STATE OF MARYLAND

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April 27, 2018

Ms. Anne Langley
Sr. Director, Health Planning & Community Engagement
Johns Hopkins Medicine
3910 Keswick Road, Suite N-2200
Baltimore, Maryland 21211

Re: Johns Hopkins Bayview Medical Center New Inpatient Building – Matter # 18-24-2414

Dear Ms. Langley:

Staff of the Maryland Health Care Commission ("MHCC") reviewed the Johns Hopkins Bayview Medical Center's above-referenced Certificate of Need application. We appreciate your patience with our need for an extended review period. At this time we have the following completeness questions. We will follow very soon with a short second set of questions concerning construction costs/MVS calculations related to the parking garage that need further consideration.

PROJECT DESCRIPTION

1. The application speaks about clinical integration that has occurred/is occurring across the Academic Division of Johns Hopkins Medicine, and how a failure to implement this project would limit the ability of the Johns Hopkins Academic Division to optimize JHBMC for specialty services. Please explain the strategy and vision of that integration, and whether and where it centralizes different centers of excellence at one or the other of JHH and JHBMC (p. 20 speaks to such consolidation).

2. The application describes Bayview's average age of plant as comparable to peers as measured by Standard and Poor's rating service, but goes on to say that this is due to "several major medical equipment purchases in recent years having shorter useful lives, and not investments in building improvements" (p. 63).
    a) In order for this rationale to be relevant, Bayview's investments of the described nature would need to be disproportionate to that of other similar hospitals; do you have reason to believe that, and can you document it?
    b) If the average age of the plant without equipment is 16.1 years and the major clinical building will be 24 years old this June, doesn't it follow that the balance of the plant would be relatively new and not in need of replacement?

3. In discussing the needs of a variety of services and departments the application cites space deficiencies as compared to the FGI (or other) Guidelines. It would be useful to the review to provide a table that summarizes these deficiencies in one place. Example below.

Department or Service	Current space	Benchmark (source)	Proposed space	Benefit(s)

4. Questions related to the PROJECT SCHEDULE:
    a) What is the expected total elapsed time to complete the project?
    b) It appears that the negative numbers entered into the project schedule indicate an overlap of that step with work related to prior steps in the process; please confirm/explain.

5. A new power plant is part of phase 2 of the project despite the statement on p. 41 that "[t]he existing steam generation system located in the Power Plant has sufficient capacity to serve the NIB;" please explain, and describe where on the site this new plant will be constructed.

PROJECT BUDGET

6. How was the inflation allowance calculated and what assumptions underlie the calculation?

7. How much of the $48M projected philanthropic funds are in-hand, what is pledged, and how was the remaining amount projected? How will any shortfalls in that projection be covered?

8. How were the permit fees for each project component (new hospital construction, parking garage, and renovations) estimated or allocated?

9. Please submit the calculations for the contingency allowance for each project component (new hospital construction, parking garage, and renovations).

10. What is included in the "other capital costs," Line c (4), totaling $23,666,000?

11. What is covered by the $7,266,000 in non-building related consultant costs?

12. How were the "other capital costs," and consultant costs referenced in the two preceding questions allocated to the Hospital Building and the Parking Garage?

13. Please explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application as called for in the instructions.

14. Given that 45% of the hospital and all of the parking garage will be funded by bonds why is there no interest income listed as sources of funds?

CONSISTENCY WITH GENERAL REVIEW CRITERIA (COMAR 10.24.01.08G(3))

The State Health Plan

COMAR 10.24.10 - ACUTE HOSPITAL SERVICES standards

Information Re: Charges

15. Excerpt the language from JHBMC's policy that relates to subparts (b) and (c) of this standard, and cite their location in the policy.

Charity Care Policy

16. Please provide copies of the notices posted in English and Spanish explaining the availability of financial assistance and providing contact information (p.49 of application).

Adverse Impact

In the response to this standard JHBMC provides a table stating that its rates would be 20% less than its peer group after increasing its currently approved revenue by the 5.6% rate increase that it assumes that the HSCRC will approve. The following questions in this section relate to those rate comparisons.

17. Please provide the detailed calculations for comparison of unit rates to the peer group. Also please provide a comparison of JHBMC's estimated rates including the revenue associated with the requested rate increase to the statewide median. JHBMC's peer group has average rates well above the statewide average. In the detailed calculations please provide the comparisons including and excluding the clinic revenue center. JHBMC has a large number of clinic RVU's generated in its Psychiatric Rehabilitation Clinic that do not appear comparable to other hospitals' clinic RVU's.

18. How has the fact that JHBMC's overall volumes increased by 4.3% between FY 2013 and FY 2017 while the peer group's combined volumes have decreased by 10.4% between FY 2013 and FY 2017 according to HSCRC information affected the rate comparisons?

19. Please provide an explanation as to why JHBMC has not responded to the incentives in the HSCRC's GBR methodology in terms of reducing volumes while the other hospitals in its peer group have responded effectively in reducing volumes.

20. According to data obtained from the CMS website, Medicare paid for 2,296 patient days per 1,000 Medicare population in Baltimore City in 2015 compared to an average of 1,594 patient days statewide in Maryland, or 2,074 patient days in the District of Columbia. Although there are differences in patient demographics between Baltimore City and the rest of Maryland and the District of Columbia, it would appear that excess hospital capacity in Baltimore City is contributing to much higher than normal Medicare inpatient utilization. Given the current high Medicare utilization in Baltimore City, it would appear that there is significant opportunity for JHBMC to reduce utilization and generate sufficient revenue to fund the additional costs associated with the CON. Please provide an analysis of how much revenue would be available for depreciation and interest on the proposed CON project if JHBMC were able to reduce its volumes at a pace comparable to the other hospitals in its peer group over the last five years.

21. How will the assumed 25.8% reduction in JHBMC's outpatient clinic, imaging, and laboratory services between FY 2018 and FY 2021 affect the rate comparisons to other hospitals?

22. Did JHBMC account for the assumed 25.8% reduction in outpatient clinic, imaging, and laboratory services between FY 2018 and FY 2021 when designing the space for these departments when developing the project plan put forward in the CON application?

23. JHBMC is projecting emergency room volume increases of approximately 3% annually throughout the projection period. The most recent US Census information shows that Baltimore City's population decreased by more than 1% between 2015 and 2016. Additionally, according to the CMS website Medicare patients in Baltimore City visited emergency rooms at an average of 985 times per 1,000 population in 2015 compared to an average statewide in Maryland of 672 and an average of 918 in the District of Columbia. If the emergency room volumes do not increase as JHBMC has projected, what will be the impact on the rate comparisons to other hospitals?

24. Under the HSCRC Waiver agreement with CMS the growth in statewide Medicare expenditures is monitored closely and the overall statewide growth is limited to an annual percentage. Because the rate increase requested by Bayview for the CON project will impact the annual allowable growth in Medicare expenditures what other Maryland hospital expenditures does JHBMC believe should be reduced to offset the impact of its CON-generated requested rate increase?

Construction Cost of Hospital and Non-Hospital Space

25. Why did you classify the mechanical penthouse as excellent quality ($92 per sq. ft.) instead good quality ($82 per sq. ft.)?

26. How did you calculate the elevator add-on for the mechanical penthouse? Why was no elevator add-on calculated for the basement? Specify the number and types of elevators that will stop at the basement and number and type of elevators that will stop at the mechanical penthouse.

27. Explain why separate sprinkler add-ons were calculated for each component of new construction (basement, upper floors, and penthouse) instead of calculating a common add-on based on the total square footage of new construction, especially given the statement in Marshall in Section 15, page 37 that the square foot costs listed are based on the total sprinkler system installation on a single main connection.

28. Explain how the capitalized interest was estimated and how the adjustments for capitalized interest detailed on pages 80, 81, 89, and 96 were calculated and why the adjustments are only made for building costs and not site costs.

29. What is included d in the $1,485,158 in Site Demolition costs and the $846,268 for the demolition of adjacent structures and the $846,268 for building demolition at NIB connections? Detail the calculations of these adjustments. Regarding this last adjustment to the new hospital building costs, you also made a $2,261,475 adjustment to the renovation costs for demolition and abatement. Where in the project budget are the costs of demolition at the NIB building connections?

30. Adjustment has been made in both the hospital building and the garage for additional cost of the foundations and columns under the hospital attributable to the decision to locate the parking garage under the NIB. Shouldn't all these additional costs be included in the garage budget and; therefore, all necessary adjustments be made to parking garage MVS benchmark comparison? Explain how these costs and the adjustments was capitalized and allocated between the hospital building budget and the parking garage.

31. Adjustments were made in both new construction and renovation costs for extraordinary basement costs based on the rationale that the proposed based occupancies are atypical for hospital basements. However, in calculating the benchmarks for basements of both new construction and renovations departmental differential cost factors were use to account for such differences in occupancy. Submit a detailed explanation of how your estimated cost per square foot of $329.80 for the new basement and $218.22 for renovations. Describe the nature and extent of basement renovations.

32. Explain how the urban construction premium of $5,658,583 was calculated?

33. Explain the basis for Hopkins' estimate that the MBE inclusion program adds 4% to building costs. Submit documentation to support this estimate. Submit the calculation for the is adjustment for the new building and the renovations,

34. Regarding the calculation of the applicable capitalized construction interest and financing costs as appears on page 84, it appears that the use of $16,557,000 for the total capital interest and financing when the project budget (Table E) indicates that the total is

$18,969,000 is the allocation of $2,412,000 to the renovations. Please detail how this allocation between new construction and renovation was calculated.

35. Regarding the calculation of the MVS benchmark for the renovations on pages 85 through 89, please respond to the following:
    a. Complete the construction characteristics (Table C) for the NIB with the perimeter and wall height for the renovation component of this project.
    b. Explain or correct the discrepancy between the square footage used in the calculation of the basement (27,791) and the upper floors (21,563) and the square footage reported in Table C, 34,739 for the basement and a total of 26,954 for the upper floors.
    c. Explain or correct the discrepancy between the number of upper floors identified as 3 on page 86 and the square footage reported on Table C construction characteristics for only two floors above the basement.
    d. A departmental differential cost factors of 1.37 was used in calculation of the basement benchmark and .97 for the renovation of the upper floors but supporting calculations detailing how these factors were calculated were not provided. Please submit calculations similar to those provided for the new construction on pages 75 through 78. Submission on excel spreadsheets would be greatly appreciated.
    e. Submit the calculations of the perimeter and height multipliers for both the basement and upper floors renovations.
    f. Will the sprinkler system components be replaced as part of the renovations? If yes, specify the square footage that will be covered by floor for the renovated portion of the system and submit the calculations for add-on for the upper floors (page 87 indicates an add-on of $3.92 per sq. ft.).

36. Regarding the utility building, please respond to the following:
    a. Why is the utility building included in the calculation of the MVS benchmark for the renovation portion of the project when the Table C, construction characteristics, for the power plant indicates that the power plant project space will be new construction? Please explain or correct.
    b. Why was no departmental differential cost factor applied to the MVS base costs for the utility building given that such a factor was applied to all other portions of the project? What departmental cost factor should be used and why?
    c. Explain how the sprinkler add-on was calculated and submit the calculations.

Inpatient Nursing Unit Space

37. You have explained why the space allocated to the new Burn Center ICU/IMC and Surgical ICU exceeds 500 square feet per bed, and stated that JHBMC does not propose any rate relief related to the construction cost of this additional space. Please calculate:
    - The amount and construction cost of the "excess space" (i.e., that amount that exceeds the per bed square footage limitation in this standard attributed to these units; and
    - The portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Efficiency

38. In the discussion on pp.101-105 the application speaks to a variety of efficiency gains to be realized primarily by improving adjacencies and eliminating the need to transfer inpatients (to accommodate gender, infection control, and other issues) – yet despite the multiple examples cited, an FTE increase of almost 85 (2.6%) is attributed to the project. Given that this project is a renovation and modernization project that does not add service capacity, please explain the apparent incompatibility between efficiency improvements and increased staffing.

Financial Feasibility

39. In the projected statistics on Table F, Bayview has projected a reduction in outpatient clinic visits from 216,661 in FY 2017 to 163,192 visits in FY 2021, a reduction of 25%. Similar decreases were projected for outpatient laboratory services and outpatient imaging services. However, in the uninflated projections Bayview's total outpatient revenue was projected to decrease by only 0.2%. Please explain why large volume decreases were projected for outpatient clinic, laboratory, and imaging services and why projected outpatient revenue was not reduced to reflect the decrease in these volumes.

40. In the projected FTE's in Table L, Bayview projects that ancillary FTE's will decrease from 240.9 currently to 237.1 FTE's after the CON project is complete. Given that the volumes in outpatient clinic, imaging and laboratory are projected to decrease by over 25% why are ancillary FTE's projected to decrease by only 3.8 FTE's, or about 1.6%?

41. According to Wage and Salary Survey information provided to the HSCRC, Johns Hopkins increased its number of FTE's from approximately 9,200 in FY 2012 prior to the opening of their new facility to 10,018 in FY 2013 after the opening of their new facility. In the CON Bayview's projected total FTE's are assumed to change from the current 3,252 to 3,282 after Bayview's project is completed, less than a 1% increase. Please explain how Bayview will be able to maintain staffing at approximately the same level after the CON project is completed while Johns Hopkins had to increase its staffing by about 9% after their CON project was completed.

<u>COMAR 10.24.11 GENERAL SURGICAL SERVICES standards</u>
Transfer Agreement

42. Health-General Article §19-308.2 provides, in part, that transfers of patients between hospitals are accomplished in a medically appropriate manner and in accordance with the health care policies of the State that, at a minimum, require:
    a) Notification to the receiving hospital before the transfer and confirmation by that hospital that the patient meets that hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;

b) The use of medically appropriate life-support measures that a reasonable and prudent physician exercising ordinary care would use to stabilize the patient before transfer and to sustain the patient during the transfer;

c) The provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care would use for the transfer; and

d) The transfer of all necessary records for continuing the care for the patient.

Please provide JHBMC's policies and procedures guiding inter-hospital transfer of patients and a copy of the form that would be completed and sent with a transferred patient.

Design Requirements

43. This standard requires consistency with the "current Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines)." While Exhibit 17 confirms that the architectural design of the operating rooms suite complies with Section 2.2 of the 2014 version of the FGI Guidelines, the applicant should provide documentation with the 2018 guidelines.

Patient Safety

44. Please provide a response to subpart (a) of this standard, which requires an applicant to: *Document the manner in which the planning of the project took patient safety into account.*

45. Provide a listing of safety features that the proposed surgical facilities will bring, contrasted with current conditions.

COMAR 10.24.12 - ACUTE HOSPITAL INPATIENT OBSTETRIC SERVICES standards

Need

46. Please provide a source for the data displayed on p. 144.

47. JHBMC expects a recapture amounting to about 28% of its OB volume, based on improving birthing facilities. Is there any data-based evidence to back up the statement on p. 147 that: "JHBMC can document patients who start their care with JHU faculty, but switch to a different provider and hospital once they make an initial visit to JHBMC's L&D and assess the facilities"?

Staffing

48. Please explain the need for the projected staff increases in the OB division: 9% (2.43/27.03) in the *OB Inpatient Unit* (while the OB bed count decreases from 22 to 18); 23% (12.9/56.76) in L & D; and 21% (10.81/51.78) in NICU (while NICU bassinets decrease from 25 to 22).

MHCC staff realizes that you are projecting a 28% volume increase in the department, but is not convinced that that should translate into a roughly similar staffing increase.

Viability of the Proposal

49. Has Bayview filed a partial rate application with the HSCRC requesting approval for the projected annual rate increase of $35,140,256? Would the project be feasible if the HSCRC were to deny Bayview's request to increase revenue for the additional interest and depreciation expense?

50. JHBMC stated that it will implement performance improvements of $36,075,000 by FY 2023, the same year as the opening of the CON project, and the same year when the $30,309,000 of new interest and depreciation expense associated with the CON projected begins to be charged to Bayview's expenses. Since the assumed performance improvements of $36,075,000 are greater than the new depreciation and interest expense of $30,309,000 why couldn't Bayview offset the performance improvements against the new depreciation and interest expense leaving no additional costs to patients and third parties including Medicare and Medicaid?

51. Over the last five years, the Johns Hopkins Hospital has requested substantial rate increases above what other hospitals in the State have received. What assurances can Bayview provide that it will not need to request additional revenue above what has been projected in the CON as The Johns Hopkins Hospital has done since The Johns Hopkins Hospital opened its new facility, particularly given the fact that there are $36,075,000 in performance improvements in the projected financial statements for Bayview?

52. As part of its assumptions, Bayview projected reduced expenses related to performance improvements of $6,200,000 in FY 2018. However total expenses are projected to increase by $21,873,000 between FY 2017 and FY 2018. Please explain why expenses increased so much while $6,200,000 in performance improvements occurred in FY 2018.

53. Please explain the *service line incremental investment expenses* included in the projected financial statements.

54. Please explain the assumptions for the non-operating income line that fluctuates from ($16,299,000) in FY 2019 to $10,709,000 in FY 2025, a swing of $27,007,000. Will the proposed project be feasible if non-operating income does not improve as projected?

55. Why is interest on current debt projected to increase from $3,332,000 in FY 2022 to $6,094,000 in FY 2023?

56. In the audited financial statements, Bayview's long-term pension liability increased from $129,760,000 at June 30, 2016 to $179,434,000 at June 30, 2017, an increase of approximately $50,000,000 in one year. How does Bayview plan to fund future pension

liabilities given that profits in the projected inflated financial statements in the CON average less than $25 million per year?

57. According to the HSCRC, Bayview's current mark-up is 9.9% versus the 15.94% included in the CON assumptions. Please explain the difference.

Other

58. In the course of MHCC's projections of need for acute rehabilitation beds, MHCC learned that JHBMC was admitting and treating acute rehabilitation beds in beds licensed as special hospital chronic care bed capacity. JHBMC reported an average daily census of 17.7 acute rehabilitation patients in CY 2016 and a licensed inventory of 12 special rehabilitation hospital beds. (See the April 13, 2018 edition of the Maryland Register.)

    This is incompatible with Maryland's regulatory policy with respect to CON regulation, given that all hospital bed supply is regulated and "rehabilitation" and "chronic care" are separately and categorically regulated as distinct types of "medical service." Additionally, based on previous determinations by the Office of Health Care Quality, this use of licensed special hospital chronic care beds is not consistent with hospital licensure policy. Please outline the steps that JHBMC will take to bring its use of chronic care beds and/or its supply of special rehabilitation hospital beds into conformance with state requirements.

Please submit four copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt (as always, extensions granted as needed). Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov). Given the number of questions posed, as well as the time required for staff to compile these questions, we will certainly grant an extension to the ten day target specified in regulation as soon as you would request it.

All information supplementing the applicant must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

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

Sincerely,

Kevin McDonald
Chief, Certificate of Need

cc: Paul Parker
Leana Wen, MD, Health Officer, Baltimore City