IN THE MATTER OF THE CONSOLIDATION OF	*	**BEFORE THE**
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UNIVERSITY OF MARYLAND UPPER	*	**MARYLAND HEALTH**
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CHESAPEAKE MEDICAL CENTER AND	*	**CARE COMMISSION**
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UNIVERSITY OF MARYLAND	*	
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HARFORD MEMORIAL HOSPITAL	*	
	*	
Matter No. 17-12-EX003	*	

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STAFF REPORT AND RECOMMENDATION
REQUEST FOR EXEMPTION FROM CERTIFICATE OF NEED REVIEW

April 16, 2020

I. Introduction

A. The Applicants

University of Maryland Upper Chesapeake Medical Center (UCMC) and University of Maryland Harford Memorial Hospital (HMH) are joint applicants in this request for an exemption from Certificate of Need (CON) review. They comprise the hospital component of the Upper Chesapeake Health System (UCHS) serving Harford County from campuses in Bel Air (UCMC) and Havre de Grace (HMH).

HMH, is a relatively old general hospital in the northeastern quadrant of Harford County, constructed in phases between 1943 and 1972. Today it operates 51 licensed medical/surgical/ gynecological/addictions (MSGA) beds and 31 licensed psychiatric beds. UCHS is proposing to convert HMH to a freestanding medical facility (FMF), on a site within five miles of the HMH campus, in Aberdeen. That project, which will establish UCMC as the sole general hospital in the county is the primary basis for a capital project at UCMC that is the subject of this report.

UCMC is a general hospital that is currently licensed for 149 MSGA beds,10 obstetric beds, and two pediatric beds, for a total of 161 acute care beds. Its Bel Air campus is about 20 miles south of the HMH campus. It opened in October 2000 and was expanded to its current size in 2005.

B. The Project

UCHS has requested an exemption from CON review to change the bed capacity of UCMC, a review process available to the hospital because the change is proposed pursuant to a consolidation of the two UCHS hospitals.

Construction of a three-story, 98,000 square foot (SF) addition to the Kaufman Cancer Center on the UCMC campus is proposed. The first of those floors would be a shell floor intended to accommodate actual and anticipated cancer center growth. The other two floors would house a 30-bed MSGA unit and a 42-bed observation unit. The estimated project cost is approximately $84.4 million and would be paid for with funds raised from the sale of bonds issued by UMMS, the parent of UCHS and arbitrage on that borrowing.

The applicants state that the primary purpose for this consolidation is to allow it to better align with the State's total cost of care model. Further, the applicants maintain that this change will allow it to transform its health care delivery model, augmenting its ability to improve patient health, reduce costs, and provide better care coordination.

C. Background

This project is part of a larger plan developed by UCHS to restructure its health care facilities and services. The plan would replace HMH, which the applicants describe as inefficient and at the end of its useful life, with an FMF, located on a 36-acre site in Aberdeen, and a special psychiatric hospital, co-located in new construction with the FMF. HMH is the UCHS hospital

that provides the only psychiatric hospital service in Harford County, an adult program. The applicants seek to relocate MSGA beds from HMH to UCMC as a result of HMH's replacement with an FMF/psychiatric hospital campus.

II. Requirements for Exemption of Certificate of Need Review

Commission regulations provide that specified types of projects do not require full CON review but can be accomplished through the Commission's issuance of an exemption from CON review. (COMAR 10.24.01.04). One category of project that qualifies for the CON exemption process is "a change in the bed capacity of an existing health care facility pursuant to the consolidation or merger of two or more health care facilities . . .." COMAR 10.24.01.04A(3).

For this type of exemption from CON review, an applicant is required, under MHCC regulations, to provide information that shows, among other requirements, that the consolidation is not inconsistent with the State Health Plan. There is no opportunity for an entity to seek interested party status in an exemption review, thereby limiting the likelihood of judicial appeals.

III. Notice by the Commission to the Public

On November 26, 2018, staff requested publication of notices of receipt of the request for the exemption from CON in the Baltimore Sun. As required, the *Maryland Register* published the notice on December 7, 2018. No comments were received in response to these notices. (DI #14)

IV. Public Informational Hearing

A public informational hearing is required under certain circumstances when a hospital requests an exemption from CON review for the closure or partial closure of a hospital or for the conversion of a general hospital to a limited service hospital. *See* COMAR 10.24.01.04D. The applicants' plan to convert HMH to an FMF also required it to hold a public informational hearing and to circulate a summary of the hearing and written feedback to the Governor and other stakeholders.

Accordingly the applicants published their transition plan on UCHS's website on August 11, 2017, and convened a public informational meeting on August 30, 2017 at which they addressed: plans for transitioning acute care services previously provided at HMH; plans for the hospital's physical plant and site; and job retraining and placement of employees displaced by the conversion. When the applicants decided to change the location of the proposed FMF, it elected to hold a second public informational hearing, which was held on December 13, 2018.

V. Procedural History

Record of the Review

Docket Item #	Description	Date
1	Letter of Support from Maryland Senator Wayne Norman	8/2/17
2	Applicants submit Exemption Request to MHCC	8/4/17
3	MHCC Staff to Baltimore Sun – Request to publish receipt of exemption request	8/8/17
4	MHCC Staff to Maryland Register – Request to publish receipt of exemption request	8/10/17
5	MHCC receives notice of receipt as published in the Baltimore Sun	8/18/17
6	MHCC staff send request for completeness information on the exemption request	12/29/18
7	MHCC staff grants additional time to file completeness until 3/2/18	2/16/18
8	Applicants submit comments on proposed projects from UCHS	1/9/18
9	City of Havre de Grace Mayor submits comments on proposed projects to MHCC staff	2/6/18
10	Applicants send additional information as requested on 12/29/17 to MHCC	3/2/18
11	Applicants submit to MHCC a MODIFIED – Exemption Request	11/21/18
12	MHCC staff to Baltimore Sun – Request to publish notice of receipt of modified exemption	11/26/18
13	MHCC Staff to Maryland Register – Request to publish receipt of modified exemption	11/26/18
14	Notice of Modification as published in Baltimore Sun	12/5/18
15	MHCC staff sends request for completeness information on modification to applicant	3/22/19
16	Applicants submit completeness information as requested on 3/22/19	4/5/19
17	Letter of Support from Cecil County Dept. of emergency Services	3/28/19
18	MHCC sends summary of 6/25/19 Meeting to applicants' CEO	7/10/19
19	Applicants submit second Modified Exemption	10/21/19
20	Petition emailed to MHCC Director from medical staff of University of Maryland Upper Chesapeake Health	11/1/19
21	Letter of Support from Maryland Delegate Teresa Reilly	11/5/19
22	Delegates send comments on review to MHCC staff	11/5/19
23	Letter of support from City of Havre de Grace Chief of Staff Gamatoria received by MHCC staff	11/12/19
24	Letter from Harford County Delegation MD Senators J.B. Jennings, Bob Cassilly, and Jason Gallion – Request MHCC approve project	11/19/19
25	Letter of Support Harford County Health Officer, Russell Moy, MD	11/25/19
26	E-mail – to MHCC staff from concerned citizen with comments on project	11/26/19
27	E-mail – to MHCC staff from concerned citizen with comments on project	11/26/19
28	Mayor of Havre de Grace submits comments on project to MHCC staff	11/29/19
29	E-mail – to MHCC staff from concerned citizen with comments on project	12/1/19
30	MHCC staff sends request for completeness information on modification	12/16/19
31	Applicants submit completeness information as requested on 12/16/19	1/2/20
32	Email of Petition received by MHCC Director from medical staff of University of Maryland Upper Chesapeake Health	1/3/20
33	E-mail from applicants to MHCC staff with revenue proposal	2/13/20
34	E-mail from applicants with replacement exhibits 5 and 8	2/19/20
35	Letter of Support from Maryland Delegate Steve Johnson (email)	3/5/20
36	MHCC request to HSCRC for comments regarding project	3/5/20
37	Applicants' E-mail to MHCC staff with licensed and physical bed information	3/11/20
38	HSCRC responds to MHCC staff's request for comments	3/17/20
39	Applicants E-mail to MHCC staff with revised bed need table	4/2/20
40	Applicants E-mail to MHCC staff with corrected Table A	4/10/20

VI. Determination of Exemption from Certificate of New Review

COMAR 10.24.01.04E directs the Commission to issue an exemption from CON review if the merged asset system has provided the information required by the notice of intent and has held any required public informational hearing, and the Commission finds that the proposed action:

A. Is in the public interest;
B. Is not inconsistent with the State Health Plan; and
C. Will result in more efficient and effective delivery of health services.

Is in the Public Interest

The applicants state that the relocation of MSGA beds from HMH to UCMC is in the public interest because it is part of a larger initiative, described above under "Background," to create "an…integrated health delivery system for the residents it serves by providing care for patients in the right setting at the right time, at the lowest cost [that will]…enhance the care delivery model by building…state-of-the-art facilities [to meet]…[the] acute inpatient and behavioral health needs within its community…[and] continue to deliver consistent high quality patient outcomes and maximizes financial, operational and provider efficiencies." (DI #19, p. 45).

The applicants describe the project as relocating acute care beds from HMH to UCMC. The applicants state that transitioning from HMH will improve the health system's efficiency because HMH has an aging infrastructure, sits on a site with little room for expansion, and would be very expensive to modernize. The applicants state that the conversion will have a positive financial impact on the operating margins of UCHS, and improve the health system's overall future financial stability. (DI # 19, pp. 27, 37-38; DI # 31, Exh. 1).

The applicants state that the reduction of MSGA beds at HMH will be offset by the relocation of HMH's MSGA beds and the addition of observation beds at UCMC while staying within the bed need projections for Harford County issued by MHCC in the *Maryland Register* on Jan. 20, 2017,[1] ensuring that there are sufficient inpatient beds in the jurisdiction to meet the needs of the community, which the applicants state "is clearly in the public interest." At the same time the merger will allow the system to use beds more efficiently by consolidating the beds in one facility and eliminating redundancies. (DI #19, p. 45).

The applicants assert that this initiative will facilitate the following goals, aimed at creating a regionally integrated care network:

(1) Clinical and program development and population health collaboration;
(2) Coordination of health care throughout the services areas of the system;
(3) Shared physician recruitment activities; and
(4) Improved administrative efficiency. (DI #19, p. 45).

[1]https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/documents/shp_bed_need_msga_ped_projections_2025_%2020170120.pdf

The chief concerns of MHCC staff in its review of this project, with respect to the public interest criterion and also with respect to the impact on efficiency of health care delivery, addressed later in this report, are the related issues of the best use for the UCMC building addition and the planned number of MSGA beds at UCMC.

First, staff questioned why Harford County would be best served by operating a small special psychiatric hospital rather than replacing the HMH psychiatric program in the UCMC building project which is the subject of this report. The Maryland jurisdictions similar in size to Harford Count with a single general hospital, Frederick and Howard, have general hospital-based psychiatric units. Staff questioned why the applicants did not conclude that a single hospital campus-model would be likely to allow for lower overhead costs for administration, ancillary, and support services.

The addition of MSGA beds at UCMC (including relocation of 51 beds from HMH), bring its MSGA physical bed capacity up to 212 beds, was also questioned, in light of the fact that the combined MSGA average daily census of HMH and UCMC in 2018 was 135 patients. The development of an observation unit in the new building addition means that UCMC will be able to deploy all 212 of its proposed MSGA beds for admitted patients, something that it cannot do now because it lacks a dedicated observation unit. The applicant is projecting an average daily census of 146.6 MSGA patients in 2024 and has stated that this will require 183 beds at its target average annual occupancy rate of 80%. Staff notes that, in 2024, UCMC is proposing to operate its MSGA beds at an average annual occupancy rate of approximately 69% of its physical bed capacity.

A secondary concern of MHCC staff was the number of observation beds that UCMC is proposing to develop. In this case, a mismatch between demand and service capacity is not the issue. Rather, it is the level of observation bed use in Harford County. The UCHS hospitals have, in recent years, had a ratio of observation patients to emergency department visits that is approximately twice the state average. This high use of observation beds appears to be driving the development of observation bed capacity, suggesting that some effort to reduce what appears to be excessive use of observation status could mitigate the need for more beds. The applicants have indicated that new clinical protocols are expected to reduce the use of observation beds even before the three proposed UCHS projects are completed.

MHCC staff notes that has recommended approval of a CON application proposing establishment of the special psychiatric hospital in Aberdeen. The basis for the recommendation can be reviewed in the staff report on that CON application. That project improves the scale of the Aberdeen campus development, where the psychiatric hospital is co-located with the proposed FMF. The applicants also reduced the total number of observation beds proposed for development, at the FMF and at UCMC that were originally proposed in the October 2018 filings. Finally, staff of the Health Services Cost Review Commission has reviewed the reconfiguration of the UCHS hospital facilities and, based on discussions with UCHS, believes that the projects will reduce the level of spending for hospital services in the future when compared with what would be expended if the current two-general-hospital configuration were maintained.

For these reasons, staff recommends that the Commission find that the applicants have demonstrated that the project is in the public interest.

A. Is not inconsistent with the State Health Plan or the institution-specific plan developed by the Commission

Commission staff has reviewed this request for exemption in light of the applicant's response and the applicable State Health Plan ("SHP") standards of COMAR 10.24.10, which address acute care hospital services. This review is outlined in Appendix 1. Staff concludes that this proposal is not inconsistent with the applicable standards and recommends that the Commission find that this exemption request is not inconsistent with the State Health Plan.

B. Will result in delivery of more efficient and effective health care services

The applicant states that eliminating provision of inpatient services at HMH and relocating that bed capacity to UCMC will result in more efficient and effective services for two main reasons: (a) it will replace an outmoded facility that has outlived its useful life; and (b) a hospital bed configuration that includes a dedicated observation unit will improve operational efficiencies.

In its discussion of the public interest, above, staff has discussed why continuing to operate HMH is not feasible without modernization. Adding to that description, the applicants state that HMH is "not constructed to [meet] current best practices and energy codes," and is subject to "disruption [of] ongoing healthcare operation," and saddled with "numerous physical constraints [that] make the replacement of the facility a more cost effective alternative."

The applicants state that expanding inpatient and observation capacity at UCMC will result in operational efficiencies because: a dedicated observation unit will improve the efficiency of the care by enabling a focus on timely diagnostic treatment, which shortens lengths of stay and leads to rapid patient turnover on the unit; a dedicated observation unit, in contrast to the current situation in which observation patients are dispersed across all MSGA units, will significantly reduce the number of patient transfers between units and patient rooms in order to accommodate the needs of the acute, inpatient medical surgical patient population; the reduction of patient transfers will directly impact operational and staffing efficiencies within the nursing, ancillary, and support services teams; and cohorting observation patients in a dedicated unit will allow for the appropriate grouping of the acute care inpatient population on the medical surgical units. The applicants state that using this model of care will support optimal staffing patterns, allowing all staff to function at their highest, appropriate level (DI #19, p.46).

In addition to the information provided immediately above regarding the potential efficiency and effectiveness gains to be realized by consolidating UCHS inpatient services at UCMC and adding an observation unit, the set of proposals that are simultaneously under MHCC's review are expected to save Maryland rate-payers almost $10 million in the first year of operation, and about $15 million annually after that, as outlined by HSCRC staff, in its review of the project.[2]

[2] UCHS's negotiations with HSCRC resulted in an agreement on a GBR that would save rate-payers almost $10 million in the first year of operation, and about $15 million annually after that. (HSCRC opinion letter, DI #38).

Staff recommends that the Commission find that the applicant has shown that the project will result in the delivery of more efficient and effective health care services.

VII. Conclusion and Staff Recommendation

Staff concludes that the request by University of Maryland Upper Chesapeake Medical Center and Harford Memorial Hospital to relocate medical/surgical/gynecological/addictions ("MSGA") beds from HMH to UCMC and to construct a three story addition to UCMC pursuant to a merger and consolidation of these two facilities meets the requirements for an exemption from CON review. Thus, MHCC staff recommends that the Commission **APPROVE** the applicants' request for an exemption from a CON to relocate MSGA beds from HMH, expanding UCMC's MSGA and observation beds if the Commisison approves the conversion of HMH to an FMF, with the following conditions:

Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude:

a. $9,531,995, which includes the estimated costs of excess space for inpatient nursing units and the cost of the portions of the contingency allowance, escalation, and capital construction interest and inflation allowance that are based on the excess construction cost.

b. $16,359,163, which includes the estimated costs of shell space and the cost of the portions of the contingency allowance, escalation, and capital construction interest and inflation allowance that are based on the excess construction cost.

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Matter No. 17-12-EX003	*	

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FINAL ORDER

Based on the Commission staff's analysis and recommendation, it is this 16th day of April, 2020 **ORDERED:**

That the request by University of Maryland Upper Chesapeake Medical Center and Harford Memorial Hospital for an exemption from Certificate of Need review to relocate 51 medical/ surgical/gynecological/addictions beds from HMH to UCMC, resulting in a total physical bed capacity of 212 MSGA beds at Upper Chesapeake Medical Center, where it will construct a three-story building addition that will include physical space for 30 MSGA beds, a 42-bed observation unit, and shell space, at an estimated cost of $84,406,807 be **APPROVED** with the following conditions:

Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude:

(1) $9,531,995, which includes the estimated costs of excess space for inpatient nursing units and the cost of the portions of the contingency allowance, escalation and capital construction interest and inflation allowance that are based on the excess construction cost; and

(2) $16,359,163, which includes the estimated costs of shell space and the cost of the portions of the contingency allowance, escalation and capital construction interest and inflation allowance that are based on the excess construction cost.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1
Consistency with the State Health Plan
Acute Care Hospital Services

APPENDIX 1: CONSISTENCY WITH THE STATE HEALTH PLAN
Proposed Consolidation of University of Maryland Upper Chesapeake Health

The following review of the State Health Plan ("SHP") standards contained in COMAR 10.24.10 includes comments on the standards at

COMAR 10.24.10.04 Acute Care Hospital Services Standard. The following general standards encompass expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) <u>Information Regarding Charges.</u> 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.

This standard is intended 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. The policy must include requirements to post a current list of charges for common inpatient and outpatient services, procedures for responding to requests and inquiries, and requirements for staff training.

The applicants submitted University of Maryland Upper Chesapeake Health System's Financial Policy on Estimation of Charges (DI# 19, Exh. 3). The document provides for the provision of information on charges for hospital services to the public and on hospital internet sites;[3] procedures for promptly responding to individual requests for current charges for specific services/procedures; and states that the Patient Financial Services department "shall receive training and demonstrate the knowledge of accessing the estimator tools to ensure that inquiries regarding charges for services are appropriately handled."

Commission staff concludes that the applicants comply with this standard

[3] The list of common charges can be found on the hospital's website at https://www.umms.org/uch/patients-visitors/for-patients/hospital-charges.

(2) <u>Charity Care Policy.</u> 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.

The policy states that UCHS will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services. There is no form used to determine a patient's eligibility; UCHS's representative asks the patient or family for family size and income to make a determination of probable eligibility. (DI #19, Exh. 8, p. 8).

(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 the admissions office, business office, and emergency department areas within the hospital

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.

The UCHS policy provides that its related entities will publish notice of the availability of financial assistance on a yearly basis in their local newspapers and post notices of its availability in admissions offices, business offices, and emergency department areas. UCHS's policy also states that the "notice of financial assistance is provided at admission or preadmission to each person who seeks services in the hospital" (DI #19 Exh. 8, pp. 8- 9).

(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.

According to HSCRC's FY 2018 Community Benefit Report, HMH and UCMC are in the second and third quartiles, respectively. HMH reported provision of charity care valued at $1.9 million (2.2% of total operating expenses) and UCMC's reported provision of charity care valued at $4.3 million (1.6% of total operating expenses). The average for all general hospitals in Maryland was 2.1%. (HSCRC Community Benefit Report 2018).

Staff concludes that UCHS's charity care policy used by both applicant hospitals complies with the requirements of this standard.

(3) <u>Quality of Care.</u> 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.

Both hospitals are licensed by the State and accredited by the Joint Commission. The facilities are also currently in compliance with the conditions of participation for Medicare and Medicaid programs. (DI #19, Exh. 5).

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

Staff notes that Paragraph (b) of this standard has become outdated in recent years, as currently written. There is still a Maryland Hospital Performance Evaluation Guide (HPEG), which is the hospital consumer guide component of the MHCC website. Quality measures are included as a component of that guide. However, since this standard was adopted, the HPEG has been substantially expanded to include many more measures of hospital quality and performance. Moreover, the specific format of the quality measure component of the HPEG no longer consists of a set of measure values that conform with the format of this standard in which each measure is scored as a compliance percentage that can be ranked by quartile. The performance for most of the expanded number of quality measures is now in a comparative context, expressed as "Below Average," "Average," or "Better than Average".

Commission staff examined the latest results for UCMC as reported on the Commission's website and found that there are currently 68 quality measures for which comparisons can be drawn among Maryland hospitals. Staff found that UMCM rated above average on 16 measures, average on 28 measures, and below average on 13 measures. There were 11 measures for which there was insufficient data to produce a meaningful value. The applicants addressed each measure for which UCMC was rated as less than average and submitted a corrective action plan. (DI #19, pp. 9-10).

Staff concludes that the applicants have demonstrated compliance with Paragraph (b) of the quality standard by documenting actions it has or is taking to improve performance in those quality measures for which it scored below average compared to the other Maryland hospitals.

Staff concludes that the applicants comply with this standard.

Project Review Standards

(1) <u>Geographic Accessibility.</u> 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.

The standard is not applicable as it is not a new hospital, but a merger of two existing facilities in one location in Harford County. (DI #19, p. 13).

(2) <u>Identification of Bed Need and Addition of Beds.</u> 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.

The most recent forecast of the need for MSGA beds in Harford County is for a target year of 2025. The bed need range is 168 to 223 beds. The range is produced by adjusting the trends in bed use and ALOS observed in Harford County through the base year (2015, in this case) for the

most positive and negative statewide trends observed. In this case, the number of MSGA beds proposed for Harford County falls within that range.

The basis for allowing a project to exceed the minimum range can be reasonably based on the occupancy rate implications of a project that, hypothetically, would reduce MSGA bed capacity to the minimum of 168 beds. This bed capacity would probably be adequate at the lowest level of MSGA average daily census seen in recent years but would produce inappropriately high levels of average annual occupancy, above 80%, in the years preceding this nadir (the combined ADC of the two hospitals was as high as 177 patients as recently as 2009). This would impose an inappropriately tight fit. As previously noted, the 212 MSGA beds proposed for UCMC are probably more than will be needed, especially if the objectives of the Total Cost of Care payment model are to be realized. However, the project is consistent with the main mechanism of this standard, consistency with the plan chapter's bed need projection.

(3) <u>Minimum Average Daily Census for Establishment of a Pediatric Unit.</u> 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.

This standard is not applicable, as the applicants are not applying to establish a pediatric unit.

(4) <u>Adverse Impact.</u> 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; and

This standard is not applicable. The applicants are not seeking a rate increase from HSCRC to account for higher capital costs. HSCRC has recently adopted policies limiting eligibility for capital-related global budget revenue adjustments based on the size of the capital project relative to the size of the hospital's budget. (DI# 19, p. 25)

(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.

The applicants state that the proposed project is intended to avoid an adverse impact on availability of and access to services. UCMC believes that if this exemption request is not approved and HMH converts to a FMF, there will be an insufficient number of MSGA and observation beds to meet the projected needs of UCMC's service area, thereby creating a barrier to access to observation and acute inpatient services. (DI #11, pp. 28-29).

The proposed project does not fit the project described in this standard. Staff believes that this project is not one that is likely to have a negative impact on the availability of or accessibility to any facilities or services.

(5) <u>Cost-Effectiveness.</u> 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.

The applicants engaged architectural and construction consultants to evaluate six options to expand the capacity at UCMC to accommodate the relocation of MSGA beds from HMH to the UCMC campus. The applicants stated that their primary objectives were to develop patient care rooms in a manner that would be efficient and cost effective; that would improve the continuum of care; and that would reduce the total cost of care. Additionally, the new construction should be innovatively designed and provide room for future expansion. (DI#19, pp. 25-28). To accomplish these objectives, UCMC assessed the following options:

Option 1: *Two Floors of Vertical Expansion above the Cancer Center*
Option 1-A: *Three floors of Vertical Expansion above the Cancer Center*
Option 2: *Renovation of Levels 3 and 4 of the Ambulatory Care Center (ACC)*
Option 3: *One floor of vertical expansion of the Main Hospital towers and the ED/bed tower*
Option 4: *One floor of vertical expansion of main hospital bed towers*
Option 5: *One floor of vertical expansion of the main hospital diagnostic and treatment core*

UCHS evaluated these options against the following objectives:

- The project should result in improved efficiency, improved patient outcomes, and a reduction in the redundancy of clinical care services;
- The project should reduce the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization;
- The project should be an efficient use of capital expenditures; and
- The project should result in a modern, innovatively designed facility with future expansion capability.

Table IV-1 provides a summary of the evaluation.

Table IV-1: Six Options in Review of UCMC Merger of HMH

Option	Description	Coordination of the continuum of services for the communities served by UCHS to improve efficiency, patient outcomes, and reduce redundancy of services	Reduction of the total per capita health care expenditures by reducing unnecessary acute care hospital utilization	Efficient use of capital expenditures	Establish modern, innovatively designed facilities with future expansion capability
1	**Add two floors above existing cancer center with 1 floor of MSGA beds, 1 floor of Observation beds ($37.8M, 60 inpatient beds) Cost per bed - $430.00.**	Efficiency and outcomes improved; redundancy of services reduced in dedicated observation unit. Better patient access and services.	Reduction in costs due to decreased redundancy. Dedicated observation unit will lead to minimized unnecessary testing and decreased length of stay.	A relatively low cost per bed option.	Modern, innovative design. Not designed for future expansion capability.
1A	**Add three floors above existing cancer center with 1 floor of MSGA beds, 1 floor of Observation beds and 1 floor of shell space ($44M, 60 inpatient beds and future expansion space) Cost per bed - $499.00.**	Efficiency and outcomes improved; redundancy of services reduced in dedicated observation unit. Better patient access and services,	Reduction in costs due to decreased redundancy. Dedicated observation unit will lead to minimized unnecessary testing and decreased length of stay.	A relatively low cost per bed option. It is less expensive to construct shell space as part of this project than to construct additional space in the future.	Modern, innovative design. Provides space for future capacity increases for the cancer center or inpatient beds.
2	**Renovate two floors in existing ambulatory care center (ACC). ($45.3M, 54-60 inpatient beds) Cost per bed - $542.00**	Reduction in provision of certain services while a new medical office building is constructed to house existing providers displaced by the expansion of inpatient rooms.	No change in acute care hospital utilization.	High cost per bed option that offers fewer total beds than needed. Would require construction of a new medical office building.	This option provides limited space for future renovation on lower floors.
3	**Add one additional floor above main hospital tower ($55.3M, 60 beds) Cost per bed - $628.00**	Efficiency and outcomes improved; redundancy of services reduced.	Reduction in costs due to decreased redundancy. No change in acute care hospital utilization.	High cost per bed option. There is a cost premium for building above existing patient care space.	No future expansion possible without future new construction.
4	**Add one additional floor above main hospital core ($40.5M, 40-45 beds) Cost per bed - $693.00**	Reduction in efficiency and increase in redundancy of services on separate units.	Would increase the cost of care due to duplication of overhead and support services on multiple additions of the hospital.	High cost per bed option. The addition would require two separate expansion projects at UCMC	No future expansion possible without future new construction.
5	**Add one additional floor above diagnostic and treatment building ($25.9M, 30 beds) Cost per bed - $701.00.**	Reduction in efficiency and increase in redundancy of services on separate units.	Would increase the cost of care due to duplication of overhead and support services on multiple additions of the hospital.	High cost per bed option. The addition would require two separate expansion projects at UCMC	No future expansion possible without future new construction.

DI#26, pp. 52-66

The applicants noted that the option selected, option 1A, provides a low cost per bed while providing shell space for future growth of either the cancer center services or inpatient services as needed. Options 2-5 had higher per bed costs and did not provide the improvements in efficiency, cost effectiveness or the future expansion possibilities offered by Option 1A. (DI #19, pg. 28, DI #16, pp. 15-16).

Staff concludes that the applicants evaluated alternatives for the expansion of bed capacity at UCMC. Staff finds that the selection of Option 1A is reasonable and that, therefore. the applicants have met this standard.

(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.

The applicants are not proposing a project involving limited objectives. See the above response to section (a).

(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.

The applicants are not proposing the establishment of a new hospital or relocation to a 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.

(6) <u>Burden of Proof Regarding Need.</u> 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.

As discussed above, the applicants explained how the proposal satisfies the Commission's jurisdictional bed need projections.

Also, the applicants point out that this proposal is not driven by a current need for more beds at UCMC, but rather by the need to realign services in the region as part of a larger plan to gain efficiency. The applicants state that UCHS's new care delivery model is designed to provide accessible, high-quality care to patient, while creating substantial cost savings and operational efficiencies with dedicated observation beds. (DI #19, pp. 45-46).

Staff concludes that the applicants have met this standard

(7) <u>Construction Cost of Hospital Space.</u> 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.

This standard requires a comparison of the project's estimated construction cost, adjusted for specific construction characteristics of the proposed project, with an index cost (i.e., an expected cost) derived from the Marshall Valuation Service (MVS). The MVS methodology includes a variety of adjustment factors related to the specific characteristics of the project, e.g., timing, locality, number of stories, height per story, shape of the building (e.g., the relationship of floor size to perimeter), and departmental use of space.

The applicants provided a calculation of the per square foot costs of the program and compared these costs to the MVS Guidance. The applicants' calculations yielded an adjusted project cost estimate of $358.60 per SF. Staff calculated the MVS benchmark to be $397.31. The projected cost of the UCMC construction of $358.60 is $38.71 (9.7%) <u>below</u> the MVS benchmark.

Table IV-X Comparison of UCMC's New Construction Budget to Commission's Staff Marshall Valuation Service

Project Budget Item	UCMC Cost
Building	$35,946,047.00
Normal Site Prep.	$ 246,346.00
Arch./Eng. Fees	$ 4,628,765.00
Permits	$ 2,320,586.00
Subtotal	$43,141,744.00

Adjustments to Budget for MVS Comparison	
Total Adjustments	$13,191,517.00
Proportional A + E adjustment	$ 1,585,450.77
Net Project Costs	$28,364,776.23
Allocated Financing Exp.	$ 3,496,858.17
Project Cost for MVS Comp	$31,861,634.40
Square Footage	$ 88,850.00
Cost Per Square Ft.	$ 358.60
Adj. MVS Cost/Square Foot	$ 397.31
MVS Over(Under)	$ (38.71)
Project Over(Under) Costs	$ (3,439,519.91)

Since the projected cost of the project is below the MVS benchmark, staff finds that the applicants have met this standard.

(8) <u>Construction Cost of Non-Hospital Space.</u> 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.

This standard is not applicable, as the applicants are not proposing to construct non-hospital space.

(9) <u>Inpatient Nursing Unit Space.</u> 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.

The standard requires that inpatient nursing units should not exceed reasonable space standards, defined as Inpatient Unit Program Space in excess of 500 SF per bed. “Inpatient unit program space per bed” is defined in the SHP as

a measure of space in a given patient care nursing unit of a hospital, such as a general medical/surgical unit, which includes patient rooms, family space, and support space. Family spaces include visitor lounges, family toilets, and consult rooms. Support space includes staff work stations, nourishment areas, medication areas, physician work areas (dictation, picture archiving and communication system reading station, reporting, Health Insurance Portability and Accountability Act), clean supply areas, soiled utility areas, equipment/cart alcoves, equipment storage areas, exam rooms, environmental services, offices, staff lounges, staff toilets, and staff lockers. Patient rooms include anterooms, satellite work stations, and patient toilets/showers. Inpatient unit program space does not include space for intra departmental circulation, walls, structural space, building envelope and mechanical and electrical support space (shafts, closets, and chases) or space for vertical and building circulation. Vertical circulation space includes stairs and elevators. Building circulation space includes corridors that connect departments.

The applicants propose nursing units with 52,580 SF, which will house 72 beds, for an average of 730 program space SF per bed, 230 SF over the allowable space limit. The standard requires that if a project exceeds 500 SF per bed, any rate increases proposed by the hospital related to the capital cost not include the costs of this excess space, and any portions of the contingency allowance, inflation, escalation and capital construction interest expenditure based on this space. These costs are calculated in table IV-X.

Table IV-X Calculation of Costs Attributed to Excess Inpatient Nursing Unit Space

1	Average SF per bed	730
2	Excess SF per bed (over 500 SF)	230
3	Number of Beds	72
4	Total Excess SF (2 x 3)	16,560
5	Total Cost per SF	$358.60
6	**Excess Cost per SF**	**$5,938,416**
7	Excess SF as a percent of total (16,560/88,850)	18.6%
8	**Inflation Allowance to be excluded ($2,448,512 x 18.6%)**	**$455,423**
9	**Contingencies to be excluded ($5,118,903 x 18.6%)**	**$952,116**
10	**Escalation to be excluded ($4,309,348 x 18.6%)**	**$801,539**
11	**Capital Construction Interest to be excluded ($7,444,631 x 18.6%)**	**$1,384,501**
12	**TOTAL COSTS TO BE EXCLUDED (6+8+9+10+11)**	**$9,531,995**

Very recent adoption by HSCRC of policies limiting eligibility for recognition of capital cost increases in GBR adjustments may make this standard moot for most capital projects. The applicants have not sought such adjustments for this project. That said, the regulations in place indicate that any approval of the project should be accompanied by the following condition. At this time, out of caution, MHCC staff recommends that this condition be attached to any approval of this request for exemption from CON

Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $9,531,995. This figure includes the estimated costs of excess space for inpatient nursing units and the cost and portions of the contingency allowance, escalation and capital construction interest and inflation allowance that are based on the excess construction cost.

(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.

This standard is no longer applicable because the Global Budget Revenue (GBR) model has replaced the rate reduction agreements referenced by the standard. Staff will consider the ongoing validity and/or revision of this standard in its next iteration of COMAR 10.24.10, the SHP chapter used in the review of general hospital projects.

(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

The relocation of MSGA beds from HMH to UCMC does not require replacement or expansion of any diagnostic or treatment facilities at UCMC. However, there is a need to expand non-clinical support services, including dietary, environmental, and security services. (DI #19, p. 37).

(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

The project includes the construction of a dedicated observation unit of 42 beds. Currently, UCMC has its observation patient population scattered throughout all of its medical surgical units. The applicants point out that "[a] clinical practice model that incorporates a dedicated observation unit provides a setting for focused attention to lower acuity patients from admission to the observation unit through discharge, thereby minimizing unnecessary testing and ultimately reducing lengths of stay" (DI#19, p.37). UCMC believes that, in addition to reductions in length of stay, the clinical practice model will also support enhanced clinical outcomes and have a positive impact on overall patient experience.

Staff concludes that the applicants met the requirements in this standard.

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

This is not applicable, as the consolidation of MSGA beds by two hospitals into one hospital and the development of dedicated observation beds should improve operational efficiency.

(12) <u>Patient Safety.</u> 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.

The applicants state that the current hospital, with the exception of a 10-bed clinical decision unit, lacks a dedicated observation unit. This results in observation patients being scattered throughout general medical surgical units. UCMC points out that the comingling of observation patients in MSGA units does not support optimum patient management. The proposed project seeks to relocate MSGA beds from HMH to UCMC and create a dedicated observation unit. The applicants state that this relocation of MSGA beds and centralization of observation patients will allow UCMC to effectively distribute patients and enhance efficiencies that will ultimately support patient safety and improve patient experience.

UCMC provided the following overview (Table IV-X) of the clinical, safety, and efficiency factors that it states will support enhanced security benefits, enhanced room design, and enhanced patient experience in the new facility.

Table IV-X Patient Safety Features of UCMC's Proposed Hospital Expansion

Goal	Factors Supporting the Goal
Improved Infection prevention and control	Provision of individual toilets and showers; Physical separation within the semi-private rooms.
Improved Fall Prevention	Rooms are configured so staff can see the entire patient room from entry; Rooms are designed to provide area for individuals helping patients stand or walk; Rooms are designed to provide a clear path of travel within the room; Bathrooms are configured in close proximity to the head wall, thereby reducing the distance patients need to ambulate to the bathroom; Rooms are designed to include continuous handrails from the head of the bed to the toilet; and Toilets and showers are designed to minimize fall risk.
Improved Operational Efficiencies	Rooms are designed with clear paths of travel for efficient patient transfers and transports; Design allows for adequate space at each patient zone for mobile lift equipment, when needed.
Improved Patient Care	Standardized head walls provide clear individual patient zone; Rooms are designed to provide physical, visual, and auditory separation between patients.

Improved Patient & Family Experience	Rooms are designed to provide physical, visual and auditory separation between patients, thereby enhancing the patient privacy and experience; Rooms are designed to allow for a patient's family member to stay with them 24/7 and provide additional support.

Source: (DI#19, pp. 37-38)

Staff concludes that the proposed project complies with this standard.

(13) <u>Financial Feasibility.</u> 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.

UCMC states that it derived its financial projections from the FY 2019 budget. UCMC's key financial assumptions are:

a) Revenue: assumptions:

- A 2.1% annual revenue update factor;
- Contractual allowances equivalent to 9.4% of gross revenue;
- Charity care equivalent to 3.2% of gross revenue;
- Bad debt equivalent to 2.8% of gross revenue; and
- Cafeteria and other revenue increase of 1.0% per annum.

b) Expense assumptions:

- Salary expenses will be variable based on projected patient volume and the resultant FTE need;
- Inflation assumptions for other expense categories ranges between 2 to 3% per annum; and
- Interest expense will range between 3.6% and 5.8% for old and newly acquired debt (DI #19, Exh. 1, Table K).

Through the relocation of services, UCHS anticipates that its total discharges will not change due to market forces, but will continue to grow with demographic changes, especially the aging of the population. While this outlook can be questioned, in light of the downward trend in hospital use rates seen in the last ten years, the applicants have complied with this standard.

(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;

(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), 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-3 shows historical and projected volume, revenue, and expenses for UCMC from 2016-2024.

Table IV- 3: Selected Current (FY 2016 - FY 2017) and Projected (FY 2018 – FY 2024) Utilization and Financial (Statistics
University of Maryland Upper Chesapeake Medical Center, All Operations

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
MSGA Inpatient Days	55,976	54,089	49,901	52,206	55,481	60,972	58,856	60,294	61,783
Annual Change		-3.4%	-7.7%	4.6%	6.3%	9.9%	-3.5%	2.4%	2.5%
Patient Services Revenue (Uninflated)	N/A	435,821	$444,814	$423,062	$443,514	$457,159	$460,773	$473,908	$487,422
Annual Change			2.06%	-4.89%	2.38%	0.66%	-1.57%	0.44%	0.44%
Total Operating Expenses (Uninflated)	N/A	$430,484	$426,605	$409,186	$434,309	$429,246	$430,948	$431,911	$433,512
Annual Change			-0.90%	-4.08%	6.14%	-1.17%	0.40%	0.22%	0.37%
Staffing/ Contractual Expenses (Uninflated)	N/A	$258,223	$244,766	$256,004	$274,464	$269,880	$263,304	$263,311	$264,002
Annual Change			-5.21%	4.59%	7.21%	-1.67%	-2.44%	0.00%	0.26%
% of Operating Expenses	N/A	59.98%	57.38%	62.56%	63.20%	62.87%	61.10%	60.96%	60.90%
Net Income (Uninflated)	N/A	$24,248	$38,881	$27,217	$12,858	$19,875	$12,235	$13,424	$14,143
Net Income (Inflated)	N/A	$24,248	$38,881	$27,217	$13,868	$22,231	$16,405	$19,162	$21,490

Source: DI #31, Exh. 1, Tables F, G, and H

UCMC projects growth of approximately 18% in patient days between FY 2019 and FY 2024. The increase in patient days and case volume are projected to increase patient service revenue by 15% in that time period. Operating expenses are projected to rise 6% during this time.

Even with an increase in FTEs, needed to serve the larger number of patients, the percent of operating costs attributed to staff salaries will decline by 2.3% from FY 2019 through FY2024. The applicants attribute this reduction to an increase in operating efficiencies and a reduction in redundancies. Overall, UCMC projects revenues to exceed expenses for the hospital through FY 2024. (DI #19, pp. 38-40).

While staff does not find the case for the applicants' utilization projections compelling. staff concludes that UCHS will be capable of generating income even if its projections of greater demand for inpatient care are overstated. HSCRC has found that the suite of UCHS projects, as HSCRC intends to treat them, will produce savings over the current UCHS configuration.

Staff recommends that the Commission find that the project is financially feasible and will not jeopardize the long-term financial viability of UCMC. The applicants comply with this standard.

(14) Emergency Department Treatment Capacity and Space

(15) Emergency Department Expansion

Neither of these standards are applicable. The project does not involve changes in ED facilities.

(16) Shell Space. Unfinished hospital space for which there is no immediate need or use, known as "shell space," shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective. 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 considers the most likely use identified by the hospital for the unfinished space and the time frame projected for finishing the space. The applicant shall demonstrate that the hospital is likely to need the space for the most likely identified use in the projected time frame.

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.

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 Service Cost Review Commission.

The shell space proposed will support two floors of finished building space on upper floors. The applicants state that the shell space will be used within the next three years to house a hematology and oncology practice as part of the Kaufman Cancer Center's diagnostic and treatment services. Expansion of the Kaufman Cancer Center is a part of UCHS's approved strategic capital plan. (DI #19, p.43)

Table IV-X Calculation of Costs Attributed to Shell Space

1	SF of Shell Space	26,290
2	Shell Space as a Percentage of Total SF (26,290/88,850)	29.6%
3	Construction Cost of Shell Space (35,946,047 x 29.6%)	**$10,640,030**
8	**Inflation Allowance to be excluded ($2,448,512 x 18.6%)**	**$724,760**
9	**Contingencies to be excluded ($5,118,903 x 18.6%)**	**$1,515,195**
10	**Escalation to be excluded ($4,309,348 x 18.6%)**	**$1,275,567**
11	**Capital Construction Interest to be excluded ($7,444,631 x 18.6%)**	**$2,203,611**
12	**TOTAL COSTS TO BE EXCLUDED (3+8+9+10+11)**	**$16,359,163**

Based on this analysis, staff recommends that the Certificate of Need for the project contain two conditions. As with the excess space standard previously considered, recent adoption of capital cost policies by HSCRC will require reconsideration of this standard in the future, but, in order to comply with the standard currently in place, and in light of the applicants' statement that GBR adjustments related to the costs of the proposed project are not proposed, *at this time*, staff recommends inclusion of the following condition:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $16,359,163. This figure includes the estimated costs of shell space and the cost and portions of the contingency allowance, escalation and capital construction interest and inflation allowance that are based on the excess construction cost.

APPENDIX 2

PROJECT BUDGET

Project Budget

Uses of Funds	
Capital Costs	
Renovations	
Building	$2,852,180
Fixed Equipment	$4,736,462
Architect/Engineering Fees	$300,045
Permits (Building, Utilities, Etc.)	$142,879
Subtotal-Renovations	**$8,031,566**
New Construction	
Building	$39,639,186
Fixed Equipment (not included in construction)	$0
Site and Infrastructure	$246,346
Architect/Engineering Fees	$4,628,765
Permits (Building, Utilities, Etc.)	$2,320,586
Subtotal-New Construction	$**46,834,883**
Other Capital Costs	
Movable Equipment	$2,520,000
Owner Contingency Allowance	$4,511,181
Gross interest during construction period	$6,566,503
Technology / Information Systems	$2,000,000
Furniture / Artwork / Signage	$1,340,790
Food Service Equipment	$300,000
Subtotal-Other Capital	$18,724,324
Total Current Capital Costs	$73,590,773
Inflation Allowance	$2,448,512
Land Purchase	
Total Capital Costs	**$76,039,286**
Financing Cost and Other Cash Requirements	
Loan Placement Fees	$709,979
CON Application Assistance	
Legal Fees	$110,322
Other Consulting Fees	$884,309
Non-CON Application Assistance	
Legal Fees	$227,508
Other Consulting Fees	$1,181,081
Debt Service Reserve	$5,254,322
Subtotal	**$7,375,008**
Total Uses of Funds	**$84,406,807**
Sources of Funds	
Bonds	$82,718,126
Other (Interest Earned)	$1,688,681
Total Sources of Funds	**$84,406,807**

(DI #30, Exh. 1, Table E).

APPENDIX 3

HSCRC Letter

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

MEMORANDUM

TO: Kevin McDonald, Chief - CON, MHCC

FROM: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Deputy Director, Hospital Rate Setting, HSCRC

DATE: March 17, 2020

RE: **University of Maryland Upper Chesapeake Health Projects:**
Modified Request for Merge/Consolidation UM UCMC and UM HMH, Matter No. 17-12-EX003
Modified Request to Convert UM HMH to an FMF in Aberdeen, Matter No. 17-12-EX004
Modified Certificate of Need for Special Psychiatric Hospital at Aberdeen Medical Center, Docket No. 18-12-2436

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On March 5, 2020, MHCC sent a memo requesting HSCRC staff to review and comment on the financial feasibility of University of Maryland Upper Chesapeake Health System's (UCHS) three intertwined proposals. Because of their interdependence, HSCRC staff reviewed them as concurrent projects and understand that MHCC will act on them simultaneously.

As per the description in the March 5 memo, two projects involve requests for exemption from Certificate of Need (CON), while one is a CON application. One exemption request is to convert University of Maryland Harford Memorial Hospital (HMH) to a freestanding medical facility (FMF) to be built in Aberdeen, while the other is to merge and consolidate certain inpatient services from HMH with University of Maryland Upper Chesapeake Medical Center (UCMC). The third element of this package is a CON application to establish a Special Psychiatric Hospital in Aberdeen, which would occupy the second floor of a building, constructed above the first floor FMF. This facility would be the centerpiece of what Upper Chesapeake Health System is calling the "Aberdeen Medical Campus" (AMC).

According to the memo, the primary objectives of the project package are to reconfigure and modernize the UCHS's delivery system to enable the continuation of quality of care and to consolidate services for cost savings and efficiency. A brief description of each project follows:

Upper Chesapeake Behavioral Health at Aberdeen:

- approximately 75,000 square feet ("SF") of new construction;
- 33 beds and shell space that could eventually accommodate 7 more beds;
- Total project budget is just below $63 million.

FMF:

- 25 ED treatment spaces
- 17 observation rooms
- approximately 69,000SF of new construction (on the first floor of the building that would include the psychiatric hospital)
- a diagnostic imaging suite with related staff and support spaces;
- non-treatment spaces, including triage/blood draw rooms, consultation rooms, staff support spaces, and offices; and
- a laboratory and pharmacy;
- Total project budget is $56,665,400.

Addition at UCMC to accommodate merging of HMH services:

- addition of three floors above the current cancer center (approximately 98,000SF);
- a shelled floor to accommodate actual and anticipated cancer center growth;
- one floor with 42 observation beds;
- one floor with 30 medical/surgical beds;;
- Total project budget of $84.4 million.

UM UCHS will fund the total project as well as the other capital projects for which UM UCHS and its constituent hospitals have sought approval from MHCC through a combination of $214.3 million in tax exempt debt and $4.0 million of interest earned on bond proceeds. The bonds are anticipated to be issued in fiscal year 2020 through the University of Maryland Medical System.

In commenting on the revenue and expense projections and financial feasibility of the proposed project, MHCC staff advised HSCRC staff to assume that UM UCH will achieve the projected volumes for the FMF and psychiatric hospital, but that there is not sufficient need shown for the 30 additional inpatient beds in the merger.

HSCRC Staff Comments:

We have reviewed the financial projections presented by UCHS and numerous schedules and narratives in support of such projections. These projections were reviewed in the context of the individual projects and the collective UCHS system, with a focus on the regulated service entities while maintaining awareness of the unregulated service components. The main purpose of our review was to determine what level of revenue should be retained by the regulated entities of UCHS and to determine the financial feasibility of the resulting UCHS as a whole.

The proposed construction is to be complete, and the related services are to commence by fiscal 2023. At that time, the projected GBR equivalent of HMH is to be approximately $119,400,000. Based upon the data provided by UCHS, the volume of business previously conducted at HMH would be redirected as follows: approximately $43.8M to UCMC; $17.0M to the Special Psychiatric Hospital; $36.0M to the FMF; and $22.6M to other third party regulated hospitals or to unregulated components.

Of the $22.6M volume directed to other third party/unregulated, UCHS would be allowed to retain $11.3M in revenue. Of the remaining $96.8M volume directed to regulated UCHS entities, UCHS would

be allowed to retain $86.9M in revenue to be distributed among those entities, respectively. Therefore in total, UCHS would be allowed to retain $98.2M in GBR revenue.

The state-wide public health care system would save approximately $9.9M (gross reduction in retained GBR of $21.2M less $11.3M retained by UCHS). This would be coupled with approximately $4.7M of savings resulting from reduced Medicare reimbursement on billings from a standalone psychiatric hospital. Such reimbursement would not be based upon HSCRC rates as was approved at HMH, and which rates were paid by Medicare, but rather based upon the national Medicare fee schedule.

Financial Feasibility:

When the aforementioned $21.2M reduction in GBR revenue is applied to the 5-year projections (FY 2023 through FY 2027) the results imply the need to ramp up the reduction as follows: $15.2M in the first year of operations; $18.2M in the second year; and the full $21.2M in the third year of operations and forward. Focusing on the projected fifth year of operation (FY 2027) for the regulated entities (UCMC and AMC), gross patient revenues approximate $503M; net operating revenues approximate $425M; total operating expenses approximate $412M yielding an approximate $13M positive operating margin or 3%.

Although the HSCRC is focused upon regulated volumes, revenues and profitability, we noted the impact upon UCHS as a whole inclusive of UCHS owned physicians' practices and other UCHS owned but unregulated components. Again focusing on the fifth year of operation (FY 2027), the profit/loss was measured at a net loss of approximately $4M before non-operating income, which has averaged a positive $11M per year over the past three fiscal years, and averaged a positive $5M per year over the past five fiscal years. This implies that the UCHS system as a whole has the ability to absorb the planned reduction in GBR and remain profitable. We anticipate that UCHS will take full advantage of the current historically low interest rates on its financing needs, and that UCHS will continue to monitor and manage its operating costs. In addition, UCHS has the prerogative to amend its plans of financing this project should it wish to reduce the interest expense included in the projections. Further, UCHS has the prerogative to increase the shell space and defer certain of the fit-out should it wish to defer the depreciation expense included in the projections.

HSCRC staff believes that this project can be feasible. However, as is often the case, feasibility will depend on UCHS's ability to manage the project and the resulting operating expenses after the completion of the project. As pointed out, decisions on how to finance this project now will have an impact upon future operating margins. HSCRC staff believes that UCHS will make the decisions that they believe are appropriate in the future and that allow them to operate most efficiently.

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