of 70 percent during this eleven-year period for the 25-bed unit. (DI #3, pp. 204-207).

The applicant states that the need for the 25-bed observation unit is based on the projected growth in the number of visits to its emergency department (ED).[41] The hospital projects that the ED will experience an annual increase in patients placed in the observation unit of 0.9 percent to 1.0 percent annually during the construction period for the new hospital. The hospital projects an increase in observation cases from 3,602 cases in FY 2022 to 3,951 cases in FY 2032. This represents a cumulative 9.7 percent increase in ED visits from FY 2022 to FY 2032 resulting in patients placed in their observation unit. (DI #3, p. 205-6). The increase in ED visits that lead to an observation unit admission supports the need for the 25-bed observation unit in the proposed replacement hospital.

Staff Analysis

Staff reviewed the information regarding the physical plant age and current condition and concludes that the applicant has documented the need for the construction and relocation of a replacement hospital. The current hospital is landlocked in the City of Easton and does not offer options for either expansion or upgrades to the existing facility. The hospital structure, composed of various components dating back to its origin in 1915, has not aged well with time, resulting in an obsolete and outdated hospital design and layout. The applicant has submitted evidence that supports the need for the relocation and construction of a state-of-the-art hospital that will improve the level of care and health care services offered by the staff and to the patient. The applicant projects that the increase in admissions based on visits to its emergency room support the need for a 25-bed observation unit.

Staff concludes that the applicant has demonstrated need in accordance with the applicable State Health Plan chapters. Staff concludes that the applicant adequately addresses the need for the relocation and replacement of the hospital and the addition of a 25-bed observation unit.

C. *COMAR 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.

[41] [1] Please see previous discussion under COMAR 10.24.10.04B(14), Emergency Department Treatment Capacity and Space, for UM SMC's historical and projected utilization in the Emergency Department for FY 2017 through FY 2032. (DI #3, pp. 100-111).

Applicant's Response

The evaluation of alternatives in planning the proposed project has been addressed in the applicant's response to COMAR 10.24.10.04B(5) – Cost Effectiveness. (supra pp. 29-33).

In addition to the alternatives the applicant considered in response to the Cost Effectiveness standard, the applicant outlined the ways in which it provides population health initiatives in order to avoid or lessen hospital admissions and improve delivery of care. The applicant stated that through the planning process, it has designed a plan to couple population health initiatives with a more efficient and modern hospital. (DI #3, p. 208). The plan includes the establishment of a pilot mobile wellness team, composed of a nurse coordinator, a social worker and two community health workers, which works within communities to provide health education, perform health screenings, and coordinate wellness activities. (DI #3 p. 209). The team provides preventative services aimed at reducing medical conditions that could worsen and require hospitalization.

In order to lessen the rate of readmissions, the applicant has implemented a number of support systems for high-risk individuals in the service area. These include:

- Providing patients who are at high risk for readmissions with nurse navigators to provide support for 30 days after discharge to help to effectively manage transitions between care settings.
- Implementing a call back system for patients within 48 hours of discharge to address issues related to medications, discharge instructions, and access to follow-up care.
- Providing the services of a Pharmacy Led Transitions of Care Program to provide medication consults for primary care offices, senior centers, and community agencies in the service area.
- Implementing chronic care management programs for heart failure and as well as a remote patient monitoring program.
- Creation of a pilot mobile wellness team (MWT) composed of a nurse coordinator, social worker, and two community health advocates in Kent County to address Social Determinants of Health as well as clinical issues. The team provides education, performs screenings, and oversees wellness activities. The team also makes home visits to assess living conditions, facilitate telehealth consults, and link people with needed services.
- Implementation of a palliative care program, both outpatient and inpatient, to decrease end of life hospital utilization, and increase the use of signed advance directives. (DI #3, pp. 208–210).

The applicant provided evidence showing that risk adjusted readmission rates at the current Easton hospital have been below the statewide average from CY 2016-2022. (DI #3, Exh. 24).

Staff Analysis

In the previous sections of the application, UM SHS has shown that the drive time to other regional facilities is too lengthy for patients in the primary service area, making those alternatives inefficient to the proposed plan. (DI #3, p. 54). The applicant has implemented programs to bring health and wellness into communities to reduce health conditions which could lead to hospitalizations, and that work with community agencies identify individuals in need of services.

The applicant has also identified a robust list of measures to reduce readmissions and provide support for high-risk individuals. Finally, the applicant has implemented a palliative care program to reduce end-of-life hospital utilization.

Staff concludes that the proposed project is a cost-effective alternative for providing care to residents of the Mid-Shore.

D. *COMAR 10.24.01.08G(3)(c)* — 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.

Applicant's Response

UM SHS states that the cost of the project is $539.6 million, with funding sources of cash ($38.6 million), philanthropy ($50 million), debt financing ($333.3 million), investments earnings on interest during construction ($17.6 million), and State support ($100 million). The applicant has used $20 million of the $36.6 million in cash to fund the purchase of land, design of the hospital and the CON preparation costs. The remaining $16.6 million is restricted on the UM SHS balance sheet. (DI #3, p. 211).

UM SHS projects that it will be able to meet the $50 million target of philanthropic support for the project. The applicant has not yet made its fundraising target, but it will use a multifaceted approach for fundraising. While the majority of funds is expected to be raised by the UM Memorial Hospital Foundation contribution, UM SHS is also applying for funding from the Federal Government in the form of grants and Congressional Directed Spending. The applicant is also seeking funds from State grants (in addition to the Governor's capital budget allocation), Mid-Shore County/City/Town Governmental contributions, community foundation support (unaffiliated with UM SHS), and a community-focused capital campaign. If the applicant does not meet this goal it will use UM Memorial Hospital Foundation's unrestricted funds and/or increase borrowings to cover the shortfall. (DI #11, p. 60).

As for the State funding of $100 million, the applicant has received $10 million pay-as-you-go funds for FY 2024, and a pre-authorization of $20 million for FY 2025. (DI #18, p.2). The applicant stated that it expects further state funds to be made available in future years as outlined in the table below.

Table IV-43 Schedule of Expected State Funds

FY 2024	$10 Million (*committed*)
FY 2025	$20 Million (*pledged*) and $5 Million (*requested*)
FY 2026	$25 Million (*requested*)
FY 2027	$20 Million (*requested*)
FY 2028	$20 Million (*requested*)

Source: DI #25.

The applicant provided the required revenue and expense tables for both the proposed new facility in Easton as well as the health system as a whole. (DI #15 Exh. 42, Exh. 45). UM SHS projects a positive net income for UM SMC Easton and UM SHS as a whole through FY 2032. The applicant expects a reduction in the workforce of 98.7 FTE by 2027 and therefore does not expect that staffing the new facility will be a problem. (DI #11 p. 64).

The applicant also stated that the project has strong community backing, shown through the documentation of numerous letters from community members (DI #3, Exhibit 23). UM SHS has presented updates to the community as well as meetings with physicians/providers, partner agencies and donors. The applicant reports that there are constant inquiries as to when the project will move forward. (DI #3, p. 213).

Staff Analysis

Regarding the applicant's application for rate relief. In Appendix 4, the HSCRC describes the applicant's projected award as included in the initial CON and the Responses may be quite optimistic, and likely overstated.

Staff has also reviewed the financial plans and projections submitted by the applicant and concludes that once completed, the hospital will likely be profitable, contingent on the applicant maximizing the planned increases in efficiencies of the project. However, there remains a question whether the remaining $70 million in state funds will be realized. Staff understands that state funding for large capital projects, such as the hospital in Easton, is often spread over multiple budget years, with the likelihood of additional funds being committed to UM SHS. The staff also considered the applicant's plan for raising the required philanthropic funds and finds the plan to be credible. UM SHS has committed to using other UM Memorial Hospital Foundation unrestricted funds and/or increasing borrowing to cover any potential shortfall.

In Appendix 4, the HSCRC memo to Commission staff concluded that the project may be viable as long as the applicant strives:

> to maximize the potential liquidation value of the current campus; to realize greater efficiencies in operating the hospital services as compared to its peer hospitals; to realize the performance improvements assumed in the projections; to minimize potential cost overruns on the project budget; and to maximize fund raising both philanthropic and governmental. (DI #22, p. 6).

The opinion of the HSCRC concerning the financial viability of the project is discussed previously, (supra, pp. 41-44). The applicant has also documented substantial community support through letters submitted by government and community leaders. (DI #3, Exhibit 23 and DI #10).

Staff reviewed the financials submitted by the applicant and concluded that if run efficiently, the hospital, once completed, will likely be profitable. Although staff understands that government funds are often spread out over several years, there remains a question about whether the remaining $70 million in state funds will be realized. UM SHS has committed to using other UM Memorial Hospital Foundation unrestricted funds and/or increasing borrowing to cover any

shortfall. Staff concludes that the applicant's proposed project could be successfully implemented with resources that should be available to UM SHS, and that the ongoing viability of UM SHS may be sustainable if the project follows the applicant's projections. Due to the uncertainty of the state funding, staff recommends the inclusion of the following conditions in the CON approval:

> Shore Health System shall provide, in its quarterly project reports, detailed updates on its progress towards obtaining the anticipated State funding, including how much has been obtained and efforts made to secure the remaining funds.
>
> If Shore Health System fails to secure the projected State source of funds by July 2027, UM SHS shall request a project change to amend the project source of funds.

E. *COMAR 10.24.01.08G(3)(c)* — Compliance with Conditions of Previous Certificates of Need.

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.

Applicant's Response

The applicant states that since 2000, UM SMC Easton has obtained two Certificates of Need and one Certificate of Conformance. The applicant attached copies of the Certificates of Need to the application as Exhibit 26.

In July 2003, UM SMC Easton received a Certificate of Need for the "Capital Renovation and Expansion to Memorial Hospital at Easton." (Docket No. 03-20-2112). There were no specific conditions placed on the Certificate of Need project and the Certificate of Need was completed as approved.

In September 2004, UM SMC Easton received a Certificate of Need for the "Establishment of a Twenty-Bed Acute Inpatient Rehabilitation Unit at The Memorial Hospital at Easton." (Docket No. 03-20-2128). There were no specific conditions placed on the Certificate of Need project and the Certificate of Need was completed as approved.

In April 2016, UM SMC Easton received a Certificate of Conformance to provide primary and secondary percutaneous coronary intervention (PCI) services. (Docket No. CC-15-20-0001).

The hospital implemented the Certificate of Conformance for PCI services in 2017. (DI # 33, p.214).

Staff Analysis

Staff concluded that the applicant has complied with all previous Certificates of Need as

well as the Certificate of Conformance.

F. *COMAR 10.24.01.08G(3)(c)* — 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 service area, 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.

(1) 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.

Applicant's Response

The applicant states that it assumed all hospital market shares to remain constant for each age cohort through all projection years, ending in fiscal year 2032. The applicant states that, with the exception of inpatient psychiatric services, the only changes in market share for each service line will be due to the aging of the population or other demographic changes.

Inpatient psychiatric care is the only service line with a market shift impact due to increased admissions. This is due to a projected decrease in referrals from UM SMC Easton to Delaware hospitals. The applicant states these referrals should be recaptured when the replacement facility is opened. As stated in the analysis of the need standard of the Acute Care Psychiatric Services Chapter 10.24.21.05B(2), (supra pp. 116-121). inpatient psychiatric census at UM SMC Easton was limited due to staffing related capacity constraints and physical limitations in fiscal years 2021 and 2022. The new hospital should be able to admit all psychiatric patients previously referred to Delaware hospitals. The increase in market share does not reflect a shift in volume from other Maryland hospitals but rather a decline in psychiatric referrals to Delaware hospitals. (DI #3, pp 216-217).

(2) On access to health care services for the service area population that will be served by the project.

Applicant's Response

The applicant states that the location of the new facility will improve geographic access. The applicant reviewed this in its drive time analysis in response to COMAR 10.24.10.04B(1) – Geographic Accessibility. The applicant states that the proposed site for the replacement hospital will make inpatient services available within a 30-minute drive time for a much greater portion of the projected service area population. In addition, the applicant states that the proposed site will improve access for EMS services, patients, and staff due to its proximity to major roadways, and more convenient parking options with larger lots compared with the current site's location in a

congested area with limited parking availability. The applicant's response to the Cost-Effectiveness Standard COMAR 10.24.10.04B(5) concluded that it would not be possible to find one spot that was within 30 minutes from every zip code in all five counties; however it selected a site that was an improvement on the current location. (DI #3, pp. 65-66). Additionally, the proposed site will be equipped with a helipad to accommodate Maryland State Police helicopter transports to the facility. Currently, Maryland State Policy helicopters must land at the Easton Municipal Airport and patients must be transported by vehicle to the hospital. (DI #3, p. 215).

The applicant also states the project will improve the service area's access to health care services by addressing and resolving considerable deficiencies in the current site, which are discussed in the General Need Criterion COMAR 10.24.01.08G(3)(b) and include the age and location of the facility as well as the obsolescence and/or deficiencies in design and usability in existing infrastructure.

The applicant states that the design of the new facility was selected to meet the projected future demand for services in the service area and preserve necessary access to care. The applicant conducted a demand analysis to account for peak demand and surge capacity, which it states is particularly important in preserving timely access to care for residents in a rural area with the distances to the next nearest providers. The applicant also states that it included important lessons learned during the COVID-19 pandemic in the design review to provide adequate infection control, surge capability, and adaptability in care processes. This should assist the new building and campus to continue to serve the needs of the community for many decades to come. (DI #3, pp. 215-216).

(3) Costs to the Health Care Delivery System.

Applicant's Response

The applicant states that the proposed project will not result in any significant reduction on volumes of facilities offering similar services in the area. The applicant expects there will not be an impact on costs or charges at the other facilities in the area, nor will the project have an impact on the margin of other hospitals. The replacement hospital is intended to maintain the level of service in the service area and yield cost savings to the health care delivery system by providing care in a new, more efficiently designed facility (DI #3, p. 217).

The applicant stated in the financial feasibility section, COMAR 10.24.10.04B(13), that it intends to request a rate increase of $24 million to cover 50 percent of project-related depreciation and interest (including markup) in fiscal year 2029. The applicant believes that HSCRC's fulfillment of this rate increase would only impact the replacement hospital, and this rate increase would result in a slight increase to the hospital's charges and costs to patients. Under HSCRC's discretion, the applicant states that it is possible to implement this rate increase while maintaining the CMS guardrails and fair distribution of revenue among Maryland providers (DI #3, p. 217).

The applicant states that the proposed project will have positive effects on the health care system as a whole by addressing several issues and deficiencies at the existing facility. The existing facility has 37 semi-private rooms, which do not meet current standards of care. The new regional

medical center will have all private rooms, which will produce higher occupancy rates than are achievable with semi-private rooms. Private rooms also enhance patient satisfaction and family involvement and reduce the risk of infection. (DI #3, p. 20).

The applicant states that having a new facility will assist in recruiting and retaining physicians, which can be a challenge in the current service area. Improved retention of staff will assist in improving the quality and continuity of care.

The applicant states that the replacement hospital will be the central health care hub for residents of the service area needing higher-level care. It will work in conjunction with other components of the UM SHS to improve access and reduce costs in the surrounding service area. The applicant states that this system of care is designed to ensure that the residents of its service area are being treated at the right place, right time, and right cost given their needs. The applicant believes that doing so allows for the health system to tailor its health care delivery model to appropriately address the unique rural population health needs of the Mid-Shore region. (DI #3, pp. 217-218).

Staff Analysis

Staff concludes that the proposed project is unlikely to have a detrimental effect on existing health care providers or the overall health care delivery system The applicant has presented a thorough response, outlining measures to address potential concerns, such as the expected impact on psychiatric services and the improvement in geographic accessibility. Therefore, staff recommends that the Commission find that the project's impact is acceptable. The anticipated modernization of UM SHS's facilities is expected to yield benefits for both staff and patients of the hospital. While the applicant has stated that a rate increase from the HSCRC is likely to slightly increase the costs to the state and to patients, the negative effect of a small increase in costs is outweighed by the benefits of state-of-the-art care for residents of the service area.

V. STAFF RECOMMENDATION AND CONCLUSION

Staff concludes that this project complies with the State Health Plan standards and that the hospital has demonstrated the need for the project, its cost-effectiveness, its viability, and is consistent with the remaining Certificate of Need review criteria. Staff recommends that the Commission APPROVE the Certificate of Need application with the following conditions:

1. The University of Maryland Shore Medical Center at Easton shall provide to the patient, upon inquiry or as required by applicable regulations or law, information concerning an estimate of out-of-pocket charges prior to arrival for surgery.

2. Shore Health System shall provide, in its quarterly project reports, detailed updates on its progress towards obtaining the anticipated State funding, including how much has been obtained and efforts made to secure the remaining funds..

3. If Shore Health System fails to secure the projected State source of funds by July 2027, UM SHS shall request a project change to amend the project source of funds.

IN THE MATTER OF	*	**BEFORE THE**
	*	
	*	**MARYLAND HEALTH**
SHORE HEALTH SYSTEM, INC.	*	
	*	**CARE COMMISSION**
	*	
Docket No.: 23-20-2463	*	
	*	

*** ***

FINAL ORDER

Having reviewed and considered the information and analysis contained in the Staff Report and Recommendation, it is, this 18th day of January 2024:

ORDERED, that the findings of fact and conclusions of law included in the Staff Report and Recommendation are adopted by the Maryland Health Care Commission and incorporated into this order; and it is further

ORDERED, that the application for a Certificate of Need by Shore Health System, Inc. for a project that will relocate and modernize the University of Maryland Shore Medical Center at Easton, at an estimated project cost of **$539,558,871** be **APPROVED,** subject to the following conditions:

1. The University of Maryland Shore Medical Center at Easton shall provide to the patient, upon inquiry or as required by applicable regulations or law, information concerning an estimate of out-of-pocket charges prior to arrival for surgery.

2. Shore Health System shall provide, in its quarterly project reports, detailed updates on its progress towards obtaining the anticipated State funding, including how much has been obtained and efforts made to secure the remaining funds.

3. If Shore Health System fails to secure the projected State source of funds by July 2027, UM SHS shall request a project change to amend the project source of funds.

VI. APPENDICES

Appendix 1: Record of the Review
Appendix 2: Budget
Appendix 3: MVS Analysis
Appendix 4: HSCRC Opinion Letter
Appendix 5: Site Plans/Floor Plans/Drawings
Appendix 6: Summary of Compliance with State Health Plan Chapters

APPENDIX 1

RECORD of the REVIEW

Record of the Review

University of Maryland Shore Health System – Docket #23-20-2463

Item #	Description	Date
1	MHCC acknowledges Letter of Intent	11/7/22
2	Applicant submits its Letter of Intent to relocate the existing UM Shore Medical Center in Easton	12/22/22
3	Applicant submits a Certificate of Need application to relocate the existing UM Shore Medical Center in Easton	1/6/23
4	MHCC acknowledges the receipt of the Certificate of Need Application	1/11/23
5	MHCC sends Notice of Receipt of Application from UM Shore Health System to Chesapeake Publishing for publication in the *Star-Democrat*	1/11/23
6	MHCC sends Notice of Receipt of Application from UM Shore Health System for publication in the Maryland Register	1/11/23
7	Notice of Receipt as published in the *Star-Democrat*	1/13/23
8	Following completeness review, MHCC sends to applicant a request for completeness information	1/25/23
9	Emails between applicant and MHCC concerning a 2/7/23 meeting on the project	2/2/23 – 2/7/23
10	Mid Shore Regional council submits a Letter of Support for the project	2/7/23
11	Applicant submits on behalf of UM Shore Health System, completeness responses to staff questions	2/22/23
12	MHCC sends to applicant a request for completeness information requested by the HSCRC	2/28/23
13	MHCC submits second request for completeness information and clarification to first round of completeness questions	3/8/23
14	Applicant. requests clarification on completeness questions which is sent to the applicant	3/1/23 - 3/21/23
15	Applicant submits on behalf of UM Shore Health System, completeness responses to HSCRC questions	3/21/23
16	Applicant submits on behalf of UM Shore Health System, completeness responses to second round of staff questions	3/22/23
17	MHCC requests clarification on completeness responses from applicant	4/14/23
18	Applicant submits on behalf of UM Shore Health System, clarification requested by staff	4/28/23
19	MHCC submits request to HSCRC for an opinion on the financial feasibility of the UM Shore Health System project	5/9/23
20	Applicant. submits a request for docketing of application	6/20/23
21	Emails between MHCC and applicant setting up a meeting for 7/21/23	6/28/23 – 7/10/23

22	HSCRC submits comments to MHCC concerning the financial feasibility of the UM Shore Health System project	7/14/23
23	MHCC notifies applicant that the formal start of the review will be 8/11/23	7/27/23
24	MHCC sends notification of formal start of the review for publication in the Maryland Register	7/27/23
25	MHCC sends notification of formal start of the review and extended date for interested party comments to Chesapeake Publishing for publication in the *Star-Democrat*	9/21/23
26	Emails between MHCC and applicant concerning the status of State funding	10/5/23 – 10/6/23
27	Email from applicant's attorney updates on progress made toward grant funding	11/29/23
28	Email from applicant's attorney regarding behavioral health treatment spaces	12/19/23
29	Applicant provides additional information on C-section ORs	12/21/23
30	MHCC requests clarification about the C-section ORs	12/31/23
31	Applicant provides clarification about the C-section ORs	1/3/24

APPENDIX 2

BUDGET

Uses of Funds			
	Hospital Building	**CUP[42]**	**Total**
Land Purchase	$2,464,658		$2,464, 658
New Construction			
Building	$210,528,602	$6,110,000	$216,638,6020
Fixed Equipment	In Building	In Building	In Building
Site and Infrastructure	$36,933,315	$7,476,645	$44,409,9600
Architect/Engineering Fees	$9,013,929	$1,986,071	$11,000,0000
Permits (Building, Utilities, Etc.)	$5,027,314	$1,107,686	$6,135,0000
Subtotal	**$261,503,160**	**$16,680,402**	**$278,183,562**
Movable Equipment	$85,060,730	$40,000,000	$125,060,730
Contingency Allowance	$16,974,712	$2,478,023	$19,452,735
Gross interest during construction period	$44,210,733	$5,788,267	$49,999,000
Easton Utility Fees	$9,000,000		$9,000,000
Impact Fee (Town) / County	$1,500,000		$1,500,000
Builder's Risk Insurance	$500,000		$500,000
HOSPITAL MOVE	$2,000,000		$2,000,000
UMMS/OVHO	$1,500,000		$1,500,000
Previous Expenditures (Design/Planning/etc.)	$10,078,129		$10,078,129
Subtotal	**$170,824,304**	**$48,266,290**	**$219,090,594**
TOTAL CURRENT CAPITAL COSTS	**$434,792,122**	**$64,946,691**	**$499,738,814**
Inflation Allowance	$25,435,020	$3,305,038	$28,740,058
TOTAL CAPITAL COSTS	**$460,227,142**	**$68,251,729**	**$528,478,871**
Financing Cost and Other Cash Requirements			
Loan Placement Fees	$2,635,012	$344,988	$2,980,000
CON Application legal fees	$150,000		$150,000
Accounting, Architectural, Planning	$850,000		$850,000
IT Design	$75,000		$75,000
SHA Study	$300,000		$300,000
Geo-tech consult (if needed)	$75,000		$75,000
Project Development Consultant	$4,500,000		$4,500,000
CM Preconstruction Fees	$200,000		$200,000
Exterior Wall Mock Up & Testing	$500,000		$500,000
Scheduling	$200,000		$200,000
Third Party Inspections	$750,000		$750,000
Third Party Building Permit Review	$400,000		$400,000
Curtainwall Testing	$100,000		$100,000

[42] CUP-Central Utility Plant

SUBTOTAL	***$10,735,012***	***$344,988***	**$11,080,000**
Total Uses of Funds	***$470,962,155***	***$68,596,717***	***$539,558,871***
Sources of Funds			
Cash	$38,588,871		$38,588,871
Philanthropy (to date and expected)	$50,000,000		$50,000,000
Authorized Bonds	$264,727,283	$68,596,717	$333,324,000
Interest Income from bond proceeds	$17,646,000		$17,646,000
State Grant	$100,000,000		$100,000,000
TOTAL USES OF FUNDS	***$470,962,155***	***$68,596,717***	***$539,558,871***

Source: DI #11, Ex. 27, Table E.

APPENDIX 3

MVS ANALYSIS

Marshall Valuation Service Review

The Marshall Valuation System – what it is, how it works

In order to compare the cost of a proposed construction project to that of similar projects as part of a cost-effectiveness analysis, a benchmark cost is typically developed using the Marshall Valuation Service ("MVS"). MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses.

The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs *do not include* costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, general contingency set aside for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[1]

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs, the base costs are adjusted for a variety of factors (e.g., an add-on for sprinkler systems, the presence or absence of elevators, number of building stories, the height per story, and the shape of the building. The base cost is also adjusted to the latest month and the locality of the construction project.)

Developing the MVS Benchmark for the Proposed Project

Both UM SHS and MHCC staff performed independent analyses to arrive at the MVS benchmark value calculated for the proposed project. In this project, UM SHS proposes the new construction of a six-story, 407,872 SF addition. UM SHS calculated an MVS value of $583.51 per SF (DI #11, pp. 12-24), while Commission staff arrived at an MVS value of $582.15 per SF. Both UM SHS and Commission staff used the base cost for a good quality, Class A construction for a general hospital. UM SHS submitted its CON application in January 2023, and used the MVS base costs and multipliers that were available at that time. MHCC staff updated the MVS figures to those available in October 2023. The differences in these figures are highlighted in yellow in the table below. Other differences, mostly due to differences in rounding, can be seen in green.

Table 1: Calculation of Marshall Valuation Service Benchmark

New Construction	Applicant Calculation			MHCC Staff Calculation		
Class	**A**			**A**		
Quality	**Good**			**Good**		
Type Structure	**New Patient Tower**	**Mechanical Penthouse**	**CUP**	**New Patient Tower**	**Mechanical Penthouse**	**CUP**
Floors	6	1	1	6	1	1
Total Square Footage		2,510	22,385	382,977	2,510	22,385
Average Perimeter		204	610	1,366	204	610
Average Height		21.83	20	15.3	21.83	20
Average Area Per Floor		2,510	22,385	63,830	2,510	22,385
Base Cost	$485.00	$105.00	$485.00	$485.00	$105.00	$485.00
Department Differential Cost	1.05	1.0	0.7	1.05	1.0	0.7
Gross Base Cost	$511.62	$105.00	$339.50	511.62	$105.00	$339.50
Perimeter Multiplier	0.902213343	1.053432	0.9197208	0.9022	1.0534	0.9197
Story Height Multiplier	1.076	1.22609	1.184	1.076	1.226	1.184
Multi-story Multiplier *	1.015	1.020	1.000	1.015	1.000	1.000
Multipliers	0.98534328	1.3174	1.0890	0.9853	1.2915	1.0889
Refined Square Foot Cost	$503.99	$138.33	369.71	$503.95	$135.61	$369.69
Elevator Add on			($8.70)			($8.70)
Sprinkler Add-on	$3.09		7.38	$3.09		$7.38
Adjusted Refined Square Foot cost	507.07	$138.33	367.60	$507.04	$135.61	$368.37
Current Cost Modifier	1.21	1.21	1.21	1.22	1.22	1.22
Local Multiplier	0.97	0.97	0.97	0.96	0.96	0.96
CC & Local Multipliers	1.174	1.174	1.174	1.171	1.171	1.171
MVS Building Cost Per Square Foot	$595.15	$162.36	$431.46	$593.74	$158.80	$431.36
Building Square Footage	382,977	2,510	22,385	382,977	2,510	22,385
MVS Building Costs	$227,928,762	$407,524	$9,658,232	$227,388,764	$398,588	$9,655,994
Final MVS Cost Per Square Foot			$583.51			$582.15

Source: DI#11, p. 16-17.
*Multi-story Multiplier – Add .5% (1/2%) for each story over three, above ground, to all base costs, including basements. (Marshall & Swift Valuation Service, Section 15, Page 25, November 2019).
Green – Differences in numerical rounding, Yellow – differences due to multiplier updates.

For UM SMC Replacement Hospital – October 2023

Comparing Estimated Project to the MVS Benchmark

UM SHS calculated an estimated cost of $583.51 per SF for the new patient tower, whereas Commission staff calculated the cost at $582.15 per SF, a difference of $1.36 (> 1%). Please see Table 2 below, which compares UM SHS's and MHCC staff's analyses in evaluating the new construction project costs with the MVS benchmark value.

Table 2: UM SHS and Commission Comparison of New Construction Budget To Marshall Valuation Service Benchmark

Project Budget Item	Applicant	MHCC
Building	$170,364,261	$170,364,261
Fixed Equipment	Include Above	Include Above
Site Preparation	$649,215	$649,215
Architectural Fees	$11,000,000	$11,000,000
Permits	$6,135,000	$6,135,000
Cap. Construction Int. & Finance Fees	$28,248,645	$28,248,645
Total	**$188,048,476**	**$188,048,476**
Loan Placement Fees	$2,024,675	$2,024,675
Capitalized Construction Interest	$30,277,902	$30,277,902
Adjusted Total for MVS Comparison	**$218,326,378**	**$218,326,378**
Total Hospital Square Footage	**407,872**	**407,872**
Adjusted Hospital Cost Per SF	**$535,28**	**$535,28**
MVS Benchmark Cost Per SF	$583.51	$582.15
Total Over (Under) MVS Benchmark	**($48.23)**	**($46.87)**
Total Over (Under) MVS Total Cost	**($19,671,667)**	**($19,116,961)**

As shown above, Table 2 indicates that UM SHS (DI #11, pp. 15-18) and the Commission staff calculated different values for The MVS benchmark for the construction of the replacement hospital. Both the applicant and staff calculated a benchmark above the projected cost of construction of the new facility. As the project costs do not exceed the calculated MVS benchmark, there is no MVS related exclusion any rate request submitted to the HSCRC.

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[1] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2016).

APPENDIX 4

HSCRC LETTER

maryland
health services
cost review commission

Memorandum

To: Wynee Hawk, Director, Facilities Planning & Development, MHCC
Jeanne-Marie Gawel, Acting Chief, CON, MHCC
Moira Lawson, Program Manager, CON, MHCC

From: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Director, Revenue & Regulation Compliance, HSCRC
Bob Gallion, Associate Director III, Revenue & Regulation Compliance, HSCRC

Date: July 14, 2023

Re: University of Maryland Shore Regional Health, Inc. (SRH)
University of Maryland Shore Health System, Inc. (SHS)
University of Maryland Shore Medical Center at Easton (SMCE)
Certificate of Need – Relocation and Construction of Replacement Hospital

This memo is in response to your communication dated May 9, 2023, requesting our review of financial projections as provided in the Certificate of Need (CON) application dated January 6, 2023, and our opinion on the financial feasibility of the proposed project.

BACKGROUND

SRH is a subsidiary of the University of Maryland Medical System (UMMS). SRH is the parent corporation of SHS, Chester River Hospital Center, Shore Medical Group, and other non-hospital entities. SHS operates SMCE, Shore Emergency Center at Cambridge (SECC), and Shore Emergency Center at Queenstown (SECQ). In addition, SHS operates several unregulated facilities in Easton, Denton, Cambridge, and Centreville.

SHS has submitted a CON application proposing to construct a 407,872 square feet (SF) 110-bed replacement hospital in Easton. SHS explained that the existing hospital, which dates in part to the early 1900's, is obsolete and located in a residential neighborhood, which limits any hospital expansion and makes accessing the hospital inconvenient for patients and staff.

The applicant filed a CON application for a similar project on the same site in 2012, but it was withdrawn in 2018 due to significant changes post docketing. The applicant again filed a CON application in 2018 for a similar project on the same site, but review was deferred at the applicant's request pre docketing.

THE PROJECT

SHS is proposing a capital expenditure of approximately $540 million to construct a six-story hospital with 110 acute care beds and 12 special hospital rehabilitation beds, as well as 25 observation beds. The hospital will also include a surgery suite with 7 operating rooms, an emergency department (ED) containing 27 treatment spaces, and 3 behavioral health holding spaces, regulated outpatient clinics, a full-service laboratory, and space for administrative and education functions.

The project's budget was assembled in November 2022 and is based upon cost estimates collected mid-2022. At this time there are no firm bids or contracts, such are to be solicited closer to the completion of the CON process. The applicant is to complete the proposed project in 36 months after signing the construction contract. The total cost of the project is approximately $540 million, with approximately $471 million for the hospital building and $69 million for the central utility plant. The hospital component budget consists of $2.5 million for the land purchase; $261.5 million for construction; $85.1 million for movable equipment, $17.0 million contingency allowance, $44.2 million for gross interest during construction; $24.6 million for other capital costs, $25.4 million for inflation allowance; and $10.7 million for financing costs. SHS plans to finance the project with $38.6 million in cash; $50 million in philanthropic gifts; $333.3 million in authorized bonds; $17.7 million on interest income from bond proceeds; and $100 million in state funds. MHCC staff notes that, to date, the state has authorized $30 million towards the project.

MHCC has stated that the utilization projections included in the CON are reasonable, and that HSCRC staff may assume that the new hospital will achieve its projected utilization volumes.

HSCRC STAFF REVIEW, DISCUSSION, and OPINION

HSCRC staff (Staff) reviewed the following materials: the SHS CON dated January 6, 2023; SHS Responses to Completeness Questions dated February 22, 2023; SHS Responses to Additional Questions dated March 21, 2023; SHS Responses to Additional Questions dated March 22, 2023; SHS Responses to Additional Questions dated April 28, 2023; UMMS presentation dated July 13, 2023, and the Independent Audit Report for UMMS for fiscal years ended June 30, 2022, and June 30, 2021.

Staff noted that the CON application (page 21) referred to the existing hospital campus and SRH's plans for convening a special study group focused on the disposition of the existing hospital site in downtown Easton. The Staff understands that the proceeds of any liquidation, should it follow the new construction, may well be material in value and would effectively lower the net cost of this project. The Table E Project Budget, as it stands currently, does not provide a credit provision against the usage cost for such value, nor does it include this potential windfall among the sources of financing. Any liquidation value realized will lower the cash drain of this project.

Staff noted that the CON application (page 56) also referred to the applicant's intent to seek an increase in rates for 50% of the incremental regulated capital costs (plus markup) associated with the proposed project. The applicant's request for rate relief is to be filed as a Full Rate Application (FRA) in the first quarter of fiscal 2024 (after July 1, 2023). The P&L projections as provided in the initial CON tables are representative of SHS and include SMCE, SECC, and SECQ. The P&L projections include an estimate for a requested GBR award of $24 million to result from a planned FRA, which as per Responses dated March 21st, is to be made on behalf of SMCE to be effective fiscal 2029. Staff prepared a high-level test for the reasonableness of measured incremental depreciation and interest. Acquired depreciable assets valued at $526.0 million divided by 19 years average useful life as per stated assumptions yields $27.9 million in average annual depreciation. Assumed $333.3 million in debt financing over 30-year bond life at 5% as per stated assumptions, yields $10.6 million in average annual interest. Together, interest and depreciation tally $38.5 million. A 50% request plus markup would approximate an ask of $19.25 million. A preliminary review of the capital model implies that no material capital award would result, due to the relative inefficiency of the hospital's service cost as compared to its peer group hospitals. The formula for a full rate application differs from these high-level tests. However, the projected award as included in the initial CON and the Responses may be quite optimistic, and likely overstated.

Staff noted that the CON application (page 99) referred to the format of Tables F, G and H (representing Entire Facility Statistics, P&L Uninflated and P&L Inflated, respectively) as being representative of SHS (inclusive of health care facilities in Easton, Cambridge, and Queenstown). Such a contention is based on the premise that Cambridge and Queenstown are outpatient extensions of the Easton facility. Given that each of the three (3) health care facilities that comprise SHS file separate annual reports and have separate Medicare identification numbers, and only one of the three is expected to file an FRA seeking award to fund incremental capital related operating costs, Staff requested stand-alone P&L projections for SMCE, in addition to the consolidated projections for SHS.

Staff noted that the P&Ls for SHS labeled as "Actual" for FY 2021 and FY 2022 and as reflected in the initial CON Tables G and H (with operating income of $25,090,000 and $30,787,000, respectively) did not tie to the P&Ls for those same periods as reflected in the audited consolidating financial statements (with operating income of $47,657,000 and $55,157,000, respectively). The Tables were corrected and resubmitted as part of the February 22nd responses. In addition, the February 22nd Responses note (page 26) that SHS is composed of SMCE, SECC and SECQ, while SRH is composed of SHS, Chester River Hospital Center in Chestertown, Shore Medical Group, and other non-hospital entities. Additionally, and consistent with the Responses dated March 21st, it should be noted that SHS's operating performance as presented in the audit report is inclusive of allocations of the operating results of the Shore Medical Group. Allocations of the losses incurred by the physician group are not included in the projections.

Staff has noted recently reported project cost escalations on other hospitals' capital projects related to delayed and extended construction schedules owing to the global supply chain interruptions, employment issues, and economic price inflation related to the continuing impacts of the COVID-19 pandemic. Staff recently assisted in studying a request for a post approval project change related to a 38% project budget cost increase and a year-long construction delay on the Shady Grove patient tower project, and Staff has been requested to assist on a post approval project change related to a 37% project budget cost increase on the UMMC Greenebaum Cancer Center. Staff notes that such cost escalations make budget provisions

for contingencies and inflation very important, and potentially result in changes to any Marshall Valuation Service (MVS) exclusion measure. As per the March 21st Responses, the construction phase on this project is estimated to conclude in the summer of 2028. And the project budget is based upon cost estimates received in mid-2022, not bids or contracts. That implies a 6-year span of exposure. As per the February 22nd Responses, the budget provision for contingencies is 7% of construction costs, and the provision for inflation is 5.75% of capital costs. Together, these provisions provide approximately $48.2 million in cushion for budget cost overruns.

The Table E Project Budget included in the initial CON reflects sources of funds to include $100 million from state grants. Such value was based upon former Governor Hogan's budget proposal. Currently the commitment from the state stands at $30 million. As per the February 22nd Responses, if the shortage were to be covered by increases in bond financing, it would imply a $4.70 increase in annual interest and a $0.60 increase in annual depreciation for every $100 increase in borrowing. Accordingly, it follows that $70 million in added borrowing would push approximately $3.29 million in annual interest and $0.42 million in annual depreciation. As per the April 28th Responses, SRH expects to work with the current administration, Governor Moore, to lobby for more funding.

The Table E Project Budget included in the initial CON reflects sources of funds to include $50 million from philanthropy. As per the February 22nd Responses, approximately $7 million to $10 million sits with the Memorial Hospital Foundation (MHF) as restricted funds. As per the March 21st Responses, the timeline for securing pledges is the end of the construction phase of the project (summer 2028). Should pledges fall short of the goal, then SRH plans to tap into MHF unrestricted funds and additional borrowing.

Staff tested the reasonableness of the P&L implications of the project budget components. The high-level tests of average annual depreciation expense ($27,961,000), capitalized interest during construction ($49,999,000), interest expense by year following construction ($15,694,000 in 2029), and interest income on bond proceeds ($17,646,000) resulted in immaterial variances, and therefore such are judged to be reasonable.

Staff noted cumulative projected "performance improvements" of $15.3 million are spread between 2024 and 2027. As per the March 21st Responses, these performance improvements are related to efficiencies to be achieved in payroll expense ($8 million due to agency normalization and staffing demand in patient care centers); supplies expense ($7 million due to 340B drug savings and inventory management); and purchased services expense ($0.3 million due to repairs and maintenance savings). Staff has noted that such performance improvements are anticipated to be achieved at the existing facility now that the pandemic has concluded and prior to the planned opening of the new facility in 2029. Staff takes caution that to the extent that such performance improvements are not realized, such may represent negative cushion in the projections.

Staff prepared a pro forma presentation of Table G - P&L Uninflated for entire facilities of applicant SHS, with revenues reflective of review of the 2023 rate file, adjustments (-$610,012) for All Payer Reduction for TCOC Medicare Compliance, a $0 award in 2029 for incremental capital expense, 0.05% annual rate increases as per Table G assumptions; and expenses reflective of $15.3 million performance

improvements as submitted per the March 21st Responses. Average annual operating loss for the four (4) years ended 2032 was -$17.0 million. The average annual net loss for that 4-year post opening period was -$1.8 million. And average annual cash flow from operations for the 4 years was a positive $26.1 million.

Staff prepared a pro forma presentation of Table H – P&L Inflated for entire facilities of applicant SHS, with revenues reflective of review of the 2023 rate file, adjustments (-$610,012) for All Payer Reduction for TCOC Medicare Compliance, a $0 award in 2029 for incremental capital expense, 2.55% annual rate increases as per Table H assumptions; and expenses reflective of $15.3 million performance improvements as submitted per the March 21st Responses. Average annual operating loss for the four (4) years ended 2032 was -$14.3 million. The average annual net income for that 4-year post opening period was +$3.3 million. And average annual cash flow from operations for the 4 years was a positive $28.8 million.

Staff prepared a pro forma presentation of Table J (or Alternate Table G) – P&L Uninflated for new facility SMCE, with revenues reflective of review of the 2023 rate file, adjustments (-$558,978) for All Payer Reduction for TCOC Medicare Compliance, a $0 award in 2029 for incremental capital expense, 0.05% annual rate increases as per Table G assumptions; and expenses reflective of $15.3 million performance improvements as submitted per the March 21st Responses. Average annual operating loss for the four (4) years ended 2032 was -$10.8 million. The average annual net income for that 4-year post opening period was +$4.4 million. And average annual cash flow from operations for the 4 years was a positive $30.8 million.

Staff prepared a pro forma presentation of Table K (or alternate Table H) – P&L Inflated for new facility SMCE, with revenues reflective of review of the 2023 rate file, adjustments (-$558,978) for All Payer Reduction for TCOC Medicare Compliance, a $0 award in 2029 for incremental capital expense, 2.55% annual rate increases as per Table H assumptions; and expenses reflective of $15.3 million performance improvements as submitted per the March 21st Responses. Average annual operating loss for the four (4) years ended 2032 was -$6.6 million. The average annual net income for that 4-year post opening period was +$10.3 million. And the average annual cash flow from operations for the 4 years was a positive $35.1 million.

Staff requested, but did not receive, projected balance sheets for SHS and SMCE for the periods beyond 2022. Thus, Staff is not able to comment on projected days' cash on hand to fund cash basis operating expenses, nor debt service coverage ratios for the projected operating periods through 2032. However, given that the projected cash flow for SHS and SMCE is positive throughout the periods projected, cash is not expected to be depleted during the periods projected. Also, given that accrual basis losses are reflected in all four of the pro forma tables discussed above, there may be times when the debt service coverage ratios for SHS and SMCE may become uncomfortably modest.

As per the March 21st Responses, the obligated group for debt service for any bonds issued (anticipating $333.3 million MHHEFA bonds expected to be issued around October 2025) to finance the project is UMMS, inclusive of all thirteen (13) obligated group members. As per review of the audit report for 2022, UMMS had $1.7 billion in cash, equivalents, and unrestricted investments at June 30, 2022. Cash

basis operating expenses per day were $12.7 million, and that implies days' cash on hand to fund cash basis expenses of 132 days. The cash planned to fund this project is $38.6 million which equals three (3) days' cash supply. At June 30, 2022, the Debt Service Coverage Ratio (DSCR) for UMMS was approximately 1.92:1 (EBITDA of $307,507,000 / Debt Service of $159,544,000). If the planned debt for this project were assumed at June 30, 2022, then the pro forma DSCR for UMMS would have been approximately 1.70:1 (based on a debt service increase of $21,683,205).

Based upon review of the materials submitted, it is the opinion of Staff that launching this project *may* be financially feasible, and that this project *may* be viable on an ongoing basis. The financial feasibility of this project is dependent on a number of factors described in this report. Specifically, the applicant's management will need to work towards realizing the potential of several challenges presented here: to maximize the potential liquidation value of the current campus; to realize greater efficiencies in operating the hospital services as compared to its peer hospitals; to realize the performance improvements assumed in the projections; to minimize potential cost overruns on the project budget; and to maximize fund raising both philanthropic and governmental.

APPENDIX 5

SITE MAP/FLOOR PLANS/DRAWINGS

UNIVERSITY of MARYLAND MEDICAL SYSTEM

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EASTON, MD

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SHORE HEALTH SYSTEM
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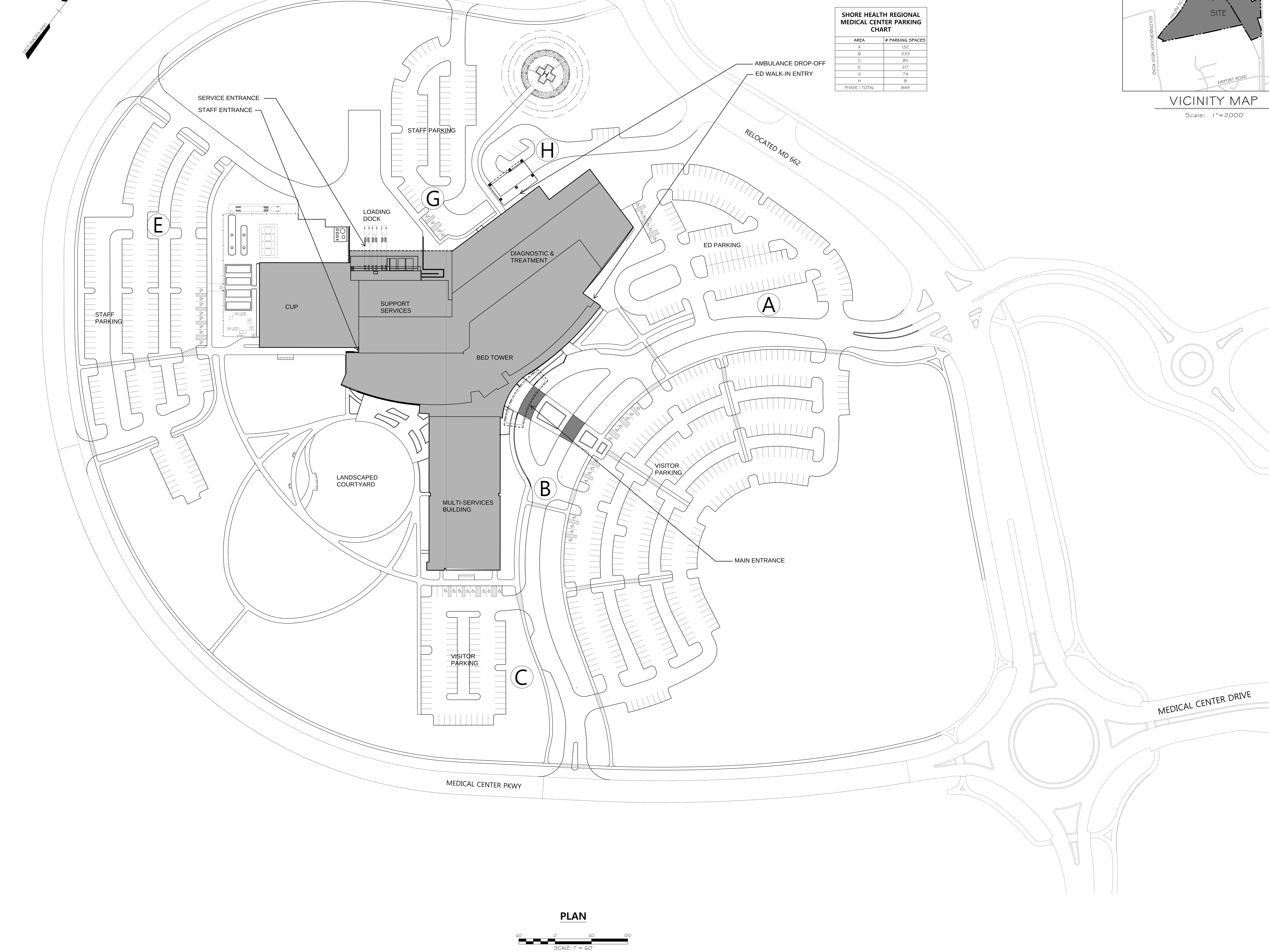
CON SUBMISSION

JANUARY 6, 2023 [UPDATED]

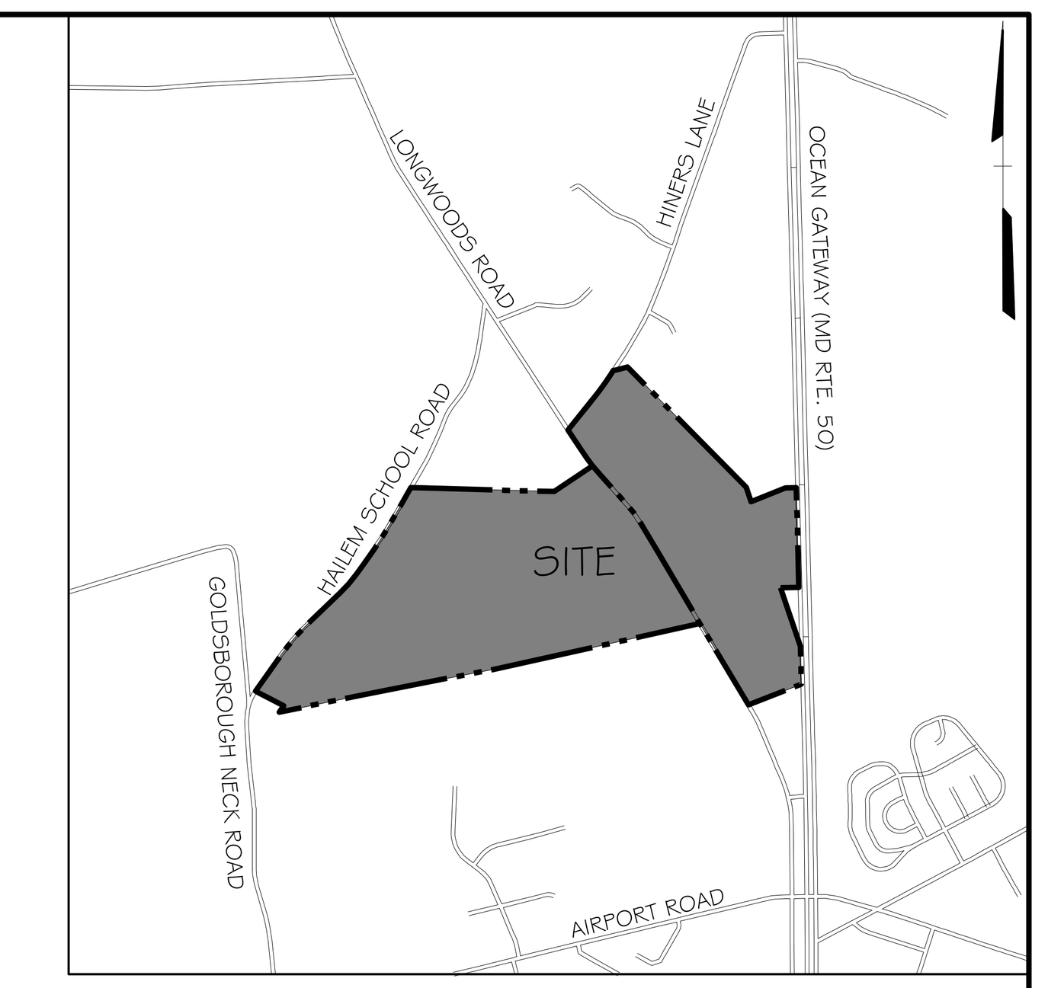
HKS # - 19782.000



SHORE HEALTH REGIONAL MEDICAL CENTER PARKING CHART	
AREA	# PARKING SPACES
A	132
B	333
C	85
E	217
G	74
H	8
PHASE I TOTAL	849

PLAN

SCALE: 1" = 60'



VICINITY MAP

Scale: 1"=2000'

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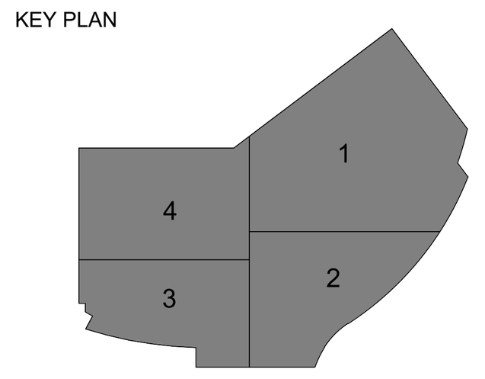
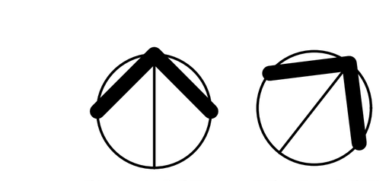
INTERIM REVIEW ONLY

These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.

Civil Engineer: Kristy M Bishoff
PE Reg. No.: 28823
Date: 10/25/2022

KEY PLAN





REVISION

NO.	DESCRIPTION	DATE

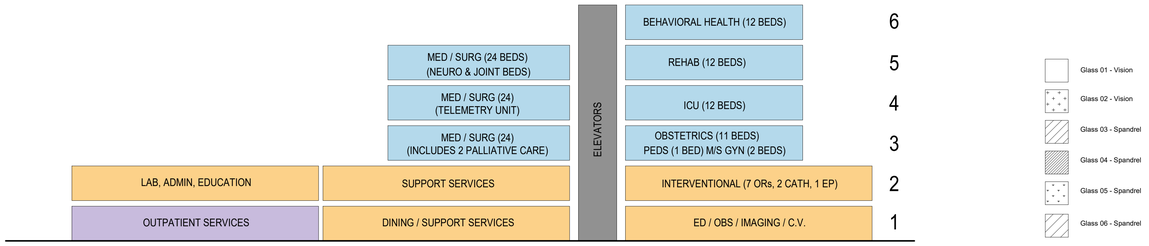
HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
PHASE 1 DEVELOPMENT SITE PLAN

SHEET NO.
CON 07



03 STACKING DIAGRAM
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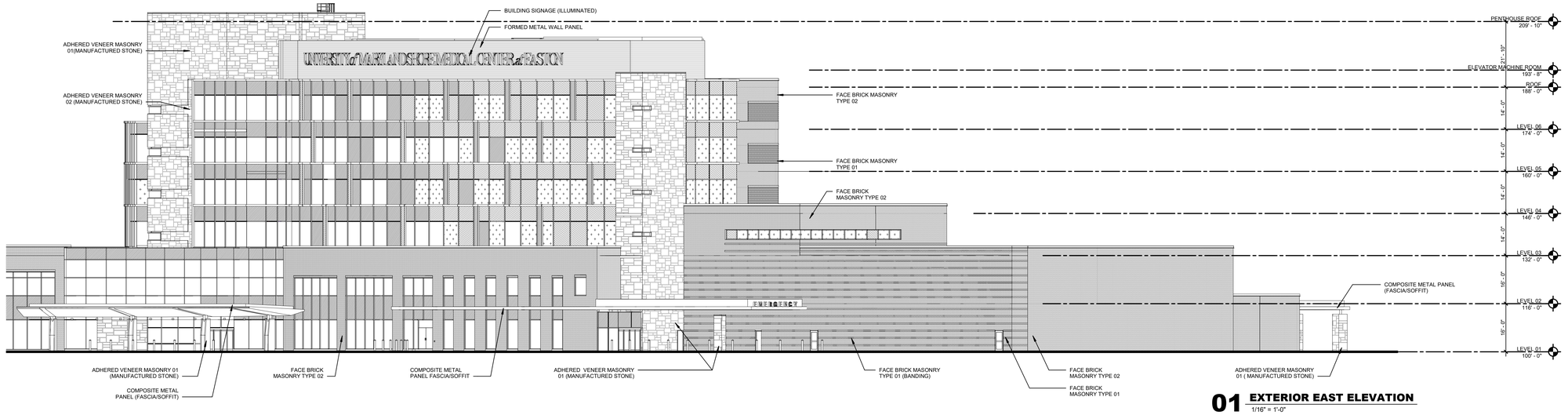

01 EXTERIOR EAST ELEVATION
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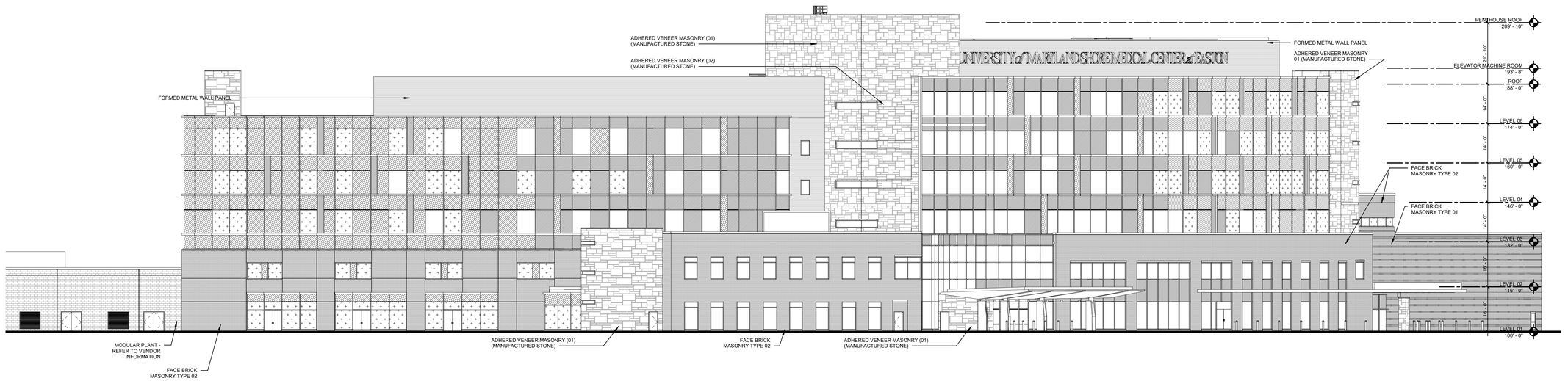

02 EXTERIOR SOUTH ELEVATION
1/16" = 1'-0"

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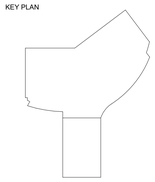
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

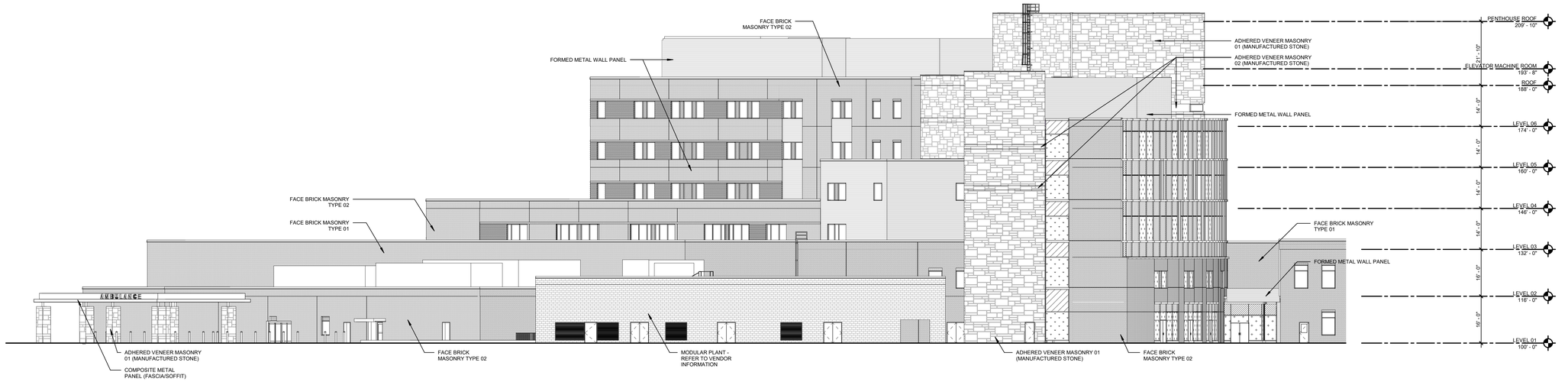
HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
EXTERIOR ELEVATIONS

SHEET NO.
A5.010



01 EXTERIOR WEST ELEVATION
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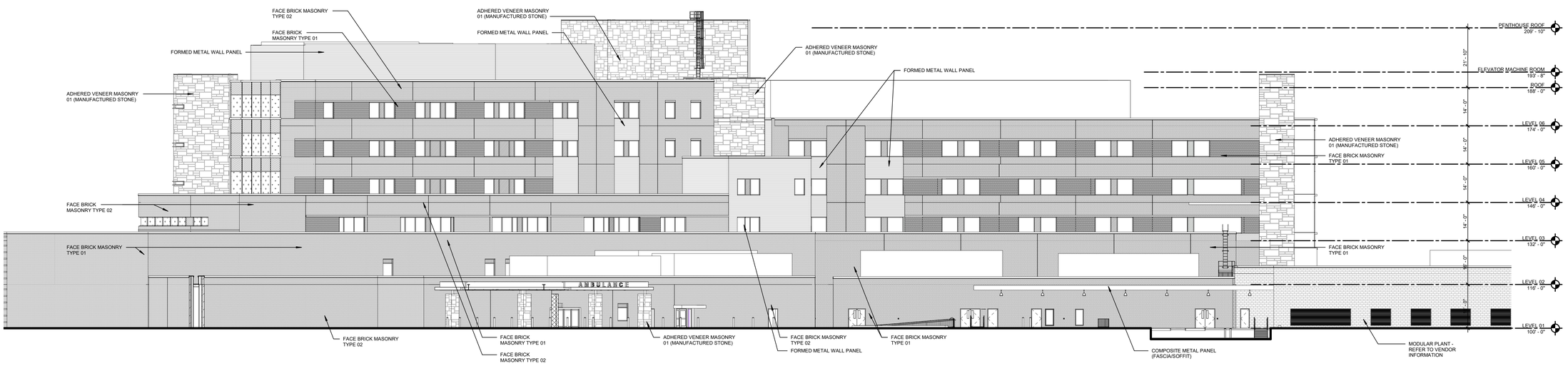

02 EXTERIOR NORTH ELEVATION
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Architect: Shannon B. Kraus
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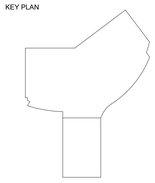
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION

NO.	DESCRIPTION	DATE

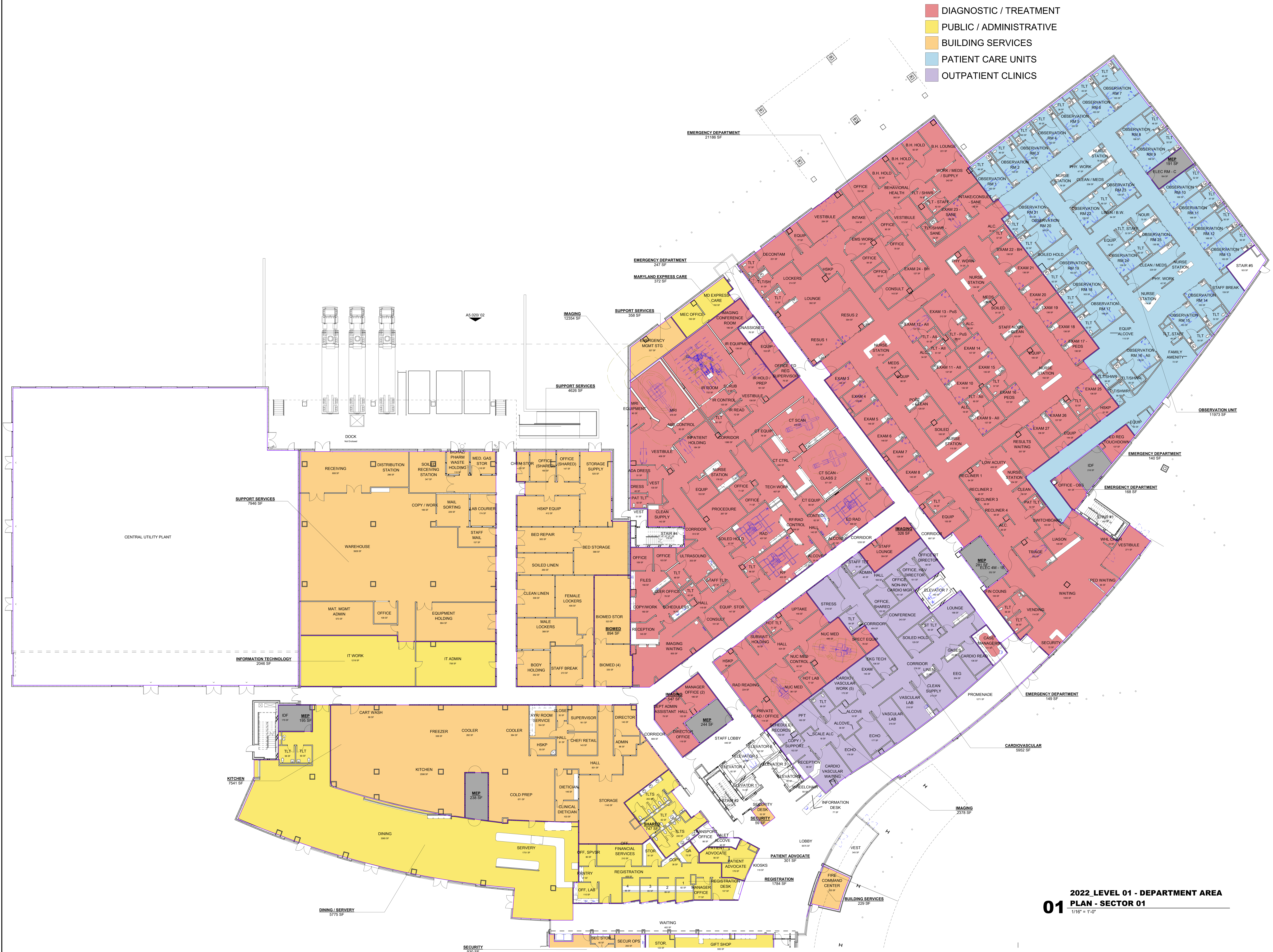
HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
EXTERIOR ELEVATIONS

SHEET NO.
A5.020



01 **2022_LEVEL 01 - DEPARTMENT AREA PLAN - SECTOR 01**

1/16" = 1'-0"

PLOT DATE: 11/28/2022 4:12:08 PM

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INTERIM REVIEW ONLY
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Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN
1
2
3
4

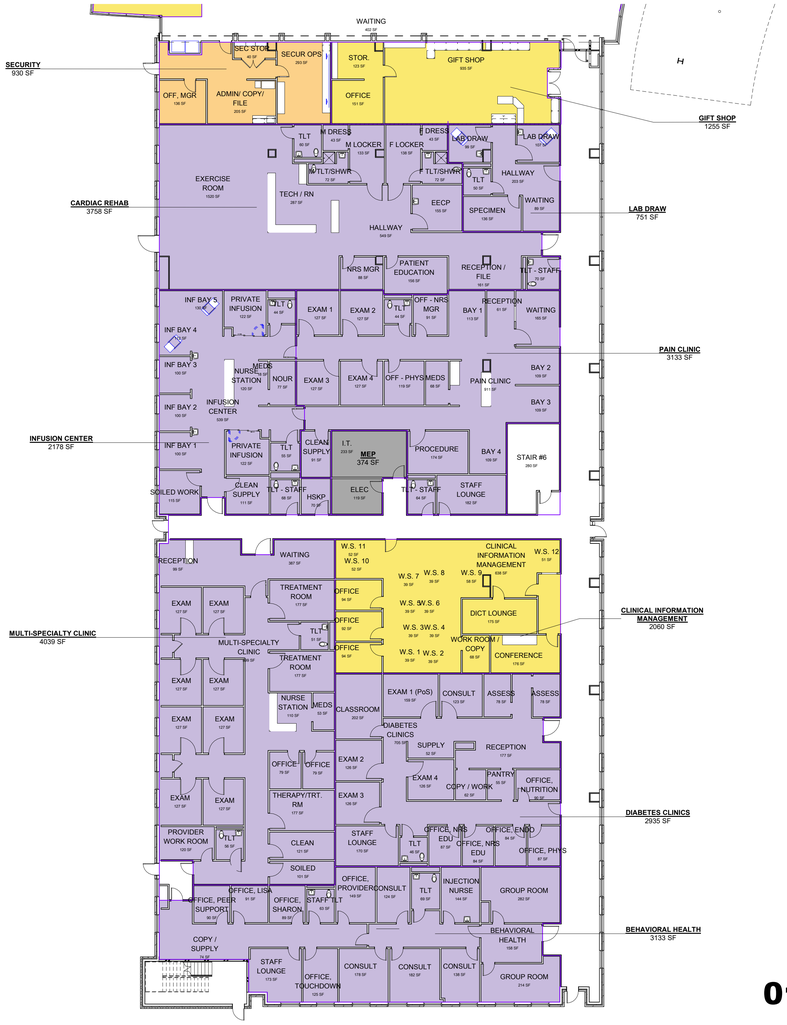
PLAN NORTH
TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010
DATE
JANUARY 6, 2023
ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 01 - DEPARTMENTAL AREA PLAN SECTOR 01
CON 08

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS



01 2022_LEVEL 01 - DEPARTMENT AREA PLAN - SECTOR 02
1/16" = 1'-0"

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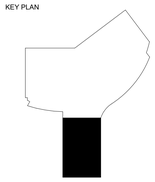
Architect: Shannon B. Kraus
Arch. Reg. No.: 16103
Date: 10/25/2022

KEY PLAN



PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 01 - DEPARTMENTAL AREA PLAN SECTOR 02

CON 08A

PLOT DATE:
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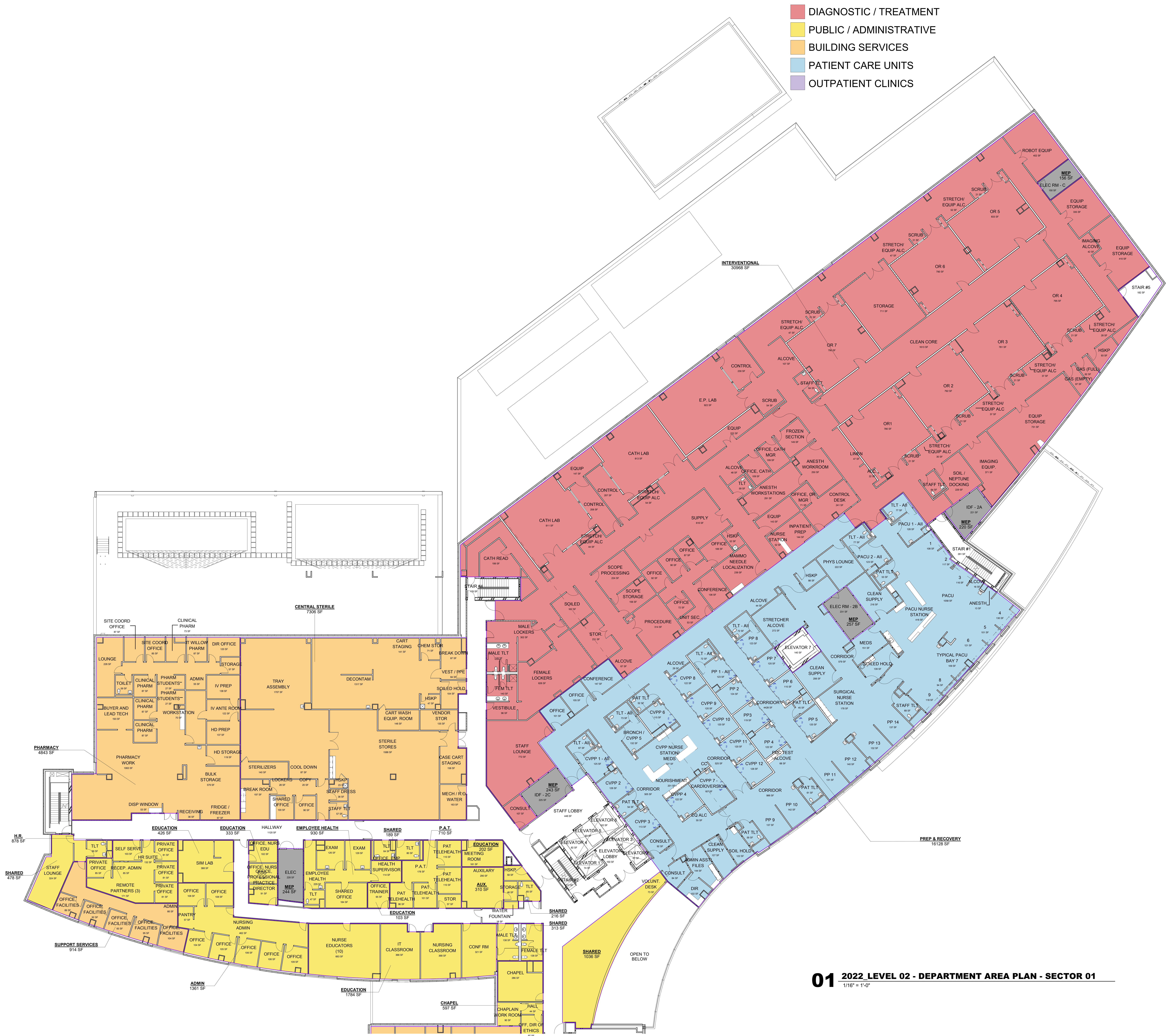

01 **2022_LEVEL 02 - DEPARTMENT AREA PLAN - SECTOR 01**
1/16" = 1'-0"

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Date: 10/25/2022

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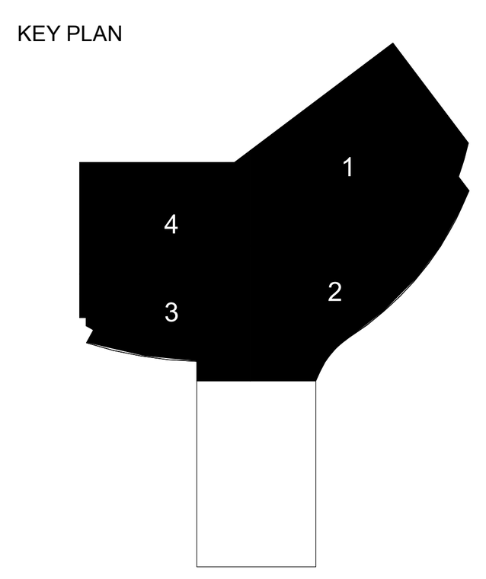

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HKS PROJECT NUMBER
19782.010
DATE
JANUARY 6, 2023
ISSUE
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SHEET TITLE
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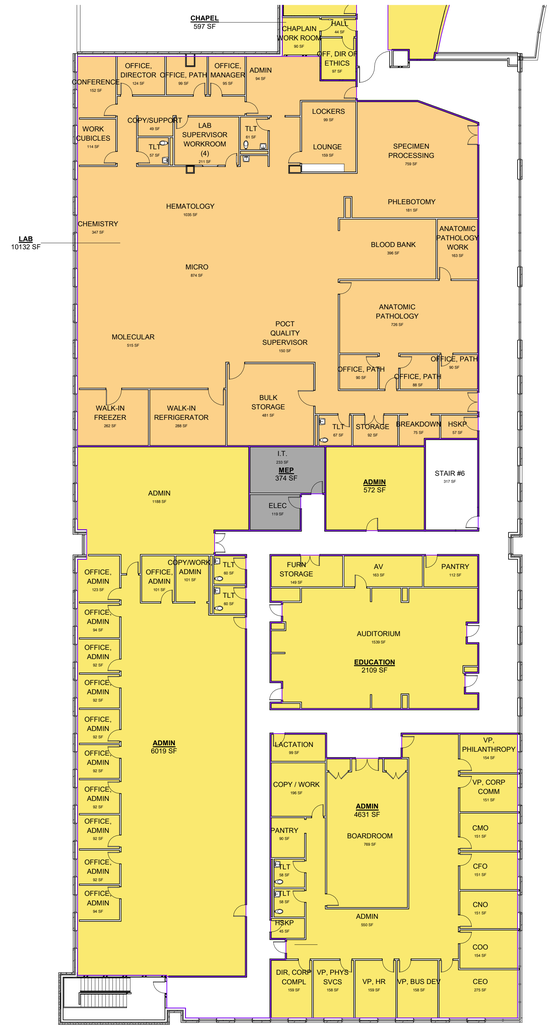
CON 09

PLOT DATE: 11/29/2022 4:12:51 PM

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS



01 **2022_LEVEL 02 - DEPARTMENT AREA PLAN - SECTOR 02**
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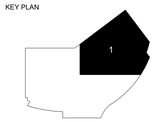
Architect: Leslie Hanson
Arch. Reg. No.: 16795
Date: 01/23/2013

KEY PLAN



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NO. DESCRIPTION DATE

HKS PROJECT NUMBER
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DATE
JANUARY 6, 2023
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SHEET TITLE
LEVEL 02 - DEPARTMENTAL AREA PLAN SECTOR 02
CON 09A

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DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

01 **2022_LEVEL 03 - DEPARTMENT AREA PLAN**
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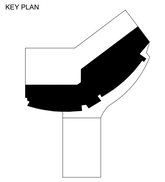

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REVISION

NO.	DESCRIPTION	DATE
A	Perinatal Unit reduces to 11 Beds with adjacent 5 Bed Med/Surg Unit	Jan. 13, 2017

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

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LEVEL 03 - DEPARTMENTAL AREA PLAN

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CON 10

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

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1/16" = 1'-0"

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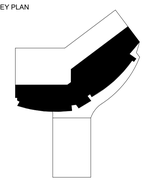

PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010

DATE
JANUARY 6, 2023

ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 04 - DEPARTMENTAL AREA PLAN

SHEET NO.
CON 11

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS

01 **2022_LEVEL 05 - DEPARTMENT AREA PLAN**
1/16" = 1'-0"

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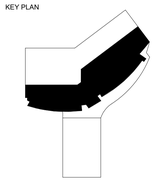


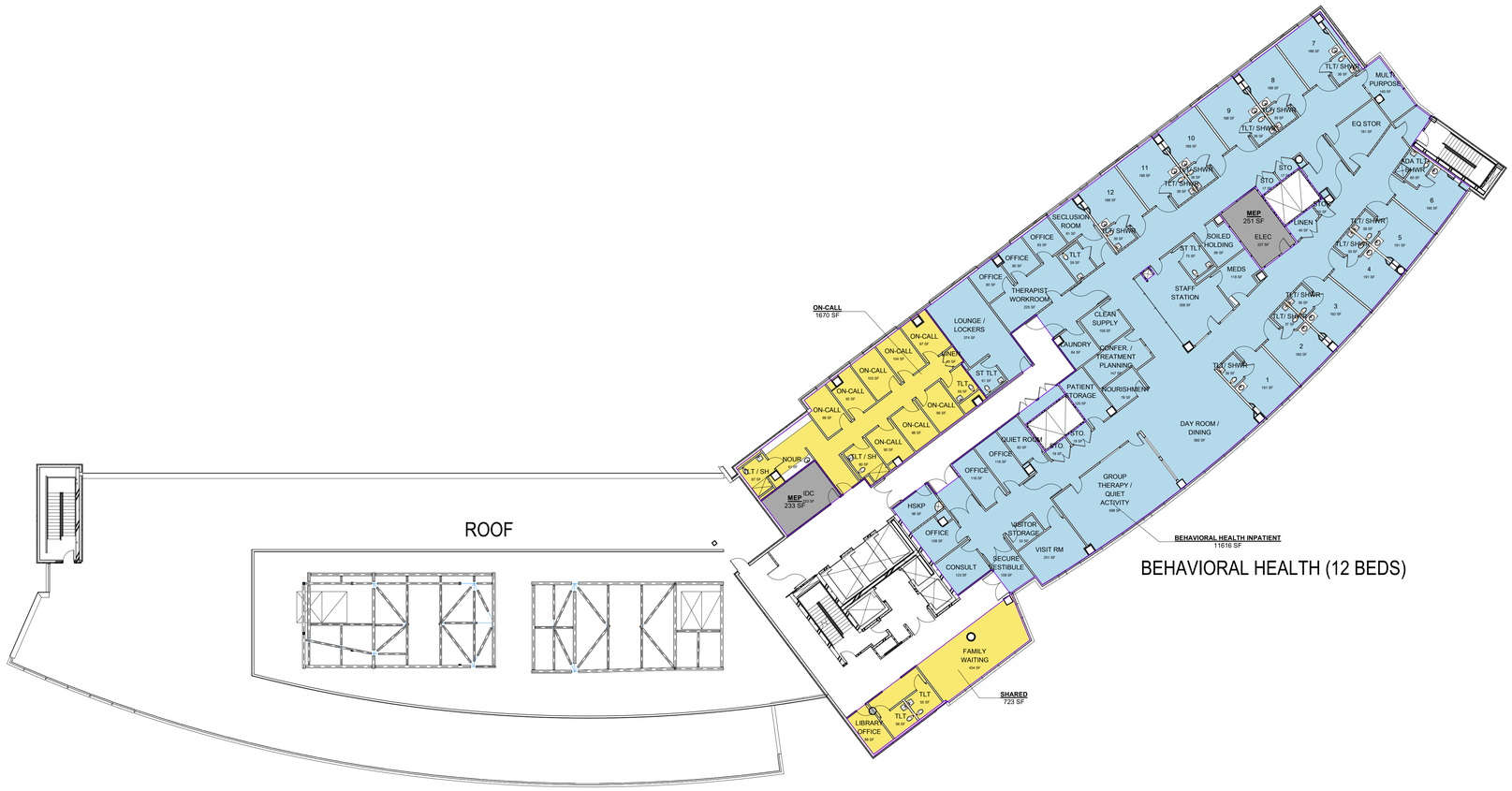
PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010
DATE
JANUARY 6, 2023
ISSUE
CON SUBMISSION

SHEET TITLE
LEVEL 05 - DEPARTMENTAL AREA PLAN
SHEET NO.
CON 012

DIAGNOSTIC / TREATMENT
PUBLIC / ADMINISTRATIVE
BUILDING SERVICES
PATIENT CARE UNITS
OUTPATIENT CLINICS



BEHAVIORAL HEALTH (12 BEDS)

01 2022_LEVEL 06 - DEPARTMENT AREA PLAN
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PLOT DATE:
1/26/2023 4:13:52 PM

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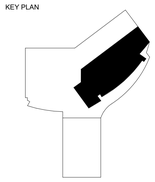

PLAN NORTH TRUE NORTH

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.010

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JANUARY 6, 2023

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SHEET TITLE
LEVEL 06 - DEPARTMENTAL AREA PLAN

SHEET NO.
CON 013

APPENDIX 6

SUMMARY OF COMPLIANCE WITH STATE HEALTH PLAN CHAPTERS

COMAR 10.24.10 - Acute Care Hospital Services

COMAR 10.24.10.04A — General Standards.

(1) Information Regarding Charges

Staff reviewed the applicant's policy for the provision of information to the public concerning charges and the list of charges on the website. The applicant's policy (DI #3, Exh. 5, page 2) aligns with the stipulated standards, requiring a written and online list of services and charges. The provided link directs users to a comprehensive list of services and associated charges. Additionally, the policy includes procedures for responding promptly to individuals requests for current charges and emphasizes staff training to ensure the appropriate handling of inquiries related to service charges.

Given this approach, staff concludes that the applicant meets this standard.

(2) Charity Care Policy

The applicant stated that UM SMC Easton offers care to all patients, irrespective of their ability to pay, and has provided documentation of its *Financial Assistance Policy* (DI #3, Exhibit 7). Additionally, the applicant submitted evidence of its *Notice of the Availability of Charity Care* (DI#3, Exhibits 8 and 9). Staff reviewed these policies and found them adequate. Staff further confirmed UM SMC Easton's level of charity care is above the bottom quartile in the most recent HSCRC hospital benefit report. In the application, the applicant provided a response that discussed its commitment to community benefit.. Staff concluded that the application is consistent with the Charity Care Policy standard.

(3) Quality of Care

The applicant has demonstrated that UM SMC Easton adheres to the quality of care standards, holding licenses from the Maryland Department of Health and certifications from Medicare and Medicaid, along with accreditation by the Joint Commission (DI#3, Exhibit 10 and 11). In addressing below-average measures in the *Maryland Hospital Performance Evaluation Guide*, the applicant has outlined specific corrective actions, such as implementing noise reduction measures and enhancing maternity care services. The staff concludes that the applicant satisfactorily explains how the below-average measures are being addressed and is ready to implement corrective actions . Staff concludes that the applicant meets the quality of care standard.

COMAR 10.24.10.04B - Project Review Standards

Geographic Accessibility

This standard requires an evaluation as to whether a proposed project is located to optimize accessibility in terms of travel time for its likely service area population. The standard defines

optimal travel time as being within 30 minutes under normal driving conditions for 90 percent of the population of a hospital's likely service area. The applicant's methodology shows that on aggregate, the travel time to the new site is less than the travel time to the existing hospital for individuals living within the primary and secondary service areas.

While four of the 23 ZIP codes in the service are outside of the required 30-minute drive, staff recognizes that the proposed facility is within a 30-minute commute for more individuals than the existing facility. Staff understands that UM SMC Easton will be the closest hospital for many residents living in the five county mis-Shore region and the new location is suitable to meet the needs of the vast majority of the service area. Staff therefore concludes that the proposed project meets this standard.

Identification of Bed Need and Addition of Beds

Taking into account a modest growth in population within UM SMC Easton's five-county service area, a modest increase in MSGA use rates, and the increased diversions due to Yellow and Red Alerts at Shore's emergency department during the pandemic, the applicant projects a need for 86 MSGA beds by FY 2032.[45] In addition, the inclusion of a one bed pediatric unit will allow UM SMC Easton to provide a needed continuum of pediatric services to the residents in the hospital's five-county service area. Staff concludes that the applicant complies with this standard.

Adverse Impact

This standard says that capital projects undertaken by hospitals shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. Staff concludes that the comparison group of hospitals developed by the applicant appears to be within reason and provides a fair comparison regarding its rates and average of plant. The information provided indicates that the hospital's rates are below its peer institutions, and that the current average age of the physical plant assets is greater than its peer institutions.

Staff has reviewed the changes in physical and licensed capacity. The total licensed beds are projected to increase from 118 to 122. This increase is based on the projected demographic trends in the marketplace and the utilization trends. The proposed change will not inappropriately diminish the availability or accessibility to care in the primary service area, including access for the indigent and/or uninsured. Staff concludes that, because there will not be an unwarranted adverse impact on hospital charges nor a change in the availability of or access to services resulting from this project, the applicant complies with the standard.

Cost-Effectiveness

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[45] Red Alert means the hospital has no ECG monitored beds available, defined as all critical care and telemetry beds. Yellow alert means the Emergency Department temporarily requests that absolutely no patients in need of urgent medical care be transported to the facility. Yellow alert is initiated because the Emergency Department is experiencing a temporary overwhelming overload of patients that may not be managed safely.
https://www.miemss.org/home/Portals/0/Docs/Guidelines_Protocols/Reg5_YellowAlertPolicy_2005.pdf

The identified objectives of this project include:

1. Providing flexibility to meet the long-term health care needs of its regional service area population;
2. Meeting the needs of an aging population;
3. Improving access to services;
4. Increasing physician recruitment; and
5. Improving the financial performance of the hospital.

In its evaluation, the applicant compared four options to meet the identified goals of this project to the needs of its service area population. The analysis, comparing the redevelopment of the existing campus and relocation to three different sites, weighed factors such as consumer confidence, operational disruptions, bed capacity and geographic accessibility The applicant ultimately selected Talbot County Community Center as the site for future expansion based on these considerations.

Staff finds that the applicant meets the cost-effectiveness standard, having assessed alternatives and chosen a course of action aligned with the project's primary objectives.

Burden of Proof Regarding Need

Staff concludes that UM SHS has successfully demonstrated the need for this project. This includes the need for a comprehensive modernization of the current physical facilities. Staff has concluded that this level of needed modernization is most cost-effectively achieved through relocation and replacement. The applicant has also demonstrated the need for the services and capacities. Staff concluded that the applicant's assessment of these needs to be reasonable and consistent with current trends in hospital use and the changing environment of hospital service delivery and payment for hospital services. Staff concludes that the applicant meets this standard.

Construction Cost of Hospital Space

UM SHS's proposed cost per square foot for the relocation of the hospital is $50.11 per SF less than the MVS benchmark. Therefore, there would not be any exclusion from any rate request submitted to the HSCRC for excessive capital cost of the hospital construction portion of this project. Staff concludes that the applicant therefore meets the standard.

Inpatient Nursing Unit Space

The standard stipulates that space exceeding 500 square feet per bed for inpatient nursing units should not be included in any rate increase related to the capital cost of the project. The applicant's submission indicates that while the average square footage per bed for all nursing unit spaces aligns with the standard, the nursing units for the ICU and the behavioral health units exceed 500 SF due to specific requirements to accommodate, for example, specialized equipment and designated areas for family/visitors [46]. Staff finds that the proposed inpatient

[46] The FGI Guidelines for ICU units (Section 2.2-2.6.10) and Behavioral Health Units (Section

nursing unit spaces on average meet the ≤ 500 square feet per bed standard. Staff concludes that the application meets this standard.

Efficiency

UM SHS has designed the building to the latest codes and standards for hospitals, which it expects to lower utility expenses by 20 percent compared to the existing hospital and lower repair costs by 40 percent. The applicant expects that these efficiencies will have a net savings of $321,000 in 2029 dollars after an offset for the larger footprint of the new facility. The applicant provided a list of efficiencies that will be put into place due to the implementation of the project, along with the resultant savings. Staff concludes that the applicant has complied with this standard.

Patient Safety

UM SHS appropriately considered patient safety when designing the new facility. The replacement hospital's modifications and design features reflect compliance with current hospital standards, showcasing a comprehensive approach to enhancing patient safety. The proposed modifications, including private rooms, universal design for patient lifts, and strategic placement of support functions, contribute to reducing risk and improving overall safety for patients, staff, and visitors. Staff acknowledges these efforts and concludes that the applicant meets the patient safety standard.

Financial Feasibility

The applicant has provided staffing projections as well as revenue and expense projections for the replacement hospital. The projections were reasonable based on population and utilization projections across UM SMC Easton Shore, UM SMC Dorchester, and UM SMC Queenstown. As discussed in the HSCRC memo to the Commission, the applicant supports their financial rationale by including their goal of $15 million efficiency savings by 2027 and a $24 million rate adjustment in 2029. In terms of staffing, the applicant projects a reduction of 98.7 FTEs by 2029, with a reduction of 4.4 FTEs specifically due to this project.

Revenue and expense projections show a positive operating margin through 2032, although the margin is reduced significantly when the new facility is open in 2029. While this reduction is acknowledged, staff concludes that the overall financial feasibility of this project remains and that the applicant has therefore met this standard.

Emergency Department Treatment Capacity and Space

The applicant states that the existing hospital experienced higher than normal MIEMSS red and yellow alerts during the COVID-19 pandemic, which adversely affected the number of patients served by the ED. The applicant projects that the overall number of MIEMSS alerts will decrease with the decrease in pandemic related ED visits and hospitalizations.

2.5-2.2.8).

This standard requires that the number of emergency department treatment spaces and departmental space proposed by an applicant 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*. (ACEP guidelines). For the projected number of patient visits per year, the square footage of the proposed ED size falls within ACEP guidelines, while the ED will contain four more treatment beds than the guidelines suggest.

Staff agrees with the applicant that ACEP is a tool to approximate treatment space and does not believe that the ED is significantly oversized for the projected ED visit numbers. Staff concludes that the applicant meets the standard for ED capacity and space.

COMAR 10.24.12 - Acute Hospital Inpatient Obstetric Services

COMAR 10.24.12.04 - Review Standards for Obstetric Services

Need

Staff notes that the hospital's service area will continue to be served by maintaining the obstetrics services in the new facility, while at least 17 percent of obstetric patients at UM SMC Easton will be from jurisdictions outside of the service area. Given the rural nature of the counties in the service area and the driving distances to other facilities, there is a need in the five county mid-Eastern Shore region for a hospital that will support the community for all routine obstetric care and deliveries. For these reasons staff concludes that UM SMC Easton has unique needs to maintain access to quality obstetric providers, programs, and birthing sites. Staff concludes that there is need for the project, and that the standard has been met.

The Maryland Perinatal System Standards

The applicant has performed a self-assessment utilizing the *2019 Maryland Perinatal System Standards of the Perinatal Clinical Advisory Committee* at the Maryland Department of Health. The assessment, conducted in October 2022, specifically gauges UM SMC Easton's adherence to the essential perinatal standard for a Level I perinatal center. The results of this self-assessment show that the hospital satisfactorily meets all required perinatal standards. The staff concludes that UM SMC Easton meets the specified Maryland Perinatal System Standards for a Level 1 perinatal center and thereby, the applicant meets this standard.

Medicaid Access

The applicant has demonstrated a clear commitment to serving Medicaid patients as evidenced by the fact that all of the physicians credentialed by the hospital participate in the medical assistance program. Staff concludes that the applicant meets the Medicaid Access standard.

Staffing

The applicant has provided projections showing a need for 43.1 FTEs to support the obstetrics program at the replacement hospital. Staff concludes that the applicant meets this standard.

Physical Plant Design and New Technology

The applicant states that the replacement facility will be configured to consolidate and centralize resources, minimize staff travel distances, and improve continuous visibility of patients, while controlling noise in the units. It also states that the new building and the investment in technology will promote patient safety and quality of care. Staff concludes that the applicant has selected design features that will benefit the patients and meets the standard.

Outreach Program

The applicant has documented that it provides an outreach program for obstetric patients in its service area, without regard to the patient's financial background or resources. It also works to ensure that those who may not have adequate prenatal care are able to access care and provides hospital services to treat those patients. Staff concludes that the applicant meets the standard.

COMAR 10.24.11 - General Surgical Services.

***COMAR 10.24.11.05A* - General Standards**

The applicant demonstrates overall compliance with the General Standards of the General Surgical Services chapter of the SHP. The hospital has implemented a policy to make information regarding charges for surgical services available to the public to ensure transparency and accessibility. The applicant also meets the requirement to disclose its participation in health carrier networks, both for the facility and its employed surgeons and healthcare practitioners. Further, the hospital has revised its *Financial Assistance Policy*, outlining procedures for determining eligibility, disseminating public notices, and establishing criteria for charity care. The policy aligns with applicable State statutes and HSCRC regulations, including having a sliding scale for reduced-cost care based on income. The hospital's historical and projected levels of charity care fall within the appropriate quartile, as demonstrated by its performance compared to other Maryland hospitals. Finally, UM SMS Easton is duly licensed by the Maryland Department of Health and accredited by the Joint Commission, fulfilling the Quality of Care standard.

Given these findings, staff concludes that UM SHS satisfies the General Standards of this chapter.

Transfer Agreements

UM SHS submitted a number of transfer agreements with acute care hospitals. Staff concludes that UM SHS satisfies this standard.

COMAR 10.24.11.05B - Project Review Standards

Service Area

The applicant defined the current surgical service area for the hospital as zip codes in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties, and does not expect the service area to change due to relocation of the hospital. MHCC staff concludes that the hospital meets this standard.

Need – New or Replacement Facility

The staff has determined that UM SHS' request for seven general purpose ORs and two C-section ORs, upon the completion of their project's construction in FY 2029, is justified. Currently at UM SMC Easton there are constraints imposed currently by the six ORs and there is a growing demand for surgical services. The hospital has proposed a strategy to meet current standards for surgical delivery in their new facility by adding an additional general purpose OR. The applicant also discussed the need for two C-section ORs at the replacement hospital so that if there is more than once C-section at the same time, the hospital will be able to accommodate both C-section deliveries. The applicant has presented a comprehensive analysis, taking into account historical utilization data and forecasting future requirements. This examination aligns with the regulatory standards as outlined in the state health plan.

Design Requirements

UM SHS has submitted a letter from Emily Dickinson, AIA, of the architectural firm HKS. P.C., confirming that the architectural design of the operating rooms suite at UM SMC complies with Section 2.2 of the FGI Guidelines. With this confirmation, the staff concludes that the hospital meets this standard.

Patient Safety

The applicant provided a comprehensive list of design decisions that were made to prioritize patient safety in the surgical unit. The provided documentation highlights a series of considerations that were integral to the planning process, such as integrating flexibility in equipment and technology, standardizing orientation of ORs to minimize errors, integrating anesthesia support spaces for quick response times, and implementing ASHRAE-compliant ventilation and environmental control. The MHCC staff concludes that the applicant meets the patient safety standard.

COMAR 10.24.09 - Acute Inpatient Rehabilitation Services

COMAR 10.24.09.04A - General Standards

Quality of Care

The applicant states that the rehabilitation unit complies with all applicable accreditation and certification standards and is also in compliance with the conditions of participation for Medicare and Medicaid programs. The rehabilitation unit is CARF accredited. Staff concludes that the applicant meets this standard.

COMAR 10.24.09.04B - Project Review Standards

Need

The applicant has provided sufficient information to meet the applicable section of COMAR 10.24.09.05 by providing a comprehensive analysis of the need for adult acute rehabilitation in the Eastern Shore health planning region. Despite the change in the number of rehabilitation beds from the currently licensed capacity, the applicant justifies the proposal by citing the consolidation of existing facilities and the overall regional need. They provided documentation to support the claim that a change in licensed beds will not compromise access to care for Eastern Shore residents. The MHCC staff conclude that the applicant has met the standard regarding the net need projection in the health planning region of the Eastern Shore.

Impact

As an existing provider of rehabilitation services, UM SMC Easton is planning to align its number of beds with the Commission's regional need projections in the state health plan. The applicant states that the adjustment in bed capacity will not compromise the quality of care at other facilities nor impede their capacity to maintain adequate staffing levels. Based on the provided information, the staff concludes that the applicant meets this standard.

Safety

The applicant states that the new acute rehabilitation bed unit design will meet all safety-related standards set forth by accrediting bodies and will be consistent with requirements of ADA design. The applicant is committed to prioritizing a safe care environment by conducting self-inspection rounds on a semi-annual basis; these rounds will continue, per CARF requirements. Annual inspections by external authorities are also completed and will be continued. Staff concludes that the applicant meets this standard.

Minimum Size Requirements

The new hospital's rehabilitation unit will have 12 beds, which is above 10 required in the standard. The application therefore meets the standard.

Transfer and Referral Agreements

UM SHS states it has established written transfer agreements with other health care facilities to ensure the continuum of care for patients requiring transfer to another facility or entity due to the level of care required. The applicant provided a list of facilities with which it currently

has transfer agreements, and historical data on the number of patients transferred from 2017-2022. Staff concludes that the applicant meets this standard.

COMAR 10.24.21 - Acute Psychiatric Services Standards

COMAR 10.24.21.04B - Procedural Rules: Docketing

The applicant states that it meets the docketing rules as evidenced by the signed affirmation of Kenneth Kozel, MBA, FACHE. Staff concludes that the applicant meets the standard.

COMAR 10.24.21.04B - Procedural Rules: Acquisition

This standard is not applicable because the applicant is not acquiring a special psychiatric hospital.

COMAR 10.24.21.05B - Project Review Standards

Need for Acute Psychiatric Services

The applicant addresses the need for psychiatric beds at the replacement hospital through an analysis of various factors including the population served, the service area, market share, discharges, and average length of stay. The applicant sufficiently meets the standard of need for acute psychiatric services at the replacement hospital to remain unchanged from the current number of 12.

Patient Rooms

The applicant states that all psychiatric inpatient rooms in the replacement hospital will be private and has thus met this subpart of the standard.

Other Program Requirements

The applicant states that although it routinely treats older adults with depression, bi-polar and schizophrenia, it does not admit older adults with neurocognitive deficits due to concerns with acuity and safety instead referring them out to an appropriate placement. The applicant also shares that it is in the process of implementing a policy with specific provisions for the geriatric population entitled *Special Behavioral Health Population Treatment Protocols* which was in place at the prior location of the psychiatric unit at UM SMC Dorchester . Staff concludes that the applicant meets the standard.

Support for the Project

The applicant provided multiple letters of support for the project, from local businesses, colleges, state/local government, community mental health centers, mental health advisory council/agencies, and behavioral health service providers. Staff concludes that the applicant meets the standard.

Emergency Services

The applicant states that psychiatric services follow written procedures already currently implemented for providing psychiatric emergency inpatient care. It also states that the ED in the replacement hospital will have two psychiatric-appropriate exam rooms. The emergency department will also have three rooms designated as psychiatric holding areas for patients awaiting admission decisions and a seclusion room. The hospital is designated by the Maryland Department of Health to perform evaluations of persons with a mental disorder and brought to the hospital on an emergency petition. Staff concludes that the applicant meets the standard.

Involuntary Admissions

The applicant states that it will admit involuntary patients and that the new replacement hospital is designated by Maryland Department of Health to perform evaluations of persons with a supposed mental illness brought to the hospital on emergency petition. Staff concludes that the applicant meets the standard.

Access to Acute Psychiatric Services

The applicant states that it does not and will not deny admissions due to a patient's inability to pay or a patient's status as involuntary. The applicant participates in Medicare and Medicaid programs. Staff concludes that the applicant meets this standard.

Adverse Impact

The hospital has demonstrated the replacement of the physical plant is necessary and contains a right sized behavioral health unit to serve the primary service area. Staff reviewed the opinion letter from HSCRC and the projected plans for the replacement hospital and determined that there will be minimal adverse impact from implementing the proposed project. Staff concludes that the applicant meets the standard.

COMAR 10.24.01.08G(3)(b-f) – Criteria for Review of Applications

COMAR 10.24.01.08G(3)(b) - Need

The applicant has documented the need for the construction and relocation of a replacement hospital. The current hospital is landlocked in the City of Easton and the hospital building is dated and obsolete. The applicant projects that the increase in admissions based on visits to its emergency room support the need for a 25-bed observation unit. Staff concludes that the applicant adequately addresses the need for the relocation and replacement of the hospital.

COMAR 10.24.01.08G(3)(c) - Cost and Effectiveness of Alternatives

UM SHS has shown that the drive time to other facilities in the region are too long for patients in the primary service area and are therefore not efficient alternatives to the proposed plan. The applicant also provided a comprehensive list of population health initiatives to avoid or lessen hospital admissions and readmissions. Staff concludes that the proposed project is a cost-effective alternative for providing care to residents in the service area.

COMAR 10.24.01.08G(3)(d) **- Viability**

Staff reviewed the financial plans and projections submitted by the applicant and concluded that the hospital, once completed, will likely be profitable, assuming that the applicant maximizes on the increases in efficiencies planned in the project. There remains a question, however, about whether the remaining $70 million in state funds will be realized. Staff understands that state funding for large capital projects such as the hospital in Easton is often spread over a number of budget years, and that there will likely be further funds committed to UM SHS. The staff also considered the applicant's plan for raising the required philanthropic funds and finds the plan to be credible. UM SHS has committed to using other UM Memorial Hospital Foundation unrestricted funds and/or increasing borrowing to cover any shortfall.

HSCRC staff concluded that the project may be viable as long as the applicant strives:

> to maximize the potential liquidation value of the current campus; to realize greater efficiencies in operating the hospital services as compared to its peer hospitals; to realize the performance improvements assumed in the projections; to minimize potential cost overruns on the project budget; and to maximize fund raising both philanthropic and governmental.

The applicant has also documented significant community support through letters submitted by government and community leaders. Staff concludes that the applicant has proposed a project that can be implemented with resources that should be available to UM SHS and that the ongoing viability of UM SMC Easton is sustainable if the project is implemented in a manner projected by the applicant.

COMAR 10.24.01.08G(3)(e) - Compliance with Condition of Previous Certificates of Need

Since 2000, the applicant has obtained two CONs and one Certificate of Conformance for UM SMC Easton. The applicant has complied with the terms and conditions of each of the certificates.

COMAR 10.24.01.08G(3)(f) - Impact

Staff has evaluated the impact of the proposed project on existing health care providers in the service area, 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. Staff concludes that there will not be a negative impact on other providers or the health care delivery system as a result of this project and thus recommends that the Commission find that the project's impact is acceptable. The staff and patients of UM SHS will benefit from modernization of the hospital's facilities.