IN THE MATTER OF THE	*	
	*	**BEFORE THE**
LUMINIS HEALTH DOCTORS	*	
	*	**MARYLAND HEALTH**
COMMUNITY MEDICAL CENTER	*	
	*	**CARE COMMISSION**
DOCKET NO. 23-16-2466	*	

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STAFF REPORT AND RECOMMENDATION

December 14, 2023

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I. INTRODUCTION

A. The Applicant

Luminis Health Doctors Community Medical Center Inc. (Doctors, the hospital, or the applicant) is a non-profit acute care hospital in Lanham, Maryland (Prince George's County) founded in 1975. At the time of the application Doctors had 210 licensed acute care beds. As of July 1, 2023, Doctors has 208 licensed acute care beds, including 16 psychiatric beds recently approved by the Maryland Health Care Commission (MHCC or Commission) in Docket # 21-16-2448.[1]

Doctors became part of Luminis Health integrated health system (Luminis Health) in 2019 when it came together with Anne Arundel Medical Center (AAMC), an acute care hospital, to form one health system to serve the residents of Anne Arundel, Prince George's, Calvert Counties, and Maryland's Eastern Shore. Luminis Health is comprised of Doctors, AAMC, J. Kent McNew Family Medical Center, a freestanding mental health facility, and Luminis Health Clinical Enterprise (LHCE), multi-specialty ambulatory sites. (DI #3, pp.5-7). Other subsidiaries include Luminis Health Imaging, Luminis Health Services Inc., Luminis Health Real Estate, Luminis Health Research, Physician Enterprise, LLC., AAMC Collaborative Care Network, and the AAMC Foundation.(DI #3, Exhibit 21).

B. The Project

The proposed project includes two main components: the establishment of a new obstetrics program, and a capital project consisting of construction of a new acute care patient tower and renovation of the existing hospital infrastructure and surgical services to improve functionality and support services. Doctors has undergone multiple renovations between 1975 and 2015, including a six-story medical office building, followed by a two-story surgical suite expansion built in several phases between 1975 and 2015. The current hospital consists of two main buildings, an original four-story (west) tower and a six-story (east) tower.

The applicant proposes building an acute care patient care tower adjacent to the existing hospital to accommodate an expanded surgical suite, support services, and the new obstetrics program. The new tower will allow more room for support services such as the pharmacy, imaging, radiology, sterile processing, pre/post op, nutritional services, and patient flow. Surgical services will also be located in the new patient tower. The new location in the patient tower will allow for larger operating room size and improve flow to allow for more efficient care and modern surgical equipment, which is often too large to fit into older, smaller operating rooms. Because of the current surgical suite's small size, only eight of the 12 operating rooms can be utilized. The surgery suite also needs mechanical, electrical, and plumbing upgrades. (DI #3, pp.5-7). The table below shows changes to the acute care bed capacity resulting from this project.

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

Table I-1: Doctors Physical Acute Care Licensed Bed Capacity, Before/After Project[2]

	Current	After Project
MSGA	210	210
Obstetric*	0	21
Psychiatric	16	16
Total	226	247

*21 total licensed beds (18 postpartum and 3 antepartum), however there will also be an additional 8 labor and delivery rooms.
(DI #15, Exhibit 29, Table A).

Obstetrics Program

The new obstetrics program will be located on the third and fourth floors of the new 182,949 SF Acute Care Pavilion. The third floor will include labor, delivery, and recovery rooms (LDR), antepartum rooms, a birthing center for midwife use, and additional support spaces. The postpartum unit, Level II Continuing Care Nursery, and a well-baby nursery will be on the fourth floor as seen in the stacking diagram in Figure 1. (DI #3, pp.8-9). The project will add 21 obstetric inpatient beds—18 postpartum and 3 antepartum. (DI #3, p. 100).

Figure 1: Doctors Stacking Diagram

Level	Departments
Fifth Floor	mechanical penthouse
Fourth Floor	post-partum, nursery
Third Floor	labor and delivery, antepartum, birthing center, support space, c-section operating room
Second Floor	surgical services/endoscopy
First Floor	lobby, support services

(DI #3, Exhibit 4).

The applicant states that the proposed obstetric program will increase access and support Prince George's County's need for additional obstetrics services, resulting in improved maternal and infant health outcomes including:

- Local access for patients who now travel out of the county to AAMC/ Montgomery County, Washington DC
- Additional OB/GYN providers in Prince George's County
- Additional OB/GYN providers who accept Medicaid
- Better management of chronic medical conditions throughout pregnancy
- Improved quality of care and patient safety in a new facility
- Culturally responsive services to address and reduce health disparities
- Improved health outcomes. (DI #3, pp.8-9).

Capital Expenditures

[2] In FY2024 the licensed capacity dropped to 208, 2023 data was used at the time of the application.

The project will include 301,952 square feet (SF) of new construction and renovation. The estimated total cost of the project is $299,012,841. The applicant anticipates funding the project with $33,688,629 in cash reserves, $5,000,000 in philanthropic support, $152,894,229 in interest income from bonds, and $95,000,000 from the State of Maryland. To minimize disruption to hospital operations, project construction is planned to occur in three phases: the loading dock (tentative 2024), the acute care pavilion (tentative 2027), and renovations (tentative 2029). (DI #15, p.3). The full project budget estimate and anticipated source of funds are located in Appendix 5.

C. Summary of Staff Recommendation

Staff recommends project approval, with the following three conditions.

Luminis Health Doctors Medical Center shall close its obstetric program, and its authority to operate will be revoked, if: (i) it fails to meet the minimum annual volume of 1,000 obstetric discharges annually for any 24 consecutive month period, and (ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.

Luminis Health Doctors Medical Center shall continue to provide a patient with an estimate of out-of-pocket charges prior to arrival for surgery.

Before changing the funding mechanisms of the project, the applicant must submit a project change.

This recommendation is based on the conclusion that the proposed project complies with the applicable State Health Plan standards, there is demonstrated need for the project, it is cost-effective, and it is viable. Staff also concludes that the project will not have an adverse impact on other providers or the health care system while having a positive impact on patients and hospital staff. A summary of the basis for this recommendation to the standards and criteria follows:

Need

The applicant demonstrated unmet need by showing the decline in the number of obstetric beds available in Prince George's County and the current high percentage of out-migration to other counties and Washington, DC. The project's proposed goals are to provide the community with prenatal and obstetrics care to reduce poor maternal child outcomes in Prince George's County. Surgical suite modernization is also needed based on the obsolescence of the current operating rooms, they are too small for modern equipment, support services and to support the new obstetrics program.

Cost Effectiveness

The applicant provided three alternatives to the proposed project including expanding the existing hospital space. The applicant conducted an analysis of the feasibility and costs associated with several options and ruled those out before selecting the option to build an acute patient care

tower adjacent to the hospital for the new obstetrics program, expansion of the surgical suite and renovation of infrastructure and support services.

Viability

The applicant provided a reasonable funding plan to implement the project. It also provided audited financial statements from its parent, Luminis Health, that show a bottom line that "present fairly"[3] and its own financial projections that show the hospital will achieve positive net income even with the implementation of the proposed project. The project also has community support that will help to sustain future viability.

Impact

The additional obstetrics bed capacity will improve access for Prince George's County residents and a local delivery site will minimize the out migration for an essential clinical service. Applicant anticipates that the utilization of a Laborist[4] model will attract physician providers to the County that will create more access and minimize physician shortages. And finally, the modernization of the surgical suite project will produce cost savings by improved efficiency.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 1, Record of the Review.

B. Interested Party

There are no interested parties in this review.

C. Local Government Review and Comment

The Prince George's County Health Department submitted a letter from County Executive Angela Alsobrooks in support of the project. (DI # Exhibit 20).

D. Community Support

The applicant provided letters of support for the project addressing the positive impact this project will have on the healthcare community: (DI # Exhibit 20).

[3] Audited Financial Statements, Exhibit 21

[4] In a Laborist model, a Laborist employed by the hospital assists the patient through labor and delivery, allowing the patient's primary OB/GYN to focus on their clinical practice.

- Dr. Tonya Harrison, Vice President, NAACP of Prince George's County
- Mahasin El Amin, Esquire, Clerk of the Circuit Court, Prince George's County
- Dr. Bobby Manning, President, The Collective Empowerment Group
- Deborah Martinez, CEO, Mission of Love Charities
- Wanda Wheatley, Commission Chair, Town of Cottage City
- Celina Benitez, Mayor, City of Mount Rainier
- Rasheeda Jamison, President. United Communities Against Poverty
- Josephine Mourning, President, Southern Christian Leadership Conference
- Christopher DeMarco, PhD, MBA, CEO, Greater Baden Medical Services
- Multiple obstetrical and gynecological providers affiliated with Luminis Health
- Cynthia Miller, Mayor, City of District Heights
- Bennard J. Cann, Mayor, Town of Morningside

III. BACKGROUND

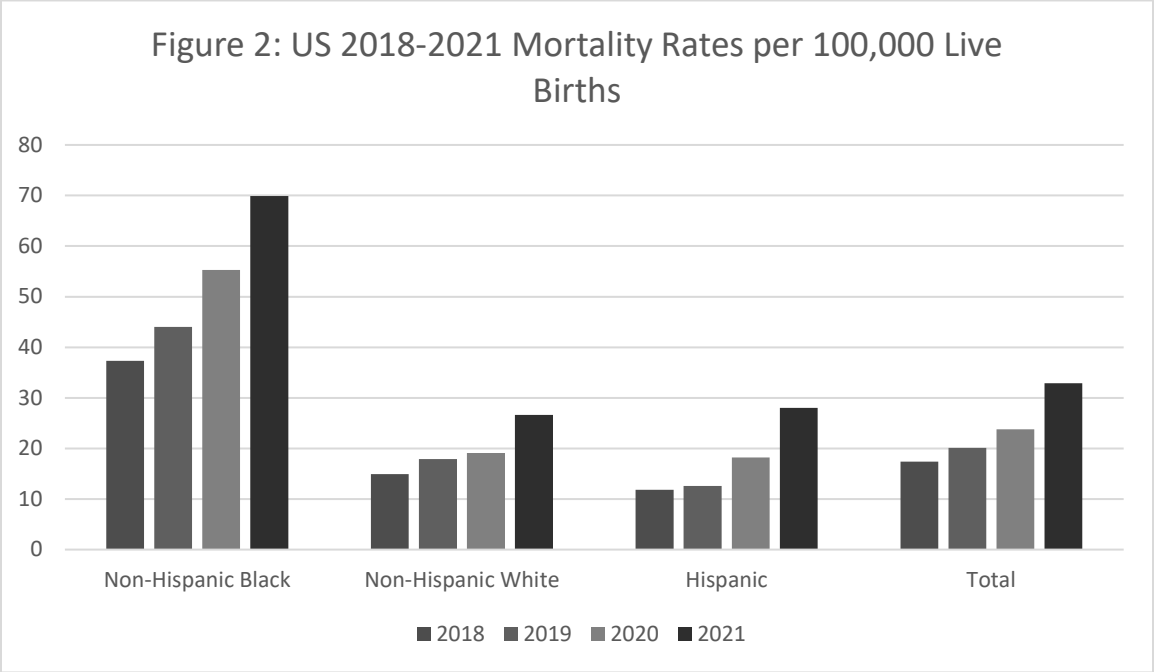
United States, Maryland, Prince George's County Population and Maternal/Infant Health

The recently published Huron report *Assessing Prince George's County Healthcare and Social Needs and 10+ Year Investment Strategy*[5] states that 42 percent of all health care is out migrating from Prince George's County. The same report states that obstetrics and gynecology are one of the specialty areas highlighted as critical demand.

As illustrated in Figure 2, the Advisory Board reported that between 2018 and 2021 pregnancy related mortality rates per 100,000 live births were higher for Non-Hispanic Blacks than for Hispanics or Non-Hispanic Whites in the United States, indicating a disparity between the groups.

[5] Huron. "*Assessing Prince George's County Healthcare and Social Needs and 10+ Year Investment Strategy."* Presented October 11, 2023

Figure 2: United States 2018-2021 Mortality Rates per 100,000 Live Births



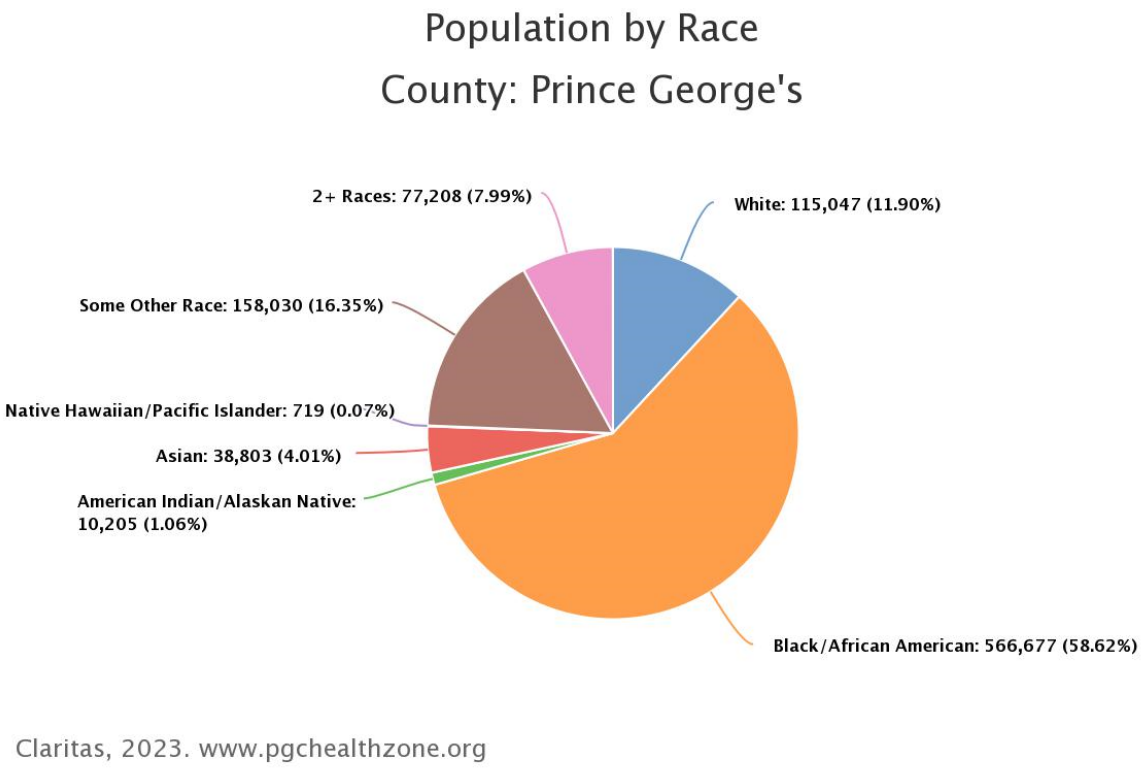
Source: https://www.advisory.com/featured/health-equity#tabs-60570160c5-item-619e90b3da-tab

The Prince George's County's 2022 Community Health Assessment (CHA) describes the Washington, D.C., metropolitan area as economically diverse, including affluent communities with above-average health outcomes, and poorer communities with below-average health outcomes. Prince George's County's health care priorities focus on addressing the social determinants of health, improving behavioral health, and reducing obesity/metabolic syndrome and cancer.[6]

The Prince George's County population grew by 12 percent over the last decade compared to only seven percent for the State of Maryland as a whole. In addition, the Hispanic population of Prince George's County has grown from 2010 to 2020 by 60 percent, now making up one in five residents.[7]

[6] Prince George's County Health Department, 2022 Prince George's County Community Health Assessment, https://www.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf
[7] *Id.* at 7.

Figure 3: Prince George's County Percentage of Population by Race 2023



Source: https://www.pgchealthzone.org/demographicdata

According to the Prince George's County CHA, in 2020, Black, non-Hispanic mothers had the highest percentage of infants born at less than 37 weeks at 11.3 percent and babies with low birth weight (<2500g) at 10.9 percent.[8]

III. REVIEW AND ANALYSIS

The Commission's decision must be based on the general Certificate of Need (CON) review criteria at COMAR 10.24.01.08G(3)(a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to all relevant State Health Plan (SHP) standards and policies. Because this is an acute hospital project that involves the addition of an inpatient obstetric program and renovation of surgical services, the project must be evaluated on all relevant standards in the following SHP Chapters: COMAR 10.24.10—Acute Hospital Services; COMAR 10.24.12—Inpatient Obstetrical Services; and COMAR 10.24.11—General Surgical Services.

A. The State Health Plan

[8] *Id.* at 43.

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

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

COMAR 10.24.10: Acute Hospital Services

.04A — General Standards.

(1) Information Regarding Charges. Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the Provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Doctors provided a written policy, *Patient Financial Services-Hospital Financial Assistance, Billing & Collection Policy,* which includes the procedure for requesting a representative list of services and charges. The list is available to the public in written form and on the applicant's website. The policy includes the procedure for responding to requests for costs of services and procedures and that the financial coordinator will respond to requests promptly. The applicant states that all staff are trained to handle inquiries regarding charges and services, including financial assistance, charity care, and billing. (DI #3, p.36 and Exhibit 7).

Staff validated that the list of charges is available online. Doctors' policy procedures require prompt responses and after reviewing the website and policy, staff concludes that all subparts are met, and applicant complies with the standard.

(2) Charity Care Policy Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis. Quote

the specific language from the policy that describes the method of implementing and provide a sample for each communications vehicle(s).

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; and

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant's charity care policy states that notice regarding the *Financial Assistance Policy* shall be provided at the time of admission/preadmission and it is mandatory that all patients receive the *Patient Information Sheet* as part of the admission packet. (DI #3, pp. 37-40). Doctors' CON application included a policy titled *Patient Financial Services — Hospital Financial Assistance,* which states the hospital will provide 100 percent free care for patients with household income up to 300 percent of the Federal Poverty Guideline. (DI#3, Exhibit 7). This exceeds the Maryland mandated minimum of providing free care to those with family income at or below 200 percent of Federal Poverty Guidelines. On page two of the policy, under Policies and Procedures it states:

> The following two-step process shall be followed when a patient or a patient's representative requests or applies for financial assistance, Medical Assistance, or both.
>
> Step One: Determination of Probable Eligibility. Within two business days following the initial request for financial assistance, application for Medical Assistance, or both, Luminis Health shall: (1) make a determination of probable eligibility, and (2) communicate the determination to the patient and/or the patient's representative. To make the determination of probable eligibility, the patient or his/her representative will be required to provide information about family size, insurance, assets and income, and the determination of probable eligibility will be based solely on the information provided by the patient or patient's representative. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility.
>
> Step Two: Final Determination of Eligibility. Following a determination of probable eligibility, Luminis Health will make a final determination of eligibility for Financial Assistance, which (except as otherwise provided in this Policy) will be based on a

completed Uniform Financial Assistance Application and supporting documentation of eligibility. (DI #3, p.38).

Page one of the *Charity Care Policy* states that the Financial Assistance signage must be located in the Emergency Department, Cashiering, and Financial Counseling office. Patients who need to discuss financial assistance in another language can access a number for interpretive services. (DI #3, p.39). Staff validated that the *Financial Assistance Policy* and *Uniform Financial Assistance Application* were located on the Doctors website in both English and Spanish. The applicant states that financial assistance information is in each patient guide and on the *Patient Information Sheet,* which are both available at all access points to the hospital and direct those with questions about paying their bill to the hospital Financial Coordinator. Applicant included a copy of the *Patient Information Sheet* and *Patient Handbook* in its application. (DI #3, pp. 37-40). The applicant included photographs of the required signage posted in the hospital. (DI #3, pp. 37-40, Exhibits 10 through 12).

The applicant provided documentation that shows regulated charity care relative to total operating expenses and Doctors is in the top quartile of all Maryland hospitals at 3.13 percent, as shown in the Health Services Cost Review Commission's (HSCRC) 2020 data. (DI #3, p.41, Exhibit 13).

The applicant's charity care policy meets the requirements of the standard, including all subparts, and the applicant has shown that it is providing charity care at a percentage of revenue that is above the bottom quartile of all hospitals in Maryland. Staff concludes that the applicant has met the 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.

(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.

For subpart a, the applicant has demonstrated that it complies with Medicare and Medicaid programs, as evidenced by its license from the Maryland Department of Health and accreditation from the Joint Commission. (DI# 3, Exhibits 14 and 15). In reference to the parent company, Luminis Health, staff also looked up the accreditation of AAMC and incorporated it into the record. (DI #23, p.1).The quality of care is surveyed as part of the licensure and accreditation process.

Staff notes that paragraph (b) of this standard has become outdated in recent years because the Maryland Performance Evaluation Guide no longer exists. Notwithstanding the obsolescence, applicant identified below-average ratings on the quality reporting utilizing the data on the Commission website (based on Medicare data) and provided an action plan for resolving any below-average rankings. (DI #3, p.41, Exhibit 16).

Staff review identified discrepancies in the data submitted as part of Exhibit 16 because the applicant accessed the data in the first quarter of 2023 and staff accessed the data in the second quarter of 2023. The applicant resubmitted its quality improvement plans for the additional metrics identified by staff as part of the completeness review as seen in the table below. (DI #10, pp. 4-5).

Table IV-1: Quality Measures with Below Average Performance Ratings at Doctors

Measure	Action Plan
2021-2022 Influenza Vaccination Rate	Improve education, make egg free vaccine available, improve tracking, purchase scanning devices for uploading data into health records, utilize new health record system, improve communication incentivize departments and develop an easy submission of outside vaccine documentation
Nurse communication with patients	Use of rounding tools, employee coaching, values training- review progress in the biweekly Patient Experience Committee
How well do patients understand their care when they leave the hospital?	Performance improvement workgroups, rounding tools, improved patient discharge packets, white boards in rooms, enhanced RN onboarding
Were patients always given information about what to do during their recovery at home?	Improved patient discharge packets, rounding tool, white boards in rooms, enhanced RN onboarding
How often did staff always explain about medicines before giving them to patient?	Implementation of discharge folders, review progress in the biweekly Patient Experience Committee
How often were the patients' rooms and bathrooms always kept clean?	Issued monitored and discussed in the biweekly Patient Experience Committee
How often patients received help quickly from staff	Call bell data used to work on improved response times, review progress in the biweekly Patient Experience Committee
How often was the area around patients' rooms always kept quiet at night?	Workgroup focuses on quietness, monitoring by unit directors, review progress in the biweekly Patient Experience Committee
How long patients spent in the ED before being sent home?	Doctors plans to identify common reasons for delayed discharges and work with physician groups/discharge planners to create an action plan.
How long patients spent in the ED before being sent home?	ED throughput super track, performance improvement led ED workgroups
How do patients rate the hospital overall?	Performance improvement workgroups, rounding tools, white board in patient rooms, enhanced RN onboarding
Would patients recommend the hospital to friends and family?	Improved discharge packet, patient thank you cards, multi-lingual signage in hospital rounding tools, white boards in patient rooms, enhanced RN onboarding
How often patients die in the hospital after a heart attack?	100% mortality review tool and analysis of turnaround times and bottlenecks
Wait time for cardiac patients needing transfer	Use of high sensitivity troponin, provider education, partnership with Washington Hospital Center and AAMC for quick transfers, track discharge data, review progress in the biweekly Patient Experience Committee
Contrast material dye used during an abdominal CT scan?	Reduce repeat scanning by 15%, monthly multidisciplinary leadership meetings to monitor
How often wounds split open after surgery on abdomen or pelvis?	Infection prevention, staff education, nutrition
Deaths within 30 days after hospital treatment of pneumonia	Institute early warning sign protocol, sepsis navigator, identify hospice candidates to reduce readmissions, developed a mortality review tool and review progress in the biweekly Patient Experience Committee

(DI #3, Exhibit 16 and DI #10, pp.5-6).

In addition to the metrics for which the hospital has submitted improvement plans, Commission staff accessed the Maryland Quality Reporting page of the MHCC website on May 26, 2023, and notes that 60 percent of patients surveyed "would recommend" the hospital and 62 percent would rate the hospital a 9 or 10 out of 10 on the patient satisfaction measures. In comparison, the State as a whole scored higher at 63.8 percent, and 64.4 percent respectively. Based on the applicant's detailed quality improvement interventions, the Commission staff is confident of the applicant's commitment to working to continually improve quality outcomes and concludes that the applicant has met the requirements of the standard.

COMAR 10.24.10.04B-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.

This standard is not applicable. The proposed project does not involve a new hospital or an existing hospital that is relocating.

(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.

This standard is not applicable. The proposed project does not involve an addition of MSGA or pediatric beds.

(3) Minimum Average Daily Census for Establishment of a Pediatric Unit

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

This standard is not applicable as Doctors is not establishing a pediatric unit.

(4) Adverse Impact

A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

(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 applicant met with the Health Services Cost Review Commission (HSCRC) in April 2023, prior to submitting its application. At the time of the application, Doctors was seeking an increase from the HSCRC to its Global Budget Revenue (GBR) beginning in 2027 related to this capital project. The applicant's rate order dated March 2023 had a GBR of $309,657,371. (DI #15, p.5). Doctors was seeking an increase to its GBR via the HSCRC's Capital Funding Policy. This policy takes an average of the statewide capital ratio and a hospital's pro forma capital ratio

and subtracts the hospital's current capital ratio to determine eligible additional capital funding. At the time of the application, the applicant stated that there would be financial stress on the project if the rate increase was not approved, but expressed confidence that it has adhered to HSCRC requirements for rate relief and that its associated spending met the needs of the HSCRC's *Capital Funding Policy*. (DI #15, p.4). The applicant also stated that if the HSCRC requested rate relief was not granted, Luminis Health would have to reevaluate the project. (DI #15, p.4). In November of 2023 the HSCRC issued a memo with their analysis of the feasibility and ongoing viability of the proposed project and stated that it estimates Doctors may be eligible to receive an incremental capital adjustment of approximately 6.92M to its GBR upon completion and full operation of the proposed project. (DI #20, pp 1-5).

The HSCRC no longer publishes an average age of the plant, therefore the additional requirement of subpart (a) no longer applies. (DI #3, p.43). The applicant also states that for subpart (b), this project does not involve any service elimination or downsizing (including services provided for the indigent or uninsured). (DI #3, p.43).

Staff concludes that based on applicant's statement that it will either obtain an increase to its GBR or change the project design there will not be an unwarranted adverse impact on hospital charges nor a change in the availability of or access to services resulting from this project. Staff concludes that the applicant complies with the standard. [9]

(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.**
>
> **(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.**

[9] Any significant change in physical plant design would require Commission approval in accordance with COMAR 10.24.01.17.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital.

Doctors' primary objectives for the proposed project are to introduce new obstetric services and to modernize and improve outdated surgical and support service spaces. Greater access to obstetric services are needed in the County to minimize out-migration and improve outcomes. Doctors evaluated several alternative approaches and considered the following alternatives (listed below with estimated costs):

Option A: Do Nothing
Option B: Convert Existing Hospital Space
Option C: Vertical Expansion of Existing Hospital
Option D: Change model of operations from labor and delivery rooms to labor and delivery recovery postpartum
Option E: Construct New Facility (Selected Option)

Option A: Do Nothing

Given the stated challenges of an outdated facility doing nothing was not an acceptable alternative and Doctors rejected this option.

Option B: Convert Existing Hospital Space

The applicant considered adding a fourth floor to the existing hospital, above the critical care unit on the third floor of the east tower, for an estimated cost of $117.5M. This option was determined to have a negative impact on patient care and operations during the construction phase. Further, there was no space available to temporarily relocate the critical care unit during construction and thus, this option was not a viable solution.

Option C: Vertical Expansion of Existing Hospital

The applicant next considered a vertical expansion by adding three floors to the existing hospital, above the critical care unit for an estimated cost of $189M. However, there was insufficient structural load bearing capacity for this option.

Option D: Change Model of Operations from Labor Delivery Recovery (LDR) to Labor Delivery Recovery Postpartum (LDRP)

The proposed obstetric program has an LDR model of care where patients deliver in LDR and then go to a post-partum room. Doctors explored an alternative LDRP care model where the patients remain in the same room for the entire hospital stay. This option would require constructing an additional patient floor over the proposed obstetrics unit. As part of this option the applicant explored putting the nursery on the third floor; however, this would create security challenges because the nursery would be its own location separate from the postpartum area. The estimated cost of this option is $291M.

Option E: Construct New Facility (Selected Option)

The applicant determined that the west zone of the Doctors campus was the preferred location for new construction. The new facility would allow Doctors to expand into obstetric services while being located next to the existing hospital. This option will allow for a c-section suite above the expanded surgical suite and will connect the new construction to the existing Doctors support services circulation area, creating a service zone for distribution of materials. Both levels will connect using the existing entrance on the first floor and an entrance to surgical services on the second floor. (DI #10, p.1). This option also provides a new front entrance to the main facility, and access to the acute care pavilion. The estimated cost of this option is $299M, similar to the cost in Option D but more effective because there were less security challenges.

b. This subpart is not applicable because this project has more than just one limited objective.

c. This subpart is not applicable because Doctors is not proposing the establishment of a new hospital or relocation of an existing hospital. (DI #3, pp.44-46) and (DI #10, p.6).

Commission staff notes that the applicant has provided comprehensive alternatives to the proposed project. The applicant provided evaluations of three alternatives and included comparison points such as the cost of each alternative. In summary, Commission staff concludes that the applicant selected the most cost-effective approach to meeting its objectives and the standard is met.

(6) Burden of Proof Regarding Need

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

Support Spaces

Doctors states that it is undersized and undercapitalized. The current support services cannot handle the volume that will be created by the new obstetrics program. The applicant shared data that was based on an estimate provided by Cannon Design, a contractor hired to do project planning. Cannon Design used its national database and experience working with hospitals to establish benchmarks for the size of hospital departments based on departmental gross square feet (DGSF). The current DGSF of the services and departments on Level 1 of the hospital, which includes sterile processing, loading dock, imaging, laundry, kitchen, laboratory, morgue, and supply change management, range between 85 percent and 10 percent of Cannon Design's DGSF benchmarks. The current DGSF for departments on Level 2, which includes surgery, cardiac catheterization, radiology, and pharmacy, range between 59 percent and 32 percent of the benchmarks. The current size of the surgery services department, for example, is 27,295 DGSF, which is just 58 percent of the 46,750 DGSF benchmark. This project would expand the surgery

services department to 48,009 DGSF 103 percent of the benchmark. (DI #3, pp. 47-48).

In addition to the undersized department space, the applicant states that Doctors has a capitalization ratio that is among the lowest of its peer group (6.9 percent compared to an average of the peer group being 7.9 percent). The range of operational hospitals in the State have capitalization ratios between 2.4 percent (Fort Washington Medical Center) and 15 percent (University of Maryland Shore Regional Health at Dorchester).

General Surgical

Doctors is currently licensed for 12 general purposes operating rooms. Doctors is not seeking to expand the number of operating rooms in the proposed project but intends to use 10 as mixed-use operating rooms and dedicate two to cesarian sections. The existing facilities do not meet current industry standards for size, and two out of the 12 operating rooms are so small they are obsolete. The current operating rooms are an average of 526 SF, and the project will increase the operating rooms to 700 SF. In addition to being too small, the operating rooms have outdated finishings. The rooms also have subpar 30-year-old plumbing. (DI #3, pp.47-50). (DI #10, p.2).

Obstetrics

The need for the obstetrics program will be discussed *infra p. 24* of this report, in which the project is accessed against the standards in the Acute Hospital Inpatient Obstetric Services Chapter of the State Health Plan, COMAR 10.24.12.

Staff Analysis

The applicant used data in its DGSF report from Cannon Design to show that the hospital is undersized for all support department spaces. (DI #3, p.16). The applicant also discussed that its OR spaces are currently undersized and obsolete, demonstrating the need for renovation to the surgical suite. Staff concludes that the standard is met.

(7) Construction Cost of Hospital Space

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

The applicant provided a Marshall Valuation Services (MVS) analysis in its CON application attached as Exhibit 17. The total square footage of the building is 161,991 SF (cost of 741.48 per SF) and the penthouse is 20,958 SF (cost of 85.86 per SF) totaling 182,949 SF. Applicant calculated the MVS benchmark as $225.98 below benchmark for new construction and $279.76 below benchmark for renovation. Staff validated the applicant's calculation of the MVS for the proposed project by conducting its own MVS analysis as shown in Table IV-2. Staff concluded that the proposed cost of the hospital construction project is reasonable and consistent with current industry cost experience in Maryland.

Table IV-2: Analysis of the Construction Cost for Doctors – Cost in Excess of MVS

MVS Building Benchmark	$ 121,911,747
Construction costs	$139,623,357
Extraordinary costs[10]	($57,297,243)
Total	$82,326,114

The MVS benchmark for building cost is approximately $122M. After the deduction of extraordinary costs ($57M), the proposed cost is $82M and acceptable as it is below the benchmark. Based on this analysis, staff concludes that the standard is met.

(8) Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

This standard is not applicable, as the project does not include construction costs of non-hospital space.

(9) Inpatient Nursing Unit Space

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If

[10] Physical/capital variations from typical construction (approximatly7K of the exclusion) are for signage, canopy, hookup fees, impact fees, paving, storm drains, rough grading, landscaping, sediment control, sterile processing elevators and a pneumatic tube system. Process related variance (approximately 50K of the exclusion) is for constrained site, phased construction, LEED Silver Standards, MBE values, a temporary entrance. (DI #15, p.1).

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.

This standard specifies that if inpatient nursing units exceed reasonable space standards, defined as Inpatient Unit Program Space in excess of 500 SF per bed, there would be an associated penalty assessed against any rate adjustment sought by the applicant to cover the cost of the project. "Inpatient Unit Program Space per bed" is defined in the Acute Care Hospital Services State Health Plan Chapter, COMAR 10.24.10.06B(16) 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 workstations, 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 workstations, and patient toilets/showers. Inpatient unit program space does <u>not</u> 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 applicant states that the only inpatient nursing unit space involved in the project is the postpartum nursing unit, which is 508 SF feet per bed, slightly exceeding the standard. The applicant states that this slightly higher square footage is because the unit includes one patient-of-size room. (DI #3, p.51).

Table IV-3: Analysis of Costs Attributed to Excess Inpatient Nursing Unit Space

1	SF per bed	508
2	Excess SF per bed (over 500 SF)	8
3	Number of Beds	21
4	Total Excess SF	168
5	Total Cost per SF	$449.99
6	**Total Excess Cost per SF**	**$75,599**
7	Excess SF as a percent of total	0.03%
8	**Contingencies to be excluded**	**$6,825**
10	**TOTAL COSTS TO BE EXCLUDED**	**$82,424**

The excess cost factor is negligible; therefore, staff does not recommend that the

Commission attach a condition to any approval of the project concerning exclusion of these costs. The nominal amount of excess space for the bariatric obstetric patient population and related equipment space is negligible and staff concludes that the standard is met.

(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 not applicable. The applicant stated and staff confirmed that based on HSCRC's 2022 annual report, Doctors is not a high-charge hospital. (DI #3, p.52).

(11) Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic, or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

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

The applicant states a review of hospital efficiency requires consideration of department location, internal design, and workflow management. The applicant states that the project will include the following improvements:

Obstetrics

- Private rooms to improve patient experience
- Antepartum/postpartum unit designed to allow staff to streamline workflow, reduce patient transfers, and increase patient safety
- Reduce medication errors, falls, and infections
- Central location of the elevators to reduce transport times

Imaging

- Location near emergency services for swift access to support services, and proximity to elevators to minimize patient treatment times
- Synergies between imaging modalities, such as CT scans and MRI, to streamline processes and reduce waiting time
- Efficient scheduling systems and patient flow management

Surgical Services

- Prep and recovery area designed to flex between Pre- Op and, post anesthesia care unit (PACU)
- Recovery that can flex with patient demand
- Prep and recovery area adjacent to the major ORs helps to minimize transport time and treatment time
- Improve process flows for sterile supplies, and instrumentation
- Sterile processing located directly below the OR suite
- Two designated elevators allow for more efficient processing of sterile supplies
- Central staging of case carts for optimum throughput and reduction of the time to set up ORs between procedures
- Modern lighting and mechanical controls to promote energy efficiency

Support Services

- Location of materials management, lab, EVS, food/nutrition, and pharmacy placed throughout the clinical areas to minimize movement

Staffing

- Units are co-located to reduce excessive staff movement
- Gross revenue to FTE ratio monitored

(DI #3, p. 54 and DI #10, p.7).

The applicant described design and location improvements, adjacencies of related work areas and patient flow improvements demonstrates how the project will improve staffing and service efficiencies throughout the hospital. Staff concludes that the standard is met.

(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.

Doctors states that the proposed project design focuses on patient and staff safety and complies with the applicable FGI Guidelines and the American National Standards Institute (ANSI). The design includes the following programming, planning, and design elements:

- Appropriately sized Operating Rooms (OR), storage areas and clinical staff areas
- Design to optimize infection prevention
- OR suite divided into three designated areas – unrestricted, semi-restricted and restricted
- Proper storage and flow of dirty to clean and then to sterile
- Support areas of the surgical suite located off a semi-restricted corridor
- Clean core directly connects to every operating room

- Mechanical and electrical systems meet all current guidelines
- Direct line of sight from nursing work areas
- Universal OR configuration for uniformity of equipment placement
- Prep/recovery patient care stations sized to accommodate patients, staff, and family
- PACU/Prep/Recovery areas are sized correctly
- PACU/Prep/Recovery areas are functionally adjacent to OR suite
- The proposed layout supports efficient flow of staff, patients, and materials
- Surgical services supported by full replacement of sterile processing department
- Two airborne infection isolation rooms
- Two individuals of size prep/recovery patient care stations
- Extension of the pneumatic tube system to the OR Suite

(DI #3, p.54).

In addition, the applicant states that it considered patient safety features in response to COMAR 10.24.12.04(6), the Obstetric Services chapter of the State Health Plan. Staff's assessment is that key features of the project design such as the larger sized rooms and improved support services workflow will promote patient safety and aid in the prevention of errors and adverse events. Staff concludes that the applicant has met the requirements of the 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.

(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.

Applicant submitted a comprehensive table of the financial projections, (DI# 15, Exhibit 29), and states that the project's financial feasibility is based on the following:

(i) Utilization projections are consistent with observed historic trends and show that the proposed project will steadily increase its discharges from 1,460 in its first full year of operation to 2,387 in its fourth full year of operation (48%).

(ii) Revenue estimates are consistent with utilization projections and are based on current rates of reimbursement, contractual adjustments, discounts, bad debt and charity care provision experienced by Doctors. The project will achieve a positive net income by the fourth full year of operation.

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on the current expenditure levels and reasonably anticipated future staffing levels. The project expects to need 98.9 additional FTE's, the majority of which (56%) are direct care staff.

(iv) The hospital will generate excess revenues over total expenses including debt services and depreciation in FY 2031 Year 5 of the Obstetrics Program. (DI #3, p.56).

The applicant's parent, Luminis Health, submitted audited financial statements in which the independent auditors state that the financial statements "present fairly". (DI#3, Exhibit 21). The applicant's financial resources and Luminis Health are discussed further in the Financial Feasibility standard, the Viability criterion and the HSCRC Memo found in Appendix 2 of this report. (DI #3, Exhibit 21).

Staff concludes that the applicant has met the requirements of the standard.

(14) Emergency Department Treatment Capacity and Space

This standard is not applicable. The project does not involve the Doctors emergency department.

(15) Emergency Department Expansion

This standard is not applicable. The project does not involve the Doctors emergency department.

(16) Shell Space

(a) 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.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that

(i) considers the most likely use identified by the hospital for the unfinished space

and

(ii) considers the time frame projected for finishing the space and

(iii) demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.

This standard is not applicable. The proposed project will not include shell space.

COMAR 10.24.12 Acute Hospital Inpatient Obstetric Services
.04 Review Standards

The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving new acute hospital inpatient obstetric services, existing services proposed to be relocated to a newly constructed space, and existing services proposed to be located in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to applicants for a new perinatal service. Standard (15) applies only to applicants with an existing obstetric service.

1. Need.
All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

Policy 4.1 the burden of demonstrating need for additional obstetric program capacity rests with the applicant. In determining whether a new obstetric service should be established, the Commission shall consider, at a minimum,

(a) **the historical and projected service area of the applicant hospital, obstetric service utilization forecasts, the number of providers of hospital obstetric service utilization forecasts, the number of providers of hospital obstetric services in the applicant hospital's service area, the anticipated medical staff which will utilize the proposed obstetric service and the proportion of their patients expected to use the proposed service;**

(b) the information on the number of uninsured, underinsured, indigent and otherwise underserved obstetric patients in the applicant's primary service area, and an estimate of the number of women not receiving adequate prenatal care;

(c) any data and/or analyses provided by the applicant outlining improvements in the delivery of obstetric services to the defined service are population anticipated to

result from implementation of the proposed project, such as improvements in patient care outcomes, lower costs than that currently available in the service area, improvements in geographic or financial access to care, improvements in continuity of care, or improvements in the acceptability or cultural competency of obstetric care for the defined service area population or specific segments of that population;

(d) any demographic or health service utilization data and/or analyses providing a perspective on the need for the proposed project which is significantly different from that found in the Commission's forecast of obstetric service utilization; and

(e) Any other relevant information on the unmet needs for obstetric services in the service area.

Applicant Response:

The applicant states that the limited number of obstetric beds in Prince George's County is one of the main reasons why over 7,000 women deliver their babies outside of their home jurisdiction each year. (DI #10, p.9). MHCC publishes the Licensed Acute Care Beds by General Hospital and Service in Maryland annually. The most recent FY24 update was effective July 1, 2023.[11] The FY 24 annual recalculation shows 767 total obstetrics beds in Maryland. In the Southern Maryland Health Planning Region (Calvert, Charles, and Prince George's Counties) there are 62 Obstetric Beds with 34 beds in Prince George's County: 18 at MedStar Southern Maryland Hospital Center and 16 at University of Maryland Capitol Region Medical Center.

Prince George's County also has a low obstetric physician-to-population ratio that the applicant states contribute to the racial inequities in mortality rates discussed under the background section of this report. Other contributing factors are a lack of access to transportation, disjointed medical management, and lack of prenatal care. (DI #10, p.9). The applicant recognizes the need for access to both inpatient and outpatient obstetrics care in the community as critical to improving maternal and infant outcomes. (DI #3, p.60).

Service Area Utilization Forecast (subpart a)

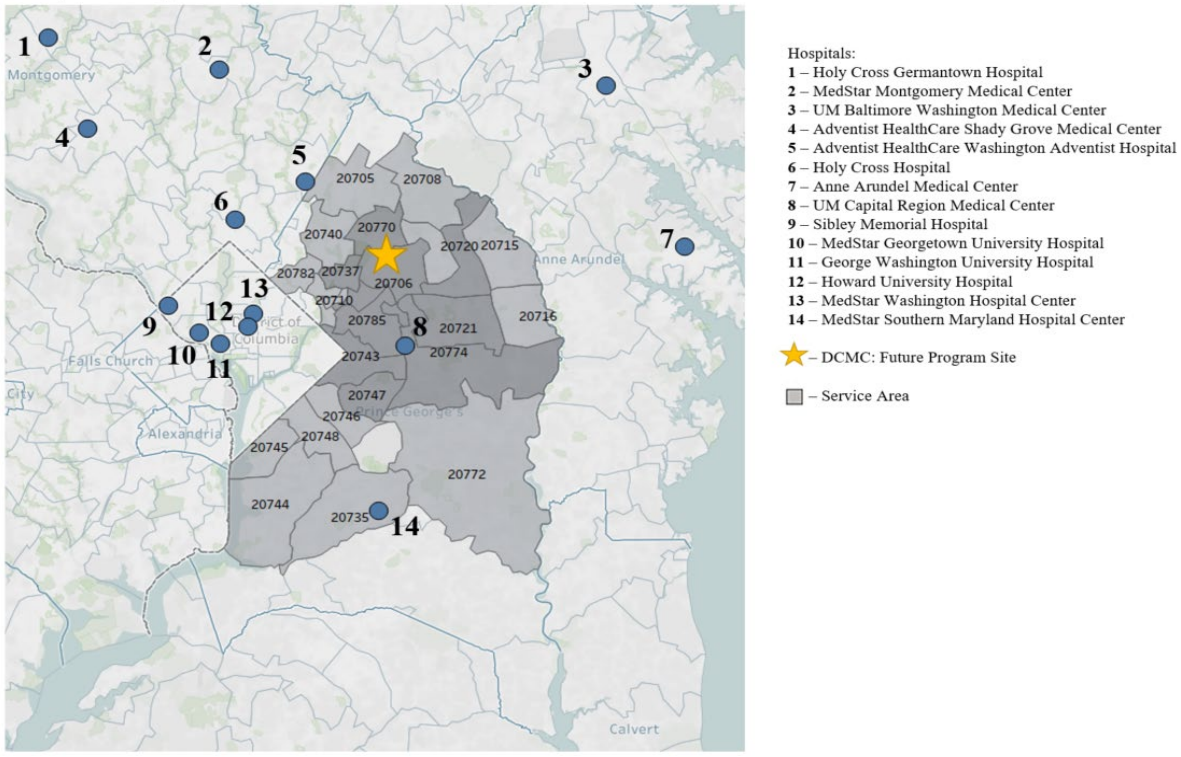
The applicant states that Prince George's County is the second most populous county in Maryland and has the second highest birth rate in the State. Women of childbearing age (15 to 44 years) make up 20.4 percent of the county's total population. Births in Prince George's County have increased over the last seven years. In 2020, Prince George's County had 11,308 births representing 16 percent of all births in Maryland. The applicant provided data showing that the ratio of births per 1000 population from 2018-2020 was 12.4 in Prince George's County compared to 11.3 in Maryland as a whole. (DI #3, p.60-61).

Doctors' obstetric service area includes the same zip codes as for the hospital as a whole. The service area includes 25 zip codes that account for approximately 80 percent of the population in Prince George's County. The primary service areas are Lanham, Hyattsville, Upper Marlboro, Riverdale, District Heights, Capital Heights, Greenbelt and Bowie. The secondary service areas include Beltsville, Temple Hills, Ft. Washington, Suitland, College Park, Clinton, Oxen Hill,

[11]https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_acute_care_FY24%20Licensed%20Beds_20230717.pdf

Bladensburg, and Glendale. (DI #3, p.75). The applicant states that the goal is to provide better access to care in the current service area and reduce the out of county migration for birth and hospital care. Figure 4 shows the service area for the proposed project and the hospitals with obstetrics units in the service area and extended region. A complete list of the service area and zip codes are in Appendix 4.

Figure 4: Obstetrics Units in Doctors Service Area and Extended Region



(DI #3, p.63).

In MHCC's *2024 Licensed Acute Care Beds by Hospital and Service* the total number of licensed obstetric beds in the Prince George's County has declined from 78 obstetric beds in FY2015 to 34 beds located at only two hospitals: 18 beds at MedStar Southern Maryland in Clinton and 16 beds at University of Maryland Capital Regional Health in Largo. Although the University of Maryland Capital Regional Health is within close proximity to Doctors it does not have a CMS distinction of a "birthing friendly" hospital.[12] MedStar Southern Maryland does have

[12] CMS, Birthing-Friendly Hospitals and Health Systems, https://data.cms.gov/provider-data/birthing-friendly-hospitals-and-health-systems (Last Accessed on Dec. 1 2023);
"Birthing-Friendly" is the first-ever CMS designation to describe high-quality maternity care. To earn the designation, hospitals and health systems report their progress on CMS's Maternal Morbidity Structural Measure to the Hospital Inpatient Quality Reporting (IQR) Program. The measure identifies whether a hospital or health system has:

1. Participated in a statewide or national perinatal quality improvement collaborative program; and,
2. Implemented evidence-based quality interventions in hospital settings to improve maternal health.

the distinction of a "birthing friendly" hospital but is located further south in Prince George's County. The closest option to the north is Washington Adventist Hospital in Silver Spring (Montgomery County) which recently relocated from Takoma Park and is a greater distance to a majority of the service area population.

Table IV-4: Obstetrics Discharges, Doctors Service Area FY 2022

Region	Hospital	Discharges	% of Total
Maryland			
Prince Georges County	UM Capital Region Medical Center	1,183	13.6%
	MedStar Southern Maryland	380	4.4%
Subtotal, Prince Georges County		1,563	17.9%
Montgomery County	Holy Cross	3,350	38.4%
Montgomery County	Adventist HealthCare White Oak Hospital	613	7.0%
Anne Arundel County	Anne Arundel Medical Center	917	10.5%
All Other Maryland Counties	All Other	987	11.3%
Subtotal, Other Maryland		5,867	67.3%
District of Columbia			
Washington, DC	MedStar Washington Hospital Center	753	8.6%
Washington, DC	Sibley	175	2.0%
Washington, DC	All other	359	4.1%
Subtotal, District of Columbia		1,287	14.8%
Total		8,717	100.0%

Source: (DI #3, p.64). HSCRC FY22 Abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC hospital discharges

The decline in obstetric beds in the region has led to 82.1 percent of service area residents seeking obstetric care outside of Prince George's County, with 67.3 percent receiving care in other Maryland jurisdictions and 14.8 percent out-migrating to Washington, DC. (DI #3, p.64).

In addition to the lack of obstetric beds, Prince George's County does not have an adequate number of medical providers for sufficient access to obstetrics, gynecological, prenatal health, maternity care, and postnatal care. Table IV-5 shows the number of OB/GYNs currently practicing in the service area.

Table IV-5: OB/GYNs Practicing in the Doctors Service Area

Practices	Providers
Capital Women's Care	7
Independent	25
Sibley	2
Luminis Health	4
Medstar	22
UMMS	2
Kaiser	23
Total	85
Total excluding Kaiser*	62

Source: (DI #3, p.65). Maryland Board of Physicians
*Kaiser will only see Kaiser patients (12.63% of service area population has Kaiser)

The applicant states that according to the Advisory Board, the National Low-Cost Quartile of physicians to population benchmark for OB/GYNs is 16 OB/GYNs per 100,000 population.[13] The service area currently has 85 OB/GYNs, which translates to 10.2 per 100,000 residents. Excluding Kaiser Permanente providers and participants, because they only see in-network Kaiser patients, this number drops further to only 8.5 providers per 100,000. The applicant states that according to the Advisory Board benchmark, the service area (excluding Kaiser) should have 116 OB/GYNs. (DI #3, pp.64-67).

The applicant states that the new obstetrics program will attract and retain clinicians which will address the provider shortage. The applicant states that its Luminis Health system sister hospital, AAMC, has an established obstetrics program that will expand to Doctors and share resources, such as the existing neonatology group at AAMC (Rindfleisch and Associates). Further, the applicant will utilize its existing partnership with Children's National Hospital (CNH) for pediatric emergency services. (DI #3, pp.64-67).

To attract and retain providers, the applicant plans to implement a Laborist model of care, in which a dedicated labor and delivery obstetric provider manages care throughout delivery as the primary physician. The applicant states that studies show the Laborist model is correlated with fewer inductions of labor and cesarean sections.[14] The Laborist model will help attract physicians to both the hospital and the County because it assures that the physician's patients deliver at the hospital while they can focus on their primary practice. The applicant states that the new obstetrics unit will be staffed with four physicians on rotation. On weekdays they will have a morning and evening 12-hour shift and on the weekends, they will have a rotating 24-hour shift. There is also a planned midwife and a resident physician on staff. The applicant anticipates that it will be successful in attracting OB/GYNs to the hospital. (DI #10, p.10).

The applicant states that Luminis Health has two providers with privileges who practice in Bowie and two newer providers who practice in Greenbelt. These four providers all currently deliver at AAMC and plan to deliver at Doctors. Luminis Health also plans to recruit and hire

[13] https://www.advisory.com/about-us
[14] https://pubmed.ncbi.nlm.nih.gov/30835985/.

four additional OB/GYN providers. (DI #3, pp.64-67). In conclusion, the applicant states that it projects having a sufficient number of providers to meet the need of the proposed project. (DI #10, p.110).

High Number of Low Income/Indigent Residents (subpart b)

The applicant states that the 2022 Prince George's County Community Health Needs Assessment (CHNA) noted the low number of Medicaid participating providers in the service area, leaving many low-income residents underserved.[15] The applicant notes that all Luminis Health providers currently and will continue to accept Medicaid.

In 2020, 89.7 percent of the County residents had insurance compared to 94.1 percent in Maryland overall. Hispanic residents were less likely to have insurance with only 70 percent insured. Of the 8,717 deliveries in the Doctors service area in FY2022, 4,528 deliveries or 65 percent were Maryland Medicaid enrollees. Of the Maryland Medicaid deliveries from the service area, 229 (5%) out-migrated to Washington, DC. The applicant projects that its payer mix will be 34 percent Medicaid. (DI #3, p.70).

Access to Quality Patient Care (subpart c)

The applicant states that its main goals are improving access to care and improving maternal and infant health outcomes. The program will provide increased local access for patients, an increased number of local providers, increased patient safety, better management of chronic medical conditions throughout pregnancy, an increased quality of care, a Laborist model of care for birthing, increased access to social services/case management, reduced travel times for care and increased access to culturally responsive services. The proposed project will also expand the number of services currently available and will include outpatient services, inpatient labor, and delivery, postpartum, antepartum, and a special care nursery. (DI #3, pp. 71-72).

Poor Patient Outcomes Due to Shortages in Care (subpart d)

The applicant provided data on poor maternal and infant health outcomes and health care disparities, citing the relationship between the low number of obstetrics providers in Prince George's County and reduced rates of prenatal and postpartum care. The applicant states that as a result of these provider shortages, women in Prince George's County must travel farther and have the poorest maternal and infant health outcomes across all jurisdictions in Maryland. (DI #3, p.76). The applicant cites the following data:

- More women in Prince George's County receive late or no prenatal care at birth compared to other women in Maryland.
- Hispanic and non-Hispanic Black women are more likely to receive late or no prenatal care in Prince George's County than across the entire state of Maryland.
- Maternal risk factors in Prince George's County including Obesity, Diabetes and

[15] Prince George's County Health Department, 2022 Prince George's Community Health Assessment, https://www.luminishealth.org/sites/default/files/2022-11/2022-Prince-Georges-County-CHA-Luminis.pdf.

Hypertension impact Black, non-Hispanic women at a higher rate when compared to other groups.

- Prince George's County percentage of low-birth-weight infants is higher than Maryland as a whole. Black, non-Hispanic women have the highest likelihood to give birth to a low-birth-weight infant.
- Prince George's County infant mortality rate is higher than the average infant mortality rate of Maryland as a whole.

(DI #3, pp.77-80).

Other Relevant Information (subpart e)

The applicant states that it addressed the unmet need for obstetric services in sections (a) through (d).

Staff Analysis

In a review of the utilization forecast, the patient demographics, provider shortages, access, and outcomes the decline of licensed obstetric beds in Prince George's County has led to provider shortages resulting in negative outcomes for women in the County.

In terms of access for service area residents to local maternal infant health care, staff notes that with only 34 obstetric beds in Prince George's County, 67 percent are traveling outside the County to other Maryland jurisdictions, and an additional 15 percent were migrating to Washington DC hospitals. Also notable is the lack of providers--only 73 percent of the needed OB/GYNs are located in the County. The creation of an obstetrics program at Doctors will draw needed providers to the area.

The data provided by the applicant also showed a lack of prenatal care in Prince George's County, indicating that 9.8 percent of births in Prince George's County compared to 6.3 percent in Maryland had no prenatal care. Data also showed racial healthcare disparities within the County of which the majority (59%) of the population are Black non-Hispanic. Black non-Hispanic mothers had a higher prevalence of co-morbidities such as obesity, and high blood pressure as well as the highest prevalence of low-birth-weight babies. In 2020 this same cohort had the highest infant mortality rate (4.24). For these reasons, staff concludes that due to its unique challenges, there is a need in Prince George's County for greater access to quality obstetric programs and providers.

Staff concludes that the applicant has demonstrated need.

2. Maryland Perinatal System Standards.
Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of the Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

The applicant states that it will comply with the requirements of a Level II Maryland Perinatal System Standards and attached a copy of its response to the Perinatal Standards. (DI#3,

Exhibit 19). Staff has reviewed the applicant's Perinatal Standards and concludes that it has satisfied the standard.

3. Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:
- **(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);**
- **(ii) posted notices in the admissions office, business office and emergency areas within the hospital**
- **(iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and**
- **(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination or probable eligibility.**

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

This standard was addressed at COMAR 10.24.10.04A(2) Charity Care. *supra p.8.* Staff concludes that the applicant meets this standard.

4. Medicaid Access.
Each hospital shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service are, and

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

The applicant estimates that in FY2022 there were 8,717 deliveries in the Doctors service area of which 4,528 or 65 percent were Maryland Medicaid deliveries. (DI#3, p.68). Of the 4,528 deliveries, 2,226 were in its primary service area and 2,073 in its secondary service area. (DI #3, pp 68-69). The applicant states that currently 15 obstetric providers have privileges at the hospital and all 15 participate in Medicaid. Further, the applicant also states that it anticipates that, with the addition of an obstetric program, up to 20 obstetric providers will deliver care at the hospital and all would participate in Medicaid. (DI #3, pp 68-69).

Regarding post-natal pediatric services, there are currently 34 pediatricians who have privileges at the hospital and participate in Medicaid. The applicant states that there are approximately 70 additional pediatric providers in the service area that will have potential patients at the hospital and 65 percent participate in Medicaid. The applicant states that to support its new obstetrics program it will identify other community providers, such as primary care, county health department, social services, community health centers partners who work with Medicaid. These

efforts, in combination with its charity care commitment, will expand access to more low-income women that require obstetrical care. (DI # 2, p.67).

Staff concludes that the applicant has demonstrated a commitment to serving Maryland Medicaid patients as evidenced by the requirement that all physicians employed by Luminis serve this population, and the applicant has met this standard.

5. Staffing.
Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post-partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

The applicant's proposed staffing is illustrated in Table IV-6 with year 5 at maximum projected volumes. The table assumptions include benefits at 17 percent of wages and a 2.5 percent annual merit increase.

Title IV-6: Doctors Proposed Obstetric Staffing

Employee Category	Year 1 FTE	Year 1 Total Expense	Year 3 FTE	Year 3 Total Expense	Year 5 FTE	Year 5 Total Expense
Labor and Delivery	**27.7**	$2,656,666	37.7	$3,946,119	42.6	$4,743,202
Post Partum	**18.1**	$1,766,836	31.9	$3,200,936	37.3	$4,029,473
Support Staff	**6.9**	$457,491	15.6	$1,125,703	19.0	$1,381,666
Total Salaries and Benefits (17%)					**FTE**	**$ 11,880,580**
Contracted Physicians						
OB Laborist	2.1	$ 1,492,508	4.2	$ 1,698,472	4.2	$1,380,009
Certified Nurse Midwife	2.1	$ 738,281	4.2	$ 1,476,563	4.2	$1,476,563
Maternal Fetal Medicine	0.1	$ 60,156	0.2	$ 120,313	0.2	$120,313
Anesthesia		$ 259,000	0.0		0.0	
Neonatologist	0.1	$ 62,656	0.2	$ 85,313	0.2	$85,313
Pediatrician/ NP	2.0	$ 733,125	4.0	$ 1,466,250	4.0	$1,466,250
Total Contract Services	***6.4***	***$ 3,345,727***	***12.8***	***$ 4,846,909***	***12.8***	***$ 4,528,446***

(DI #10, Exh.23).

Table IV-6 shows that the staffing for the new program will create an expense of almost $12M for the applicant by year 5 of the projections. In addition to its regular staff, the proposed program will also cost $4.5M in contracted physician expenses.

Staff Analysis

In addition to the table above, the applicant provided Workforce Table L (mislabeled as Table H) in DI #15, Exhibit 29 which shows a projected 98.9 FTEs for the proposed project. These include Administration (2.8), Direct Care (56.1), and Support (40) staff. There are an additional 8.7 FTEs projected in conjunction with the General Surgical expansion in the last year of projections. As a result of the completeness review, staff requested that the projected 6.4 FTEs for contractual physicians be included in the analysis. The applicant provided additional information, which included both physician expense and malpractice expense at approximately $5M annually. (DI #10, p.10, Exhibit 23). While the total staffing expense is $130,898,706, the applicant still projects it will be profitable by its fourth year of operations.

Staff concludes that the applicant has met the standard.

6. **Physical Plant Design and New Technology.**
All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care and describe expected benefits.

The applicant states that the new physical plant and investment in technology will promote safety and quality by including the following features listed below.

- LDR model of care
- The Postpartum / Antepartum Unit/ C-section room, on Level 4 are larger and all private rooms
- Well-baby nursery will exceed the minimum of 24 SF
- Level II Continuing Care Nursery, will exceed the minimum of 120 SF
- New units designed to accommodate negative pressure Airborne Infection Isolation Rooms
- Code minimum patient clearances on all sides of the bed for portable equipment access
- Handwashing sinks are immediately accessible upon entering the room
- A bedside computer in every room to minimize infection
- Same-handed room design with similar features from room to room
- Individuals of size rooms
- Antepartum rooms with extra clearance
- Ventilation and filtration systems to control and prevent the spread of infections
- Headwall design that provides easy staff access to critical infrastructure
- Patient toilet rooms that are private and sufficiently sized
- Room for family members in the lounge or at the bedside
- Both a centralized and decentralized nursing stations

- Key support spaces to locate nurses closer to the patient
- Medication rooms located on each floor
- Extending the existing pneumatic tube system
- Pharmacy clean room and anteroom
- Respiratory therapy decontamination and clean equipment storage
- Security features to prevent infant abduction such as secured doors
- Evidenced-based care used in the design (DI #3, pp. 86-89).

After reviewing the design features, staff concludes that the applicant's proposed design features will benefit the patients and has met the standard.

7. Nursery.
An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

The applicant provided data showing that 90 percent of cases or 7,874 total will require Level I care, seven percent Level II care and three percent Level III care. (DI #3, pp.89-90). Doctors' Level II Perinatal program will serve 97 percent of the service area and will partner with other providers when a patient needs a Level III NICU or higher. (DI #3, pp.89-90). The level of perinatal care is consistent with the needs of Doctor's primary and secondary service area.

Staff concludes that the applicant's data has demonstrated that the proposed level of perinatal care is consistent with the needs of the service area and that the applicant has met the standard.

8. Community Benefit Plan.
Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population. This Plan should include an outreach program component and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required. At a minimum, the Community Benefit Plan must include:

(i) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,

(ii) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and;

(iii) information on the structure, staffing, and funding of the Plan;

(iv) documentation of community support and involvement in program planning for the Plan by other agencies organizations and institutions which will be involved directly or indirectly, with the Plan;

(v) an implementation scheme the Community Benefit Plan.

(vi) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(vii) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

Needs Assessment

The applicant identified gaps in women and infant health care services using the 2022 CHNA for Prince George's County[16]. These gaps include limited access to providers, an insufficient number of providers, and a lack of providers who have cultural competence and understand the unique needs of the County. Additional factors include the lack of public transportation system, inadequate health insurance, and a lack of knowledge on how to navigate the health care system.

Measurable and Time-Limited Goals

The applicant's goals and objectives are derived from Luminis Health Women's and Children's service line that are specific to Prince George's County and also based on existing targets from Healthy People 2030[17]. The applicant's measurable and time-sensitive objectives for Prince Georges County health status improvements will focus on infant mortality, low birth weight, timely prenatal care, teen birth rate and the reduction of c-section rates.

Information on the Structure, Staffing and Funding

Doctors will build upon the current infrastructure in place to support community health needs. Components of the plan include the Wellness Van (currently $175,000 annually to operate), the pre-conception health program tool kit managed by the Women's and Children's Service Line, ambulatory programs to reduce infant morbidity/mortality and preterm birth, a prenatal program called the Centering Pregnancy Model, and post-partum contraception. All community program expenses are in the Luminis Health Clinical Enterprise's budget, and any additional funding needed will be attributed to Luminis Health if foundation support is unavailable. (DI #10, p.14).

Documentation of Community Support:

Applicant included a summary of community support for the obstetric program. (DI#3,

[16] https://www.umms.org/capital/-/media/files/um-capital/community/2022-community-health-needs-assessment-um-capital-region-health.pdf?upd=20220706134711
[17] https://health.gov/healthypeople

Exhibit 20).

Implementation for the Community Benefit Plan:

The applicant states that it is already implementing a community benefit plan and will expand outreach to the community through education, screenings, and early detection for chronic disease using health fairs, health talks, support groups, free screenings, and community based clinical services. In addition, its Wellness on Wheels mobile health clinic will assist residents with diabetes care, high cholesterol management, medication review and blood pressure screenings at a projected $800,000 in community benefit expenses.

Commitment to Implement Community Benefit Plan:

The applicant states that it is committed to implementing the Community Benefit Plan. (DI #3, pp.91-98).

Annual Report to the Commission:

The applicant states that it will submit an annual report to the Commission as it currently reports this information to the HSCRC. The report will include an evaluation of the Community Benefit Plan, as well as information on staffing levels and total costs of programs. (DI #3, p.98).

Staff Analysis

The applicant seeks to improve health status and outcomes in Prince George's County and identify care gaps so it can utilize its resources in conjunction with the community. The applicant has provided a comprehensive Community Benefit Plan that includes an assessment of need, staffing and funding. The applicant has also affirmed its commitment to implement the program and report annually. Staff concludes that the applicant has met the standard.

9. Source of Patients.
An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

The applicant states that the majority of patients for the new obstetric service will come from the hospital's primary service area. It anticipates that 776 service area patients currently served at AAMC will follow their physicians to the new obstetrics program at Doctors following a realignment of physician practices. (DI #3, p.99). The applicant also plans to add OB/GYN providers to create greater access for the service area patients. The applicant's projected market share calculation of 25 percent was based on a consolidation of its own patient base plus the existing obstetric Luminis Health volume from AAMC. (DI #3, p.99 and p.101).

Staff concludes that the applicant has demonstrated focus on improved access in the existing service area and that the standard is met.

10. Non-Metropolitan Jurisdiction.
A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

This standard is not applicable as Doctors is in a metropolitan jurisdiction.

11. Designated Bed Capacity.
An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

The applicant states that the proposed new obstetric program will have 21 licensed obstetric beds, of which 18 are postpartum, and three are antepartum beds. (DI #3, p.100). These will be designated beds from within Doctors existing licensed acute care beds.. (DI#15, Table A, p.28).

Staff concludes that applicant has demonstrated it can introduce the new obstetric service by designating beds from Doctors' existing licensed bed capacity to accommodate the anticipated ADC.

Staff concludes that the applicant has met the standard.

12. Minimum Volume.

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 1,000 admissions annually in metropolitan jurisdictions or 500 cases annually in non-metropolitan jurisdictions within 36 months of initiation of the program.

(b) As a condition of approval, the applicant shall accept a requirement that it will close the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.

The applicant states that it expects to reach a volume of 1,754 obstetric discharges by year three. This is based on utilizing the same service area as the overall hospital which translates into a 25 percent obstetric market share by year five across Maryland and Washington, DC hospitals. Using the Nielson-Claritas population projections and compound annual growth rate through FY 2031, the total service area discharge volume across Maryland and Washington, DC hospitals will increase only slightly; however, the total OB discharge volume for the service area remains above 8,700 cases annually as shown in Table IV-7.

Table IV-7: Doctors Actual and Projected Obstetric and Market Share Based on Neilsen Claritas Populations and Stable Use Rate FY 2022- 2031

Service Area	2022 Actual	2027 Projected	2028 Projected	2029 Projected	2030 Projected	2031 Projected
Population (Female 15-44)	156,228	156,412	156,452	156,493	156,534	156,575
Discharges per 1000	55.8	55.8	55.8	55.8	55.8	55.8
Total OB Discharges	8,717	8,727	8,730	8,732	8,734	8,736
ALOS	2.58	2.40	2.40	2.40	2.40	2.40
Doctors Projections						
# Service Area OB Discharges	none	517	1,363	1,629	1,940	2,216
# Out of Area OB Discharges	none	40	105	126	150	171
#Total OB Discharges	none	556	1,467	1,754	2,090	2,387
Doctors Market Share	none	6%	16%	19%	22%	25%

(DI #3, p.101). Note 1: Source is Neilsen Claritas estimates for Calendar Year 2020 and projections for CY 2021 through 2031 based on CY 2020 estimates
Note 2: Source is HSCRC FY22 abstract dataset for Maryland hospital discharges and CY21 DCHA discharge database for DC discharges

Applicant states that it accepts the condition required by this standard that it will close the obstetric program and its authority to operate will be revoked if it: fails to meet the minimum annual volume requirement of 1000 discharges for any 24 consecutive month period; fails to provide good cause for its failure to attain the minimum volume; and fails to provide a feasible corrective action plan for how it will achieve the minimum volume within a two-year period. (DI #3. P.102)

The applicant has demonstrated it can achieve the minimum volume needed to sustain the proposed project and staff concludes that the applicant has met the standard with the below condition:

> Luminis Health Doctors Medical Center shall close its obstetric program, and its authority to operate will be revoked, if: (i) it fails to meet the minimum annual volume of 1,000 obstetric discharges annually for any 24 consecutive month period, and (ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.

13. Impact on the Health Care System.

(a) An application for a new perinatal program will be approved only if its likely impact on the volumes of the obstetric discharges at any existing obstetric program, after the three-year start-up period will not exceed 20% of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program the Commission will consider whether an existing program's payer mix of obstetric patients will significantly change as a result of the proposed program, and the

existing program will have to care for a disproportionate share of the indigent obstetric patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article 19-120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

i. from an applicant as to why rules (a) through (c) should not apply to the applicant, or;

ii. from a very low volume program (fewer than 500 annual obstetric discharges) as to why to lower volume impact should apply.

Subpart (a) Volume

The applicant states that the volume shifts associated with the proposed project will not exceed 20 percent of any existing program's current or projected volume. The applicant provided discharge data in Table IV-8 that demonstrates that no other Maryland obstetrics program will have a decline of more than 20 percent of total obstetrics discharges. The proposed project will have the largest impact on obstetric volume at AAMC at 13.2 percent which is a Luminis Health system hospital. The discharge shift from AAMC is a planned outcome within the system in its commitment to provide a local delivery site to Prince George's County residents.

Table IV-8: Impact of Doctors Obstetrics Program on Existing Maryland Obstetric Units In FY 2022 Volumes

Hospital	County	Discharge Shift	Total Discharges	Percentage
Anne Arundel Medical Center	Anne Arundel	778	5,897	13.2%
Holy Cross Hospital	Montgomery	613	9,142	6.7%
Adventist HealthCare White Oak Hospital	Montgomery	103	1,528	6.8%
UM Capital Region Medical Center	Prince George's	103	1,526	6.8%
MedStar Southern Maryland Hospital Center	Prince George's	48	1,072	4.5%
Adventist HealthCare Shady Grove Medical Center	Montgomery	45	1,528	2.9%
All Other Maryland Hospitals	All Other Maryland	243	46,891	0.5%
Total Maryland		1,934	67,584	2.9%

(DI #3, p.104). Projected Discharges and Source of Volume, Fiscal Years 2027 through 2031

HSCRC FY22 Abstract dataset for Maryland hospital discharges
CY21 DCHA discharge database for DC hospital discharges

Washington DC has approximately 9,000 births each year. [18] The National Institute of Health reports that in the United States almost all (98.4 percent) of women give birth in hospitals, and the applicant projects capturing 428 of Washington, DC discharges (4.8 percent). [19, 20] (DI #3, p.103).

Subpart (b) Payer Mix

The applicant used the current payer mix at AAMC to estimate the payer mix of those cases projected to shift to Doctors. The applicant assumed that patients shifting from other hospitals reflected the average payer mix of each hospital and the remaining payer mix at each Maryland hospital will be unchanged. (DI#3, p. 104). The applicant states that these assumptions regarding potential impacts to other programs are conservative as the Medicaid percentage in the service area (65%) is higher than in the surrounding areas. (DI #3, p.68).

The subparts (c) and (d) are not applicable.

The applicant has provided data that the proposed program will not take more than 20 percent of obstetrics volume from any other hospital and that its payer mix will be in line with other Maryland hospitals. Staff concludes that the applicant has met the standard.

14. Financial Feasibility.

Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

- **(a) the applicant's projected sources of funds to meet the program's total expenses for the first three years of operation,**
- **(b) the proposed unit rates and/or average charge per case for the perinatal services,**
- **(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and**

[18] Office of the Deputy Mayor for Education, Chapter 1: Population and Students, https://edscape.dc.gov/page/pop-and-students-number-births-and-birth-rates (Last Accessed Dec. 1, 2023).

[19] Nat'l Academis of Sciences, Engineering & Medicine *et al.*, *Maternal and Newborn Care in the United States*, Birth Settings in America: Outcomes, Quality, Access & Choice (2020), https://www.ncbi.nlm.nih.gov/books/NBK555484/#:~:text=In%20the%20United%20States%2C%20the,2019%3B%20see%20Chapter%201).

[20] Dep't of Health, Gov't of the District of Columbia, 2012-13 Natality Report in the District of Columbia (2015), https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2012-2013%20Births%20Statistical%20Report%209-30-15.pdf.

(d) the written opinions or recommendations of the HSCRC.

Doctors states it has sufficient revenues necessary to implement the program for the first three years of operation. (DI #15, Exhibit 1, Tables G and H). The applicant states that without inflation it will charge an obstetric average cost per case of $11,312 and a newborn average charge per case of $2,635 based on the FY23 statewide median rates for Obstetrics, Nursery, and Delivery. (DI #3, p.105). In Exhibit 1, Tables J and K, the applicant provides project revenues that are sufficient to cover expenses by the fourth full year of operation. In addition, the applicant's parent company, Luminis Health, has sufficient financial resources to ensure program viability as evidenced by its audited financial statements and as discussed in the Viability Criterion, *infra p.59* (DI#3, Exhibit 21).

In accordance with the MHCC review process, staff requested the HSCRC's assessment of the proposed project's financial feasibility. In a November 7, 2023, memorandum, the HSCRC provided the following conclusion:

> …assuming the volumes projected for the proposed obstetrics program are realized and based upon [HSCRC] Staff's review of the applicant's likely liquidity and projected operating margin, and subject to the realizability of philanthropic gifts and governmental grants, and based upon review of all the information, Staff believes that all these issues combined call into question the financial feasibility of this project. The project could possibly be feasible if all these issues are resolved in a positive manner. However, the macro financial investment markets may be unpredictable and the applicant's reliance upon non-operating performance to service its debt may prove to be risky, and, therefore, the project's longer term financial viability may be questionable. Staff has estimated that the applicant may be eligible to receive an incremental capital adjustment of approximately $6.52 million to its GBR upon completion and full operation of the proposed addition to facility and service. This adjustment could help to improve the feasibility of the project.

The applicant responded to the financial feasibility issues highlighted by the HSCRC:

1. HSCRC questioned applicant's use of a 36-year useful life for depreciation calculations stating that other recent CON applications use of 25 years. The applicant explained that it used the American Hospital Association (AHA) depreciation guide and because this is an obstetrics project, a larger part of the capital is spent on building costs (90%) when compared to general acute care hospitals and a smaller part falls under fixed assets. This higher percentage results in a longer useful life (36 years) as shown in Table E of the CON application. (DI #22, pp. 1-3).

2. HSCRC also commented on capitalized and expensed interest, stating it

computed approximately $16.7M of capitalized interest over 24 months, whereas the applicant only computed $12.4M in capitalized interest. Further, HSCRC computed approximately $50.6M in expensed interest over the periods projected, while the applicant computed $49.1M in expensed interest. The applicant stated that neither capitalized nor expensed interest have implications on the feasibility of the project, and the difference has a negligible impact on depreciation expense and no impact on cash. The applicant also states that the difference is likely related to the timing of assumptions. (DI #22, pp. 1-3).

3. HSCRC expressed concern about the government grants and philanthropy sources of funds, specifically, if the projected grants and philanthropy are not met, the additional financing would put stress on the project by reducing days cash on hand and debt service coverage ratio. The applicant referenced Luminis Health as having a long track record of successful philanthropy campaigns and is assured of support for an obstetrics program at Doctors. In addition, applicant states the Prince George's County Executive has indicated the high priority of this project for the County, as it aligns with the findings of the recently published report by Huron, *Assessing Prince George's County Healthcare and Social Need*s *and 10+ Year Investment Strategy.* (DI #22, pp. 1-3).

4. HSCRC highlighted applicant's projected net operating margin of $5.8M or 12.2 percent, stating that HSCRC's Pro Forma for the project calculated an operating income of $3M or 6.2 percent and a cash flow operating margin of $14.5M. The applicant stated that although the HSCRC calculation is more conservative, the project is still viable. (DI #22, pp. 1-3).

5. HSCRC commented about not being provided requested projected balance sheets. The applicant states that it had previously explained to HSCRC that projected balance sheets are not part of its standard financial reporting package, and further because of the health care market uncertainty in recent years (due to the COVID-19 pandemic) it is likely that only the 2023 projected balance sheets would be reliable. (DI #22, pp. 1-3).

6. HSCRC stated that the measured debt service coverage ratios (DSCR) for 2022 and 2023 are indicative of operating performance measures that are insufficient to service the burden of present debt and planned additional project debt. In addition, HSCRC found the applicant's reliance on "below the line" income items to service its debt is reflective of additional risk. The applicant explained that the calculation of Luminis Health's DSCR is in accordance with the master loan agreement approved by the Maryland Health and Higher Educational Facilities Authority[21] (MHHEFA), the bond trustee, and with banking partners. The applicant also states investment income, including realized gains/losses and

[21] The purpose of MHHEFA is to assist nonprofit hospitals and related health care organizations as well as private non-collegiate and higher educational institutions in the construction, financing and refinancing of certain projects.

dividends and interest, are available to service the debt and thus are included in the calculations, consistent with the Maryland market. In addition, the HSCRC acknowledges that the applicant's calculation is in accordance with MHHEFA's methodology and consistent with the bond covenants and expects its performance to improve in current and future periods. The applicant states it has previously reviewed the methodology with HSCRC. (DI #22, pp. 1-3).

7. Relative to the applicant's bond rating, HSCRC noted the S&P Global Ratings lowered the applicant's long-term rating on October 25, 2023, from "A" to "A-" with a stable outlook. The applicant states that because the pandemic aftermath negatively impacted fiscal years 2021 and 2022 (mostly due to staffing costs) projecting its operating performance based on fiscal years 2022 and 2023 understates the system's financial results pre-pandemic and its own internal fiscal year 2024 and forward expectations. In addition, Luminis Health has allocated resources to understand the root cause of the revenue cycle decline and implemented corrections that are beginning to return revenue cycle performance to higher collection levels. In addition, the applicant states that the reduction in the external credit ratings would not have a material impact on Luminis Health's expected borrowing costs for the additional debt. (DI #22, pp. 1-3).

Staff Analysis

Useful Life

MHCC staff concurs with the applicant that the HSCRC concern about useful life had already been addressed in a completeness response from June 23, 2023. (DI #15, p.6).The applicant has shared that the disconnect is because for this obstetrics project, a larger part of the capital (90%) is being spent on building costs. Staff also concludes that the applicant's use of the American Hospital Association (AHA) depreciation guide[22] is a credible source.

Capitalized and Expense Interest

HSCRC calculated $16.7M of capitalized interest over 24 months, in comparison to applicant's computation of $12.4M in capitalized interest. HSCRC stated it also computed approximately $50.6M in expensed interest over the periods projected, which is a 25.1 percent difference, while the applicant computed $49.1M in expensed interest, which is only 2.96 percent less. (DI #20, pp.1-5).The applicant states that these differences have a negligible impact on depreciation expense and no impact on cash. MHCC staff concludes that the applicant's assessment that there is not a significant impact satisfies this concern.

Philanthropy/Governmental Grants

In response to the source of funds concern, the applicant provided fundraising examples

[22] American Hospital Association, 2023, 2023 Useful Lives of Depreciable Hospital Assets, Healthcare Financial Management Association

for Doctors as well such as its contribution to supplement a $20M grant to open a new Behavioral Health Pavilion on the Lanham campus in 2017 before joining the Luminis Health system. Luminis Health has a history of successful philanthropy campaigns as detailed in the viability criterion of this staff report and staff believes Doctors will benefit from that experience. Staff concludes it is reasonable that with support from Luminis Health, the applicant will reach its fundraising goals. Regarding governmental grants, although there is no guarantee that the applicant will receive all this grant money, the recent report by Huron, *Assessing Prince George's County Healthcare and Social Needs and 10+ Year Investment Strategy* provides strong evidence of the need in Prince George's County to substantiate and support the request for government funds.

Operating Margin

The HSCRC arrived at an operating margin of 5.8M as compared to the applicant projected operating margin of 3M in its financial table package. The proposed new program is still projected to achieve positive net income by 2030 and going forward. (DI #15, Exhibit 29).

Balance Sheets

Although the HSCRC requested balance sheets from the applicant, Doctors had previously explained that balance sheets are not part of its standard financial reporting package. The applicant completed all of the Commissions required tables package for the CON which includes revenue and expense projections as well as statistical projections.

Debt Service Coverage Ratio

Staff concludes that because Luminis Health's DSCR calculation is in accordance with the master loan agreement approved by MHHEFA (as well as the bank and the institutions providing bonds) it is reasonable to say that the applicant's calculation is valid.

Bond Rating

Recently the applicant's bond rating changed from an "A" to an "A-" with a "stable outlook" which was concerning to HSCRC. The applicant provided a reasonable explanation about the negative impact of the COVID-19 pandemic in recent years, especially the inflated staffing costs caused by a labor shortage post-pandemic. The applicant shared Luminis Health's commitment to looking at the decline in the revenue cycle and reasonably projects there will be improved results in 2024.

Summary

In summary, although HSCRC states that these issues call into question the financial feasibility of the project unless they are resolved HSCRC also states that if resolved the project could be financially feasible. Staff concludes that the applicant's thorough response to the HSCRC memo provides explanations and solutions to these concerns. The applicant's thoughtful response to HSCRC's concerns underscores a commitment to addressing financial

issues as they evolve. In addition, HSCRC has estimated that the applicant may be eligible for a $6.5M GBR adjustment upon full operations of the project which will also help with its financial feasibility.

Staff concludes that the applicant has met the standard.

15. Outreach Program.
Each program with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

This standard is not applicable as the applicant does not have an existing program but is establishing a new program.

COMAR 10.24.11 General Surgical Services
.05 Standards
A. General Standards
The following general standards reflect Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in Health-General §19-114(d). Each applicant that seeks a Certificate of Need for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

(1) Information Regarding Charges and Network Participation.

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

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

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

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

(e) Providing a patient with an estimate of out-of-pocket charges prior to arrival for

surgery shall be a condition of any CON issued by the Commission.

Applicant Response:

(a) The applicant states that all charges are posted on its website and also in the patient's online chart. The applicant provided a link to the Luminis Health price transparency policy at Price/Cost Transparency | Luminis Health.
(b) The applicant states that upon inquiry, it will provide the names of networks in which it participates.
(c) The applicant states that it will provide the names of the networks in which each surgeon/other health care practitioner who provides surgical services at Luminis Health currently participates.
(d) The applicant states that it occasionally receives letters from the Maryland Office of the Attorney General/Consumer Protection Division/Health Education and Advocacy Unit (HEAU). These letters are from individuals who have a question about the services received. For any letter received, the applicant has worked with HEAU representatives to provide all requested information in accordance with the law and no inquiries from HEAU have led to the filing of a complaint.
(e) The applicant states that it understands that providing a patient with an estimate of out-of-pocket charges prior to arrival is a condition of the CON.(DI #10, p.16).

Staff has reviewed the applicant's website to verify the information is available and notes the applicant has stated its commitment to addressing any questions that an individual may have regarding charges. However, Staff concludes the below condition is needed to ensure the standard is met.

Luminis Health Doctors Medical Center shall continue to provide a patient with an estimate of out-of-pocket charges prior to arrival for surgery.

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

Applicant Response:

The applicant states that it will provide to the public upon request the volume of specific surgical procedures performed at Doctors for the most recent 12 months. (DI #15, p.9).

Staff concludes that the standard is met.

(3) Charity Care and Financial Assistance Policy

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

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

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

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

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

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

(d) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

(e) A hospital shall be able to demonstrate that its historic level of charity care or its projected level of charity care is appropriate to the needs of its actual or projected service area population. This demonstration shall include an analysis of the socioeconomic conditions of the hospital's actual or projected service area population, a comparison of those conditions with those of Maryland's overall socio-economic indicators, and a comparative analysis of charity care provision by the applicant hospital and other hospitals in Maryland. The socio-economic indicators evaluated shall include median income and

type of insurance by zip code area, when available. The analysis provided may also include an analysis of the social determinants of care affecting use of health care facilities and services and the health status of the actual or projected hospital service area population.

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

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

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

(iii) If an existing ambulatory surgical facility has not met the expected level of charity care for the two most recent years reported to the Commission, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of its service area population.

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

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

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

If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that its historic level of charity care was appropriate to the needs of the population in the proposed service area. The applicant is not a health maintenance organization so this is not applicable. Based on the answers provided by the applicant, staff concludes that the applicant has met the requirements of all components of the charity care standard.

Staff assessed the applicant's compliance with this standard at COMAR 10.24.10.04A — General Standards Charity Care. *supra p.8.*

(4) Quality of Care

A facility providing surgical services shall provide high quality care. 8

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

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

obtaining Medicare certification and Maryland licensure.

(c) An existing ambulatory surgical facility or ASC shall document that it is: (i) In compliance with the conditions of participation of the Medicare and Medicaid programs; (ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation organization recognized by the Centers for Medicare and Medicaid Services as acceptable for obtaining Medicare certification; and (iii) A provider of quality services, as demonstrated by its performance on publicly reported performance measures, including quality measures adopted by the Centers for Medicare and Medicaid Services. The applicant shall explain how its ambulatory surgical facility or each ASC, as applicable, compares on these quality measures to other facilities that provide the same type of specialized services in Maryland.

(d) An applicant seeking to establish an ambulatory surgical facility shall: (i) Demonstrate that the proposed facility will meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment; (ii) Agree that, within two years of initiating service at the facility, it will obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities or another accreditation organization recognized by the Centers for Medicare and Medicaid Services as acceptable for obtaining Medicare certification and approved by the State of Maryland; and (iii) Acknowledge in writing that, if the facility fails to obtain the accreditation in subparagraph (ii) on a timely basis, it shall voluntarily suspend operation of the facility.

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

Staff assessed the applicant's compliance with this standard at COMAR 10.24.10.04A — General Standards Quality of Care. *supra p.9.*

(5) Transfer Agreements.

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

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

The applicant states that it operates in compliance with the *Emergency Medical Treatment and Active Labor Act-Evaluation, Transfer of Patients to Other Acute Facilities* (EMTALA) which in turn complies with the requirements of Health-General Article §19-308.2 and provided copies of its transfer policies (DI#10, Exhibits 24 and 25). Subpart (b) is not applicable, Doctors is not an ambulatory surgical facility.

Staff reviewed the transfer policies provided by the applicant and confirmed that they comply with the requirements of this standard. Staff concludes that this standard is met.

B. Project Review Standards

1. Service Area

An applicant proposing to establish a hospital providing surgical services or an ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

This standard is not applicable, as the applicant is not establishing a new hospital providing surgical service or expanding the number of operating rooms; however, the applicant states that the service area is the same as the service area for both the general hospital and the obstetrics program. (DI #10, p.23).

2. Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall:

- **(a) Demonstrate the need for the number of operating rooms proposed for the facility, consistent with the operating room capacity assumptions and other guidance included in Regulation .07 of this chapter.**
- **(b) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility, consistent with Regulation .07 of this chapter.**
- **(c) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:**
    - **(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;**
    - **(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and**

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

(d) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

The applicant states that while it is licensed for 12 general purpose operating rooms (ORs), only eight are currently-in-use, and applicant used eight ORs in year 1-5 projected utilization numbers illustrated in Table IV-9. The eight existing ORs have an average size of 536 SF which is too small for specialty equipment or support staff. The four ORs that are unable to be used lack proper lighting and mechanical controls which result in less efficient systems. Sterile processing and other support services are also undersized. The applicant states that in recent years repairs and maintenance have impacted OR utilization creating downtime.

Table IV-9 shows utilization for the eight ORs that are in operation. In accordance with the standard, full capacity of a general-purpose OR is 2,375 hours (142,500 minutes) and optimal capacity as 80 percent of full capacity, or 1,900 hours (114,000 minutes). Thus, eight general purposes ORs operating at optimal capacity would translate to 912,000 surgical minutes (including turnaround time[23]). (DI #10, p.18).

[23] Refers to the amount of time it takes to change over all the supplies required for the next surgery including cleaning and sterilization

Table IV-9 Doctors Total Surgical Cases During Construction and Projected

Year	Doctors OR Volume of Procedures	Doctors OR Minutes and TAT (35min.) *	ORs Required at Optimal Utilization (COMAR 10.24.11)
Year 1	6541	968,119	8.49
Year 2	6581	974,039	8.54
Year 3	6621	979,959	8.60
Year 4	6661	985,879	8.65
Year 5	6701	991,991	8.70
Projected Year 1	7101	1,050,999	9.22
Projected Year 2	7267	1,075,567	9.43
Projected Year 3	7427	1,099,221	9.64

*According to the National Institute of Health turnaround time is almost uniformly an average of 36 minutes, this is longer than the 25 minutes in the State Health Plan. Staff concludes 35 minutes is reasonable.[24]

Source: (DI #15, p.9).

The applicant states that because it is operating close to full surgical capacity, beyond optimal capacity, there is minimal growth projected; however, applicant is recruiting surgical specialists. The applicant projects that during the construction period for the proposed project, the hospital will maintain volume between 6,500 and 6,700 cases. In the first three years following the completion of construction, the applicant estimates its program will grow from 7,101 to 7,427 cases, yielding enough OR minutes to meet the need for 10 general purpose ORs. (DI #10, p.19). The applicant plans to recruit 11 surgical specialists including four OB/GYNs, three orthopedic surgeons, as well as a surgeon specializing in bariatrics, breast care, vascular and general surgery. (DI #10, p.18). In its application, the applicant included the calculations used to support the need for 10 mixed-use operating rooms and two c-section rooms once the proposed project is complete. Per the State Health Plan Chapter on General Surgical Services, special purpose operating rooms like the ones proposed for this project (for cesareans) have optimal capacity that can be determined on a case-by-case basis. (DI #3, Exhibit 27).

Staff Analysis

Although there are minimal changes in utilization projected, the main difference with this project will be designating two operating rooms for c- sections. This is especially important in Prince George's County because the Black/African American population makes up the largest (59%) cohort of the population in the County and African American women are significantly more likely to have a c-section delivery than other women[25]. The location of the two c-section

[24] https://pubmed.ncbi.nlm.nih.gov/7986513/#:~:text=Room%20turnover%20time%20(time%20from,patient)%20was%20generally%201%20hour.

[25] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386542/#:~:text=African%20American%20women%20are%20significantly,6%20or%20national%20data%20sets.

operating rooms on the third floor will allow for these special purpose operating rooms to have a separate area with dedicated on call and clinical support, while remaining close to the rest of the operating rooms (directly above the surgical suite). Staff reviewed the applicant's utilization tables that show it will need the other 10 mixed-use operating rooms by projected year three and its plans to achieve optimal capacity. Staff concludes that the standard is met.

3. Need - Minimum Utilization for Expansion of An Existing Facility.
An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

- **(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .07 of this chapter;**
- **(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and**
- **(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity, consistent with Regulation .07 of this chapter. The needs assessment shall include the following:**
  - **(i) Historic and projected trends in the demand for specific types of surgery among the population in the proposed service area;**
  - **(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and**
  - **(iii) Projected cases to be performed in each proposed additional operating room.**

This standard is not applicable because the applicant is not expanding an existing facility.

4. Design Requirements.
Floor plans submitted by an applicant must be consistent with the current Facility Guidelines Institute's Guidelines for Design and Construction of Health Care Facilities (FGI Guidelines):

- **(a) A hospital shall meet the requirements in current Section 2.2 of the FGI Guidelines.**
- **(b) An ASF shall meet the requirements in current Section 3.7 of the FGI Guidelines.**
- **(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.**

For subpart (a) of the standard, the applicant states that it will meet the requirements of current Section 2.2 of the FGI Guidelines and included a narrative from an architect in Exhibit 26 of the application. Subparts (b) and (c) are not applicable as this project does not involve an ASF. (DI #3, p.108) and (DI #10, p.17). After reviewing the guidelines and the architect narrative, staff concludes that the standard is met.

5. Support Services.
Each applicant shall agree to provide laboratory, radiology, and pathology services as needed, either directly or through contractual agreements.

The applicant states that it will provide all laboratory, radiology, and pathology services, including point of care testing, as needed for surgical services either directly or through contractual agreements. (DI #3, p.109).

Staff concludes that the applicant has met the standard.

6. Patient Safety.
The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

The applicant states that it has been working with the planning group CannonDesign and planning surgical services with patient/staff safety in mind. Clinical leadership and infection control also participated in the planning to identify patient needs/safety issues, The applicant states that the proposed design complies with the applicable FGI Guidelines and American National Standards Institute standards.

The design will have the latest programming, planning, and design elements to maximize safety. The design includes appropriately sized ORs, universal OR configuration, adequate equipment storage areas, adequately sized staff areas, infection prevention, a divided OR suite, new mechanical/electrical systems, recovery patient areas, airborne infection isolation rooms, individuals of size rooms, direct line of sight from nursing work areas and an enhanced pneumatic tube system. (DI #3, p.110).

Staff concludes that the applicant has documented its process for implementing safety into its designs by working with CannonDesign and clinical leaders to keep patient safety in the forefront of the hospital design. The applicant has met the standard.

7. Construction Costs.
The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation

Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. **The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and**
2. **Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.**

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of new construction shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. This standard does not apply to the costs of renovation or the fitting out of shell space.

(ii) If the projected cost per square foot of new construction exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

The applicant states that the total cost of the project per square foot of 741.48 is reasonable, does not exceed the Marshall Valuation Service (after the subtraction of extraordinary costs) and is consistent with current industry cost experience in Maryland, as evidenced by the MVS submitted with the CON application. (DI#3, Exhibit 17).

Subpart (b) is not applicable as the applicant is a hospital not an ASF.

Staff has reviewed and verified the applicant's MVS analysis and concludes that the standard is met.

8. Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of each applicable service by the likely service area population of the facility;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant facility or, if a new facility, the recent experience of similar facilities;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility 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 of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Utilization

The applicant states that its utilization projections are consistent with historic trends. The hospital currently has 12 licensed general-purpose operating rooms but only operates eight because the others are undersized.

Table IV-10: Doctors Current Cases at Average Time per Case Actual FY 2022

	Inpatient				Outpatient				
Hospital	Cases	Time	Cases	Minutes	Cases	Time	Cases	Minutes	#OR
Doctors	2,224	136	2,224	380,857	4,037	97	4,037	534,485	8.03

Source: (DI #10, p.24). HSCRC data for FY 2022 within the DCMC Service Area. DCMC volume reflects total surgical volume. Surgical cases are defined as any inpatient or outpatient case with a surgical DRG or procedure code, excluding Transplants and Cardiac Surgery.

In the application there was a discrepancy in the average minutes per case between what the applicant reported and staff calculations. This was corrected in a subsequent submission in which the applicant explained that the original table did not include the 35-minute turnaround times.

Revenue Estimates

The applicant states its revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments, discounts, bad debt, and charity care provision. (DI #3, p.113). The applicant states that additional revenue

for surgical cases unrelated to obstetrics is not included because it wanted to be conservative in its financial projections.

Staffing

The applicant states that the mixed-use OR renovations will require additional staff nurses (4.16 FTEs), surgical techs (2.92 FTEs), and OR assistants (1.62 FTEs). The applicant plans to add an additional 11 surgeons who will be primarily based at Doctors after project completion. The additional surgeons include one bariatric, one breast, one general, four gynecologic (these are the four OB/GYNs recruited for the obstetric program), three orthopedic (hand, joint and spine) and one vascular surgeon. (DI #10, p.20).

Revenues Over Expenses

The applicant states that it will generate excess revenues over expenses within five years of initiation of services as evidenced in the financial tables reaching a net income for the hospital of $16,091,942 by its FY2030 projections (inflated). (DI#15, Exhibit 29, Table H).

Staff concludes that after reviewing projected utilization, revenues, expenses, and staffing that the standard is met.

9. Impact.

(a) An application to establish a new ambulatory surgical facility shall present the following data as part of its impact assessment, in addition to addressing COMAR 10.24.01.08G(3)(f):

(i) The number of surgical cases projected for the facility and for each physician and practitioner;

(ii) A minimum of two years of historic surgical case volume data for each physician or practitioner, identifying each facility at which cases were performed and the average operating room time per case. Calendar year or fiscal year data may be provided as long as the time period is identified and is consistent for all physicians; and

(iii) The proportion of case volume expected to shift from each existing facility to the proposed facility.

(b) An application shall assess the impact of the proposed project on surgical case volume at general hospitals:

(i) If the applicant's needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent or more of the operating room time in use at a hospital, then the applicant shall include, as part of its impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility.

(ii) The operating room capacity assumptions in Regulation .07A of this chapter and the operating room inventory rules in Regulation .07C of this chapter shall be used in the impact assessment.

Applicant Response:

This standard is not applicable as the applicant is not establishing a new ambulatory surgical facility, and although the applicant projects the need to recruit 11 additional surgeons for the proposed project, it has only identified surgical specialties for recruitment not individual physicians with historic volumes. (DI #15. P.11).

B. <u>COMAR 10.24.01.08G(3)(b) Need</u>

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served and established that the proposed project meets those needs.

Applicant Response:

The applicant referred to its need analysis in the previous three State Health Plan chapters.

Staff Analysis

Staff assessed the need for the project based on the need analyses contained in the three SHP chapters relevant to the project in accordance with COMAR 10.24.10.04B(6) *supra p.16,* the obstetrics program is in accordance with COMAR 10.24.12.04(6) *supra p.24,* and for the surgical services in accordance with COMAR 10.24.11.05B(3)*, supra p. 53.* These standards discuss how the need for the project has been demonstrated by the small number of obstetric beds available in Prince George's County and the current high percentage of out-migration to other counties and Washington, DC for obstetrics care. In addition to obstetrics, the applicant has shown the need for the 10-mixed use ORs and two special purpose ORs.

Staff recommends that the Commission find that the information provided by the applicant satisfies the Need criterion.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3) (c) Availability of More Cost-Effective Alternatives.
The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

The applicant discussed the planning process that resulted in the proposed project, including the goals or objectives it wants to meet. The applicant also discussed the options and

alternatives considered to achieve the project's objectives through the use of other facilities and/or population health initiatives. Staff concludes that Doctors has satisfied the availability of more cost-effective alternative criterion in the response to the cost-effective standard in COMAR 10.24.10.04B-Project Review Standards- (5) Cost-Effectiveness. *supra p.14*.

D. Viability of the Proposal

COMAR 10.24.01.08G(3)(d) Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Resources to Implement the Proposed Project

Table IV-11 shows both statistical and financial projections for the entire hospital and the proposed project.

Table IV-11: Doctors Statistical Projections and Financial Metrics Uninflated Entire Facility FY2021 to FY2028

Doctors	2021	2022	2023	2024	2025*	2026	2027	2028
Discharges	10,482	9,024	9,226	10,913	10,925	10,937	11,557	12,519
Patient Days	52,591	51,966	56,359	67,100	66,611	66,127	67,314	69.337
Occupancy	75.8%	69.1%	71.5%	85.1%	84.5%	83.9%	77.8%	80.2%
Net Income	($1,040,166)	($14,503,977)	$9,325,910	$12,980,742	$8,489,557	$8,760,128	$2,881,078	$1,917,066

Proposed Project	2027	2028	2029	2030	2031
Discharges	556	1,460	1,754	2,090	2,387
Patient Days	1,363	3,596	4,301	5,123	5,852
Occupancy	17.8%	46.9%	56.1%	66.8%	76.3%
Net Income	($6,614,043)	($8,303,364)	($5,359,629)	($2,094,331)	$597,438

(DI #15, Exh.1 Tables F and G).

*2025 was the first year without additional revenues from COVID relates CARES Act and FEMA (DI #15, p.6).

Funding Plan:

The estimated total cost of the project is $299M. (DI#15, Exhibit 29). The sources of funding for the project include $46M cash from operations, $5M in philanthropic gifts, $153M in proceeds from debt financing, and $95M in State support. The applicant states that the $46M cash flow from operations are from consecutive years of operating cash flows generated to fund and support capital investment. The philanthropic funds will be generated from private philanthropy and community funding support. At the time of the application, the largest source of funding was the proceeds from debt financing, bond proceeds the applicant anticipated financing at its current credit rating which infers the issuer has financial backing, cash reserves with a low risk of default. (DI#3, p. 118). The applicant also stated that there is a partially awarded capital grant of $6M in FY2024 and $15M in FY2025 in the State's 2024 Capital Budget and preauthorized by the General Assembly, totaling $21M. (DI #3, p.118).

The applicant provided a history of successful capital campaigns including $44M for a 2010 expansion at AAMC, $10M for the AAMC Behavioral Campus, and $22M in 2022 for AAMC's cardiac surgery program. In addition, Doctors raised $800K to supplement a $20M grant to open a new Behavioral Health Pavilion on the Lanham campus in 2017. The applicant states there are shared Luminis Health resources. (DI #10, p.25).

For the projected $95M in anticipated funding from government sources, the applicant states that should that grant source not be realized, and there is no other grant source to offset that loss, there is a contingency plan. Luminis Health would explore the potential of backfilling the loss of funding with a combination of operating cash, investment redemption, and bond issuance, with bond issuance being much of the new funding. The increase of $79M in debt would result in an average annual increased interest expense over the first five years of $611,000 and the annual increased depreciation expense due to capitalized interest for the three-year construction period would be approximately $52,000. (DI #10, p.26).

Resources to Sustain the Proposed Project

Staffing Plan:

The applicant states that while it anticipates the challenges of a tight job market and staffing shortages, it will incorporate a variety of recruitment practices, including reaching out to past employees, an employee referral program, and use of a nursing externship. The applicant will leverage established relationships with educational institutions including San Jorge University, George Washington University, Johns Hopkins University, Anne Arundel Community College, and Prince George's Community College. The applicant has also evaluated its salaries and wages and increased them by $16.5M from 2022 to 2024. These increases include an overall minimum wage of $17 an hour. (DI #10, p.12).

Community Support:

The applicant provided multiple letters of community support in its application (DI # 3, Exhibit 20).

(f) Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting, and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

Performance Requirements:

The applicant documented its intent to meet the performance requirements in the Project Schedule section of its application. (DI #3, p.26) The applicant plans to work with Cannon Design of Baltimore, MD, as its lead planner. The applicant states that meetings have already occurred with Prince George's County planning and zoning and a construction management firm will be engaged early in the project. (DI #3, p.26).

Luminis Audited Financials:

The applicant provided audited financial statements by Ernest and Young for the 2021 and 2022 fiscal years. The audited financial statements comprise of the consolidated balance sheets as of June 30, 2022, and 2021, and the related consolidated statements of operations and changes in net assets, and cash flows. Ernest and Young concluded that the applicant's financial statements "present fairly, in all material respects, the financial position of the Company at June 30, 2022, and 2021, and the results of its operations, changes in its net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America."(DI#3, Exhibit 21). The consolidated financial statements are for Luminis Health and subsidiaries including Doctors, AAMC, Luminis Health Imaging, Luminis Health Services Inc., Luminis Health Real Estate, Luminis Health Research, Physician Enterprise, LLC., AAMC Collaborative Care Network, and the AAMC Foundation. The audited financial statements also note that the parent, Luminis Health has set aside $138M over a five-year period in strategic investments to Doctors to support expansion of services such as the recently approved psychiatric bed and this proposed project for obstetrics beds.

Staff Analysis

This criterion requires consideration of three aspects of viability: (1) availability of resources to implement the proposed project; (2) the availability of resources necessary to sustain the proposed project; and (3) community support for the proposed project.

The applicant presented a diverse funding plan that included cash, philanthropy, grants, with the majority of project funding, approximately $153M, from debt financing proceeds. This project is strongly supported by the State, which has already demonstrated a financial commitment for the project by appropriating $6M of the grant for FY 2024, with an additional $15M preauthorized for FY 2025. The level of public support, as evidenced the many letters and by the grants already appropriated combined with the ownership and responsibility of Luminis Health will further support Doctors philanthropic goals. As discussed in the financial feasibility

standard, *supra p.22* the HSCRC has estimated that the applicant may be eligible for a $6.5M GBR adjustment upon full operations of the project. Doctors has demonstrated that in FY 2023 it will have a net income of $9,325,910 and the data provided in the application shows it continues to have positive net income throughout the projections. In addition, the proposed project data shows that by the fourth full year of operations, it will also have a positive net income. Doctors has the support of Luminis Health financially, as evidenced by the provision of its audited financial statements, and clinically as evidenced by its experience in obstetrics at AAMC.

While the HSCRC raised concerns about the financial feasibility, highlighting the change in the applicant's bond rating from an A to an A-, the applicant provided a reasonable explanation about the negative impact of COVID-19 in recent years, especially the inflated staffing costs caused by a labor shortage post-pandemic. Applicant's response to the HSCRC concerns underscores a commitment to addressing the financial issues as they evolve, including Luminis Health's commitment to looking at the decline in the revenue cycle and reasonably projects there will be improved results in 2024.

The applicant has documented the availability of resources necessary to implement the project. To sustain the success of the project the applicant has already begun investing in its employees by increasing salaries and wages to be competitive and working with local and international universities to recruit nursing staff. Finally, there is State and community support, including Prince George's County elected officials and current Luminis Health clinicians. Although there is clear support from the State, Commission staff recommends a condition due to the unrealized full amount of State grants received. Staff recommends that the Commission find that the project is viable with the following condition:

If the proposed source of funds for the project should vary from what is approved in the CON the applicant must submit a project change.

E. Compliance with Conditions of Previous Certificates of Need

COMAR 10.24.01.08G(3)(e), Compliance with Conditions of Previous Certificates of Need.
An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned. preferences in obtaining each previous Certificate of Need or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

The applicant has been issued the following CONs since 2000 and has complied with all conditions:

1. 2006 CON-Waiver to provide Primary PCI without Cardiac Surgery On Site-Docket No. 06-16-0011

2. 2007 CON-Renewal of the Primary PCI without Cardiac Surgery Waiver- Docket No. 07-16-0025 -Granted extension for six months, then recommended to cease Primary PCI

3. 2021 CON-Application to provide inpatient mental health – Docket No. 21-16-2448

Staff concludes the applicant has met this criterion.

F. Impact on Existing Providers

COMAR 10.24.01.08G(3)(f): An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

The applicant projects that the largest impact on obstetric volume will be a volume shift from AAMC. Luminis Health supports this anticipated impact because of its commitment to provide local access to obstetric patients in Prince George's County. (DI#3, p. 121). The applicant also states that patients in the service area will continue to have access to several hospitals in the surrounding region; however, hospitals with the highest volume of obstetric cases have Neonatal Intensive Care Units (NICU). Doctors proposed project has a Level II Nursery, therefore it is not anticipated to have a significant impact on hospitals with a NICU. (DI #3 pp. 121-123). Table IV-12 illustrates the impact to other hospitals, including the Perinatal Referral Centers, which are NICU hospitals.

Table IV-12: Doctors Obstetric Program Impact on Existing Obstetric Programs FY2022 Volumes Maryland and Washington DC

Hospital	Shift of Cases	Total Cases	Shift as a %
AAMC*	778	5,897	13.2%
Holy Cross*	613	9,142	6.7%
Adventist White Oak	103	1,528	6.8%
UM Capital Region*	103	1,526	6.8%
MedStar Southern MD	48	1,072	4.5%
Adventist Shady Grove*	45	1,528	2.9%
All other Maryland Hospitals	243	46,891	0.5%
All Washington DC Hospitals[26]	428	9000	4.75%

(DI #3, p.122)
*Maryland Hospitals with a NICU program

Similar to obstetrics, the applicant projects that the largest OR impact will be to AAMC (6%). The applicant estimates that the newly renovated ORs will also impact three percent of cases from other Maryland hospitals and five percent from hospitals in Washington DC, as seen in Table IV-13. (DI #3, p.123).

[26] https://edscape.dc.gov/page/pop-and-students-number-births-and-birth-rates

Table IV-13: Doctors Operating Room Impact on Existing Operating Rooms in FY2022 Volumes Maryland and Washington DC

Hospital	Shift of Cases	Total Cases	Shift as a %
AAMC	46	761	6%
Other Maryland	150	4,994	3%
Other Washington, DC	282	5,637	5%

(DI #10, Exhibit 27).

The applicant states that the obstetrics program will improve access by creating a local delivery site and increasing the number of providers. With the assistance of Luminis Health, applicant states it will be adding more new obstetrics providers to the service area. The applicant predicts that in combination with the new obstetrics program, the Laborist model will attract new providers to the County, which will create additional access for patients. (DI #3, pp.123-124). Additionally, the operating room renovations will improve access by allowing Doctors to utilize four operating rooms for which it is currently licensed but is unable to use due to their obsolescence.

The new obstetrics program will have substantial cost savings for patients that currently go to Washington DC to access obstetric services. The applicant projects the new obstetrics program will have an average charge per care of $11,312 which is less than the average obstetric service average charge across the current Maryland and Washington DC service area which is $14,166. (DI #3, pp.124-125).

Staff Analysis

This criterion requires an applicant to provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, that this information include the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Applicant's data shows that for obstetrics, AAMC will experience the largest impact, a 13 percent shift in patients, which Luminis Health expects and supports. For general surgical services, AAMC will be expected to see a 6 percent shift of patients. The minimal OR volume shift from hospitals other than AAMC is negligible and will not negatively impact other service area providers. The proposed project will reduce travel time and increase access for Prince George's County residents by creating a local delivery site that will in turn attract needed OB/GYN providers to Prince George's County. Lastly, the proposed project is cost-effective for the health care delivery system because currently service area residents are out-migrating to Washington D.C to deliver babies where the cost per obstetrics case is higher by approximately $3,000 per case. Staff concludes that the overall impact of the project is positive.

V. SUMMARY AND STAFF RECOMMENDATION

Based on the review and analysis of Doctor's CON application and the full record in this review this proposed project will increase bed capacity and meet a crucial need for obstetric services in Prince George's County, which is currently experiencing out-migration of obstetric services. Adding obstetric services will have a positive impact on access that will contribute to improving maternal/infant outcomes that will contribute to the reduction of health disparities in

Prince George's County. The project will also attract and retain providers in the community. Staff recommends that notwithstanding concerns raised by the HSCRC the applicant has provided credible responses to the financial viability issues and therefore, is not a basis for denying the project. Staff recommends the Commission find that the proposed capital project complies with the applicable State Health Plan standards, is needed, is the most cost-effective alternative, is viable, and will not have a negative impact on service accessibility, costs, charges, or on the health care delivery system. Accordingly, staff recommends that the Commission **APPROVE** the proposed Doctors project with the following three conditions:

> Luminis Health Doctors Medical Center shall close its obstetric program, and its authority to operate will be revoked, if: (i) it fails to meet the minimum annual volume of 1,000 obstetric discharges annually for any 24 consecutive month period, and (ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.
>
> Luminis Health Doctors Medical Center shall continue to provide a patient with an estimate of out-of-pocket charges prior to arrival for surgery.
>
> If the proposed source of funds for the project should vary from what is approved in the CON the applicant must submit a project change.

IN THE MATTER OF THE	*	
	*	**BEFORE THE**
LUMINIS HEALTH DOCTORS	*	
	*	**MARYLAND HEALTH**
COMMUNITY MEDCIAL CENTER	*	
	*	**CARE COMMISSION**
DOCKET NO. 23-16-2466	*	

****

FINAL ORDER

Having reviewed and considered the information and analysis contained in the Staff Report and Recommendation, it is, this 14th day of December 2023:

ORDERED, that the findings of fact and conclusions of law included in the Staff Report and Recommendation are adopted by the Maryland Health Care Commission and incorporated into this order; and it is further

ORDERED, that the application for a Certificate of Need by Luminis Health Doctors Community Medical Center for a project that will modernize the hospital, add 21 obstetric beds, and renovate surgical services at an estimated project cost of $299,012,841 be **APPROVED,** subject to the following three conditions:

> Luminis Health Doctors Medical Center shall close its obstetric program, and its authority to operate will be revoked, if: (i) it fails to meet the minimum annual volume of 1,000 obstetric discharges annually for any 24 consecutive month period, and (ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two-year period.
>
> Luminis Health Doctors Medical Center shall continue to provide a patient with an estimate of out-of-pocket charges prior to arrival for surgery.
>
> Before changing the funding mechanisms of the project, the applicant must submit a project change.

APPENDIX 1
RECORD OF THE REVIEW

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Letter of Intent received and acknowledged	2/6/23
2	Additional Letters of Support	Various Dates
3	Certificate of Need Application	4/7/23
4	Receipt of Certificate of Need Application acknowledged by MHCC	4/10/23
5	MHCC request to publish notice in Baltimore Sun	4/10/23
6	MHCC request to publish notice in Maryland Register	4/10/23
7	MHCC request to publish notice in the Washington Times	4/12/23
8	MHCC staff sent applicant completeness questions #1	4/25/23
9	Applicant requested extension on completeness #1	5/1/23
10	Completeness responses were received #1	5/17/23
11	MHCC staff sent applicant completeness questions #2	6/2/23
12	Applicant sent supplement to completeness questions #1	6/5/23
13	Applicant requested extension on completeness #2	6/10/23
14	Email extension to file completeness granted until 6/23/23	6/12/23
15	Completeness responses were received #2	6/23/23
16	Formal start of review 7/14/23	6/29/23
17	Request to publish notice Washington Times	6/29/23
18	Request to publish notice Maryland Register	6/29/23
19	Request local Health comments	6/29/23
20	HSCRC memo	11/7/23
21	Per request applicant delayed to December meeting to respond to HSCRC	11/7/23
22	Applicant response to HSCRC	11/21/23
23	AAMC Joint Commission Accreditation	12/02/23

APPENDIX 2: HSCRC Opinion Letter

maryland
health services
cost review commission

Memorandum

TO: Wynee Hawk, Director, Facilities Planning & Development, MHCC
Jeanne-Marie Gawel, Acting Chief, CON, MHCC

FROM: Jonathan Kromm, Executive Director, HSCRC
Jerry Schmith, Director, Revenue & Regulation Compliance, HSCRC
Bob Gallion, Associate Director III, Revenue & Regulation Compliance, HSCRC

DATE: November 7, 2023

RE: Luminis Health Doctors Community Medical Center (LHDCMC)
Obstetric Service & Facility Expansion & Renovation
Docket No. 23-16-2466

This memo is in response to your request dated May 19, 2023, regarding our review of the financial projections as provided in the Certificate of Need (CON) application dated April 7, 2023, and our opinion on the initial feasibility and ongoing viability of the proposed project. In addition, you have requested that we comment on the status of discussions with the applicant regarding their seeking an increase in their Global Budget Revenue (GBR) for a capital award to cover the incremental depreciation and interest to be expensed following the construction and commencement of operations of the proposed project.

BACKGROUND:

LHDCMC is a non-profit hospital located on a 40-acre campus in Lanham, Prince George's County, Maryland, with 200 licensed acute care Medical Surgical Gynecological Addictions (MSGA) beds. The hospital was founded in 1975, and it was recently CON approved for an additional 16 psychiatric beds scheduled to be operational by 2027. In 2019, LHDCMC became an affiliate of Luminis Health, Inc., which also manages Luminis Health Anne Arundel Medical Center (LHAAMC), and J. Kent McNew Family Medical Center.

THE PROJECT:

LHDCMC proposed to establish a new obstetric program, construct a new acute care pavilion adjacent to the existing hospital building, and renovate hospital infrastructure and surgical services facilities to improve hospital functions. The new 4-story pavilion is expected to span 167,000 square feet, and to house administrative functions on the 1st floor, general purpose operating rooms on the 2nd floor, and the new obstetrics program on the 3rd and 4th floors. As per the CON, the cost of the project is approximately $286.6 million. The lower three floors of the pavilion will align with and connect to the existing hospital, while the 4th floor will not connect back to the existing hospital. The renovations to existing facilities include laboratory, imaging, morgue, loading dock, supply, kitchen, dining, laundry, and environmental services. The project is to be executed via three separate contracts, one for each of three phases: Phase One includes the loading dock relocation (18 months); Phase Two includes constructing the new 4-story pavilion (24 months, and Phase Three includes the renovation of existing spaces (24 months). The anticipated timeline includes relocating the loading dock by 2024, obtaining financing and beginning pavilion construction activities by January 2025, opening the pavilion, and beginning renovations by January 2027, and concluding renovations by January 2029. LHDCMC plans to request a GBR capital award to be effective beginning in FY 2027.

The initial CON project budget reflects uses of funds of capital cost of $254.4 million, inflation allowance of $29.1 million, and bond issue fees of $3.1 million. The sources of funds include cash of $33.7 million, philanthropy of $5 million, bonds proceeds of $152.9 million, and state grants of $95 million.

MHCC has stated that the utilization projections included in the CON are reasonable, and that HSCRC staff may assume that the hospital will achieve its projected utilization volumes.

HSCRC STAFF REVIEW, DISCUSSION AND OPINION:

HSCRC staff (Staff) reviewed the following materials: the LHDCMC CON application dated April 7, 2023; the LHDCMC Responses dated May 17, 2023 to MHCC Request for Completeness Information dated April 25, 2023; the LHDCMC Responses dated June 23, 2023 to MHCC Completeness Questions dated June 2, 2023; the LHDCMC Responses dated July 7, 2023 to MHCC Request for Table's Assumptions dated June 30, 2023; and the Audit Reports for fiscal years ended June 30, 2022 and June 30, 2021 for Luminis Health, Inc. and Subsidiaries. In addition, Staff requested and reviewed the internally prepared (unaudited) financial statements for the fiscal year ended June 30, 2023, which were received October 3, 2023.

The most recently Revised Tables were submitted July 7, 2023, with the LHDCMC responses. The revised Table E Project Budget reflects an increase of $12.4 million to project uses for capitalized interest during the construction period, and an increase of $12.4 million to financing sources from cash. The total project budget now reflects $299.0 million. As per the applicant, the obligated group for any borrowings to finance this project is Luminis Health, Inc., LHAAMC, LHDCMC, and Luminis Health Imaging. Staff noted that the estimated useful life of assets acquired ($296 million) was assumed by the applicant to be 36 years. Upon review of the Revised Table E Project Budget, Staff noted that the fixed equipment component of the new construction was grouped together with building and not segregated. Such equipment may likely be material in value and likely carry a 15-year useful life. As per Staff's review of recent CON applications, the average useful life of acquired assets in construction projects was 25 years, and as per review of the Luminis audit report, the average useful life of Luminis' assets is 25.5 years. Given that this project represents an entire hospital building, Staff believes that the 36-year average useful life assumption may be miscalculated and likely overstated. Staff notes that the effect of applying overly optimistic lives to assets may lower reported accrual based annual depreciation expense thereby inflating operating margin, but such has no impact upon cash flow from operations. Staff prepared an amortization schedule for a $152.9 million bond at 5.5 percent interest assuming the borrowing and pavilion construction begin January 2025 and the pavilion opens January 2027. Staff computed approximately $16.7 million of capitalized interest over 24 months, while the applicant computed approximately $12.4 million in capitalized interest during construction. Additionally, Staff computed approximately $50.6 million in expensed interest over the periods projected, while the applicant computed approximately $49.1 million in expensed interest. Staff notes that the potential understatement of interest to be expensed may overstate projected net operating margin.

Revised Table G (P&L Uninflated, Entire Facility & Services) and Table H (P&L Inflated, Entire Facility & Services) reflect changes to top-line Revenues for existing IP and OP services to reflect annual price inflation (2.8%), Contra-Revenues to reflect a consistent 17.1 percent annual reduction, Interest Expense on Current Debt to reflect a falling balance on debt, Interest Expense on Project Debt to strip off price inflation, and Depreciation Expense on Project's Assets to strip off price inflation, as compared to the initially submitted respective Tables. Staff notes the values presented ($4,161,451 in current 2023 dollars or $4,647,477 in future 2027 dollars) for a capital award to GBR for the proposed project's incremental cost of interest and depreciation, as well as open questions on the project's interest on borrowings (both capitalized and expensed) and project's depreciation expense given a relatively long average useful life of acquired assets. The Revised Table H (P&L Inflated, Entire Facility & Services) for fiscal 2033 which

represents the second full year after all changes due to the newly proposed service reflects top line revenues of $469.2 million, net operating revenues of $391.5 million, and an operating margin of $25.6 million profit (or 6.5%).

The revised projections are also subject to the realizability of budgeted proceeds from philanthropy ($5.0 million) and state grants ($95.0 million). As of this date, none of the philanthropy is reported as collected, and $6 million of the grant was appropriated for FY 2024, with an additional $10 million pre-authorized for FY 2025. That leaves $84 million yet to be realized. Although Luminis is confident in the realizability of gifted/granted funding, to the extent that such planned sources go unrealized, Luminis plans to increase draws against operating cash, liquidated investments, and bond financing. This would put additional stress on the financial feasibility of the project by reducing the Days of Cash on Hand and Debt Service Coverage Ratio.

Revised Tables J (P&L Uninflated, New Facility & Services) and Table K (P&L Inflated, New Facility & Services) also reflect changes to Contra-Revenues, Interest Expense on Project Debt, and Depreciation Expense on Project's Assets, as compared to the initially submitted respective Tables. The most recently submitted Table K for fiscal 2033, which represents the second full year after all changes due to the newly proposed service, reflects top line revenues of $57.5 million, net operating revenues of $47.7 million, and an operating margin $5.8 million profit (or 12.2%).

Staff prepared pro forma projections for Tables H and K. Such pro forma presentations reflect Staff's judgement on likely operating performance after consideration of gathered information. Relative to patient service revenues, the pro forma projections provide for one-time reduction to GBR for the All-Payer Rate Reduction for TCOC Performance for Medicare Compliance of $288,672 split between 2023 and 2024; and such also provide for the assumed 2.8 percent annual update factor, and a flat 17.1 percent contra revenue for each fiscal year. Relative to operating expenses, the pro forma projections provide for expensed interest as per the debt amortization test, and depreciation expense consistent with the 25.5-year average useful life of acquired depreciating assets consistent with the audit report. Staff reviewed for reasonableness the projected revenues per obstetric (OB) case and per OB patient day, as well as the reasonableness of the annual update factor of 2.8%, and the volume growth assumptions for OB cases over time due to proposed market-shift and demographic changes. These assumptions were judged to be reasonable on their face; however, specifics by year were not within the scope of our review. Staff computed an approximate capital award for incremental interest and depreciation on this project consistent with the policy model of $6.52 million, to become effective when operations commence mid-year fiscal 2027, and to grow at an annual rate of 2.8%. The Pro Forma Table K (P&L Inflated, New Facility & Services) yielded average operating results on OB Services for the 3 years ended 2033 as follows: annual operating income of $3 million or 6.2 percent of operating revenues, and annual cash flow operating margin of $14.5 million. The Pro Forma Table H (P&L Inflated, Entire Facility & Services) yielded average operating results on Hospital Services for the 3 years ended 2033 as follows: annual operating income of $20 million or 5.2 percent of operating revenues, and cash flow operating margin of $43.5 million.

Staff requested but did not receive projected balance sheets. Staff reviewed Days Cash on Hand and Debt Service Coverage Ratio (DSCR) for the Luminis Obligated Group as of the most recent audited balance sheet date (June 30, 2022), and determined 169.6 Days of Cash on Hand, and a Debt Service Coverage Ratio (DSCR) of 0.97:1 on June 30, 2022 (that is Operating EBITDA $28.735,000 / Debt Service $29,543,000). This project's budget of $299.0 million represents 120.9 days of FY 2022 cash operating expenses, which if on a pro forma basis had been transacted with no other financing sources, would have left the Luminis Obligated group with just 48.7 days cash on hand as of July 1, 2022. Alternatively, if the sources of financing were as budgeted and applied to the same balance sheet date, then the Days Cash on Hand would have been 212.8 days (due to debt proceeds and cash used) and DSCR would have been

0.83:1 on July 1, 2022. A DSCR of 1.2:1 or higher is barely sufficient, while a DSCR below 1.0:1 indicates a potential failure of a Bond Covenant. Staff notes the DSCR of the Obligated Group as measured June 30, 2022 (0.97:1), and the pro forma measure assuming the project budget was afforded on July 1, 2022 (0.83:1).

Staff requested and did receive the internally prepared (unaudited) financial statements for Luminis Obligated Group as of June 30, 2023. Staff reviewed such statements and determined 175.8 Days Cash on Hand, and a DSCR of 0.98:1 on June 30, 2023 (that is Operating EBITDA $28,219,000 / Debt Service $28,963,000). The project's budget of $299.0 million represents 124.4 days of FY 2023 operating expenses, which if on a pro forma basis had been transacted with no other financing resources, would have left the Luminis Obligated Group with just 51.4 days of cash on hand as of July 1, 2023. Alternatively, if the sources of financing were as budgeted and applied to the same balance sheet date, then the Days Cash on Hand would have been 220.2 days (due to debt proceeds and cash used) and DSCR would have been 0.94:1 on July 1, 2023. Staff notes the DSCR of the Obligated Group as measured June 30, 2023 (0.98:1), and the pro forma measure assuming the project budget was afforded on July 1, 2023 (0.94:1).

Staff believes that the above measured DSCRs for June 30, 2022, and June 30, 2023, are indicative of operating performance measures for the obligated group that are insufficient to service the burden of its present debt and its planned additional project debt.

Staff spoke with MHHEFA, the Luminis finance management team, and executive management with another large healthcare system in Maryland, regarding the computation of DSCR used in evaluating debt covenants. Staff was able to confirm that the DSCR covenant for hospitals is computed inclusive of realized investment income (interest, dividends and net realized gains) and certain other realized non-operating income items, and that such computation is consistent with MHHEFA bond covenant requirements. The DSCR inclusive of realized "below the line" income as computed by Luminis and shared with the rating agencies and MHHEFA is 1.84:1 for 2022 and 1.57:1 for 2023. By comparison, the Moody's Healthcare September 2023 report reflects a median DSCR of 3.6:1 for 2022, and the S&P's Healthcare August 2023 report reflects a median DSCR of 3.2:1 for 2022.

Staff notes that for any hospital, their investment portfolio is subject to market risks that lay beyond the control of the hospital, and the degree of reliance upon non-operating "below the line" income items to service its debt is reflective of additional risk that such income may or may not be both consistently present and of material positive value in future fiscal periods. The reliance and associated risk may grow as the Operating EBITDA may fall. Such a risk may lead to increases in the cost of debt financing which in turn may further erode the DSCR.

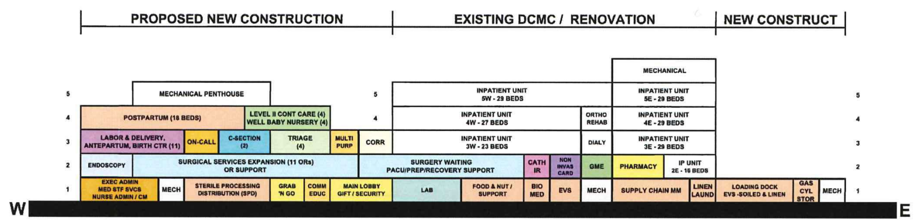
Staff notes that in a report dated October 25, 2023, S&P Global Ratings lowered its long-term rating on the MHHEFA hospital revenue bonds, issued for Luminis Health to 'A-' from 'A', with a stable outlook. To quote the credit analyst mentioned in the report, "The downgrade reflects consistently negative operating performance and modest cash flow, generating weak maximum annual debt service coverage." The report continued to state that the downgrade further reflects Luminis Health's weakened balance sheet metrics, with already light Days Cash on Hand and unrestricted reserves-to-long-term debt no longer commensurate with the 'A' rating. This downgrade from an 'A' to 'A-' rating may well result in an additional twenty-five basis point increase in its cost of capital.

In conclusion, assuming the volumes projected for the proposed obstetrics program are realized and based upon Staff's review of the applicant's likely liquidity and projected operating margin, and subject to the realizability of philanthropic gifts and governmental grants, and based upon review of all the information, Staff believes that all these issues combined call into question the financial feasibility of this project. The

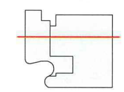
project could possibly be feasible if all these issues are resolved in a positive manner. However, the macro financial investment markets may be unpredictable and the applicant's reliance upon non-operating performance to service its debt may prove to be risky, and, therefore, the project's longer term financial viability may be questionable. Staff has estimated that the applicant may be eligible to receive an incremental capital adjustment of approximately $6.52 million to its GBR upon completion and full operation of the proposed addition to facility and service. This adjustment could help to improve the feasibility of the project.

APPENDIX 3
DRAWINGS

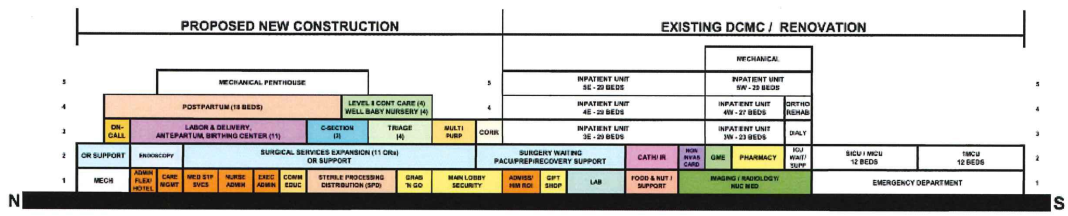
STACKING DIAGRAM
EAST - WEST VIEW



KEY PLAN



STACKING DIAGRAM
NORTH - SOUTH VIEW



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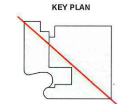

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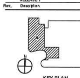
DOCTORS COMMUNITY MEDICAL CENTER
8118 GOOD LUCK ROAD,
LANHAM, MD 20706

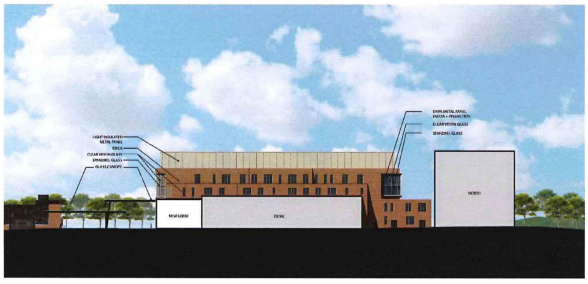
CANNONDESIGN



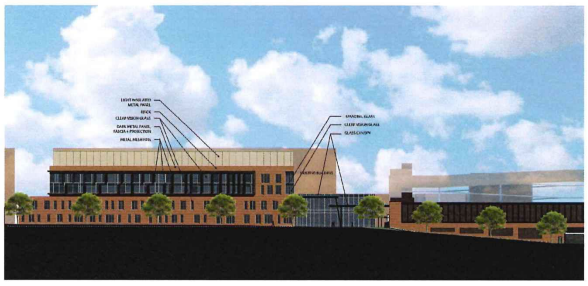
KEY PLAN

Drawing Title:
STACKING DIAGRAMS

CON401



ELEVATION - EAST FACADE



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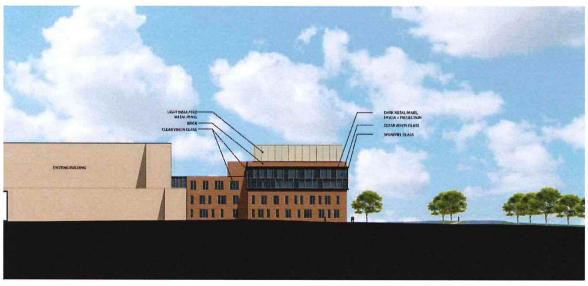
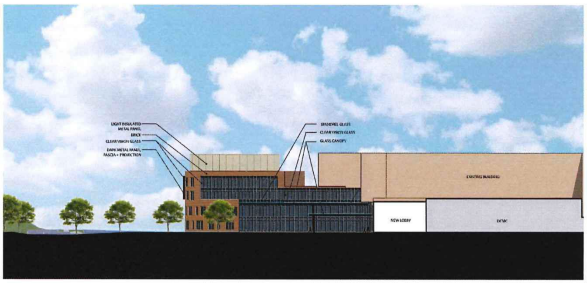


ELEVATION - NORTH FACADE



ELEVATION - SOUTH FACADE

Luminis Health.

DOCTORS COMMUNITY MEDICAL CENTER

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Rev.	Description	Date
	RELEASE 1	15 JAN 2021

KEY PLAN

Drawing Title:

EXTERIOR ELEVATIONS

Project No.: GMCDC.07 Checked by: Checker

CON501

APPENDIX 4
SERVICE AREA ZIP CODES

Primary Service Area	Zip Code
Lanham	20706
Hyattsville	20785
Hyattsville	20784
Upper Marlboro	20774
Riverdale	20737
District Heights	20747
Capital Heights	20743
Greenbelt	20770
Bowie	20720
Bowie	20721
Secondary Service Area	**Zip Code**
Laurel	20708
Hyattsville	20782
Beltsville	20705
Upper Marlboro	20772
Temple Hills	20748
Ft. Washington	20744
Suitland	20746
College Park	20740
Clinton	20735
Bowie	20715
Oxon Hill	20745
Bowie	20716
Hyattsville	20781
Bladensburg	20710
Glenn Dale	20769

Source: (DI #3, p.75).

APPENDIX 5
BUDGET

Doctors Project Budget

NEW CONSTRUCTION		
Building	$	125,033,933
Fixed Equipment		Included above
Site and Infrastructure	$	1,949,560
Architect/Engineering Fees	$	8,888,845
Permits	$	3,751,016
SUBTOTAL	**$**	**139,623,366**
RENOVATION		
Building	$	49,613,831
Fixed Equipment	$	1,438,000
Architect/Engineering Fees	$	4,961,383
Permits	$	1,488,415
SUBTOTAL	**$**	**57,501,629**
OTHER CAPITAL COSTS		
County Inspections	$	856,900
Permitting	$	1,466,613
Paving	$	1,006,000
Exterior Signs	$	50,000
Landscaping	$	150,000
Site Lighting	$	200,000
Site Development	$	30,000
Jurisdictional Hook Up Fees	$	850,000
Architectural/Engineering Fees Non MVS	$	100,500
Additional Service Elevators	$	305,000
Atrium Premium	$	322,000
Canopies	$	475,000
Pneumatic Tube System	$	1,010,600
Temporary Entrance	$	400,000
Constrained Site	$	1,450,000
General Conditions	$	1,120,000
Green Building	$	4,725,000
MBE Premium	$	2,900,000
Architectural/Engineering Other Capital	$	1,999,410
Moveable Equipment	$	5,750,000
Minor Clinical Equipment	$	2,730,000
Technology Data	$	2,550,000
Technology Safety	$	1,150,000
Technology Clinical	$	3,125,000
Pneumatic Tube	$	1,010,600
Contingency Allowance	$	22,575,000
Inflation Allowance**	$	29,100,650
Bond Issue Fees	$	3,060,000
TOTAL USE OF FUNDS	**$**	**299,012,841**
SOURCE OF FUNDS		
Cash	$	46,118,612
Philanthropy (to date and expected)	$	5,000,000
Authorized Bonds***	$	152,894,229
State Grant	$	95,000,000

(DI #15, Exhibit 1, Table E).
*Design 10%, construction 3%
**compounded inflation rate is 19.2%
***bond terms 30 years, rate 5.50% (DI #10, p.4).