STAFF REPORT TO THE PUBLIC HEALTH COUNCIL FOR THE DETERMINATION OF NEED

DoN Project Number	17112414
Applicant Name	SunBridge Healthcare, LLC
Applicant Address	55 Loon Hill Road Dracut, MA 01826
Complete Application Received	January 31, 2018
Type of DoN Application	Long Term Care Substantial Capital Expenditure
Total Value	$26,348,992.00
Ten Taxpayer Group (TTG)	None
Public Hearing	None
Community Health Initiative (CHI)	$790,469.76 to the CHI Healthy Aging Fund
Staff Recommendation	Approval
Public Health Council (PHC) Meeting Date	July 11, 2018

PROJECT SUMMARY AND REGULATORY REVIEW

The Applicant is SunBridge Healthcare, LLC (SunBridge or Applicant). SunBridge has applied for a Determination of Need (DoN) for a Substantial Capital Expenditure pursuant to M.G.L. c.111, §25C and the regulations and guidelines adopted thereunder. The Application is for construction of a 120-bed skilled nursing facility (SNF) to be known as the Merrimack Valley Center (the Merrimack or the Facility), in Dracut, MA. The facility will require construction of 78,621 gross square feet (GSF).

Applications for substantial capital expenditures are reviewed under the DoN regulation through which the Department must determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each of the six Determination of Need Factors set forth within 105 CMR 100.210. This staff report addresses each of the six factors in turn.

The Department received no public comment on the application.

Introduction and Background

The Applicant is SunBridge Healthcare, LLC, d/b/a Merrimack Valley Center (SunBridge or Applicant). In 2012, Genesis Healthcare, Inc.[1] (Genesis) assumed the licenses of and merged with SunBridge. Genesis completed its closure of Heritage Skilled Nursing Facility at the end of February 2018, which resulted in removing from operation 142 beds. Of these 142 beds, SunBridge seeks to activate and operate 120 and voluntarily relinquish the remaining 22 beds, resulting in a decrease in the number of licensed long-term care beds in the area.[2]

Using those 120 beds, SunBridge proposes to construct a new facility (the Facility or the Merrimack). Sixty-eight beds will be short-term rehabilitation beds, 40 beds will be designated for long-term care and 12 beds will be reserved for what the Applicant calls, a "highly skilled telemetry unit." The 120 beds will be arranged in three 40-bed nursing units with all private rooms: One for long-term residents, two for short-term residents, one of which will have 12 beds for telemetry.[3] The Facility will also include occupational and physical therapy spaces, a therapy courtyard, outdoor recreational spaces, and a dining room as well as dedicated space for administrative and clinical staff.

The Merrimack is expected to have the capacity to deliver highly complex care and education and training for healthcare professionals, in collaboration with University of Massachusetts Lowell Zuckerberg College of Health Sciences (UMA) and Lowell General Hospital (LGH)/Circle Health in addition to traditional skilled nursing care. The Applicant states that the Merrimack will offer a new model of post-acute care for clinically complex residents who are currently served in higher cost settings, such as through lengthier stays in acute care hospitals or in long-term acute care hospitals (LTACHs). SunBridge asserts that this new model will allow residents to safely leave the acute care hospital setting earlier or bypass LTACHs, resulting in cost savings and outcomes improvements.

Analysis

This analysis and recommendation reflect the purpose and objective of DoN, which is "to encourage competition and the development of innovative health delivery methods and population health strategies within the health care delivery system to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost advancing the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation" 105 CMR 100.001.

[1] Genesis is a holding company with subsidiaries that, on a combined basis, has a significant national presence: with approximately 450 skilled nursing centers and senior living communities in 29 states; supplying rehabilitation therapy to approximately 1,700 locations in 45 states and the District of Columbia; and operating 33 healthcare centers in the Commonwealth.

[2] The Applicant originally requested to use some of the 191 out-of-service beds that it holds from the closure of Glenwood Care and Rehabilitation Center and Colonial Heights and Rehabilitation Center. However, as set out in Condition 1, the Applicant instead will activate and operate beds from the recently closed Heritage Nursing Care Center, leading to a decrease in the number of licensed long-term care beds in the area. In addition, the Applicant has agreed to relinquish its approval to maintain those 191 out-of-service beds, which will permanently remove them from the total number of beds out of service.

[3] Telemetry is defined by the Applicant as "the continuous monitoring of a patient's heart rate and rhythm that takes place classically at a nursing station in a special unit of the hospital." Don Application 17112414, page 8.

Factors 1 and 2

Factor 1 of the DoN regulation requires that the Applicant address patient panel need, and demonstrate that the project will add measurable public health value in terms of improved health outcomes and quality of life for the existing patient panel, while providing reasonable assurances of health equity. Under factor 2 of the regulation, the Applicant must demonstrate that the project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation. This analysis will approach the requirements of factors 1 and 2 by describing each element of the proposed project and how each element complies with those parts of the regulation.

Patient Panel and Need

Because this DoN contemplates construction of a new facility, there is no existing patient panel. Instead, the Applicant has looked to patient panel data from the Genesis Healthcare Greater Lowell cluster of nursing centers (Genesis Lowell Cluster) from which it derives demographic information for a potential patient panel. The four facilities are: Heritage Nursing Care Center in Lowell MA, with 142 beds; Willow Manor in Lowell MA, with 90 beds; the Palm Skilled Nursing Care Center in Chelmsford MA, with 124 beds; and the Westford House in Westford MA, with 123 beds. Reviewing the geographic and demographic information, staff agrees that this is an acceptable way to identify a potential patient panel.

Over the past 36-month period, 4,417 individuals were served at the four facilities in the Genesis Lowell Cluster. The population was more female (59.04%) than male (40.96%), a gender distribution similar to demographic community profiles on Lowell, Chelmsford, and Westford, MA for the 65 and over population. Almost 90% of the patient panel self-reported as White which is consistent with the state for the 65 and over population.

The Applicant reports that the facilities in the Genesis Lowell Cluster provide care to residents from over 115 zip codes in Massachusetts and New Hampshire; 70% resided in Lowell, Dracut, Chelmsford, and Westford, and 12% are from Merrimack Valley communities. The average ages of the residents at each facility represented in the patient panel are: Heritage (72), Willow (74), Palm (80), and Westford (79). The majority of referrals for the Merrimack are expected to come from a 15 mile radius, and almost all are expected to reside within 10 miles of LGH/Circle Health.

Over the last 36 months, the payer mix of the Genesis Lowell Cluster of nursing centers was 9% Private Pay, 9% Medicare-A, 7% Medicare Managed Care, and 75% Medicaid. SunBridge predicts for this new Facility, higher percentages of patients in the groups insured by Medicare-A and Medicare Managed Care due to higher acuity and shorter length of stay, and estimates a future payer mix comprised of 9% Private Pay, 32% Medicare A, 28% Medicare Managed Care, and 31% Medicaid. The Applicant affirms its commitment to accepting residents to the Facility based on the ability to provide them with the required level of care and not based on payer source.

The Massachusetts Healthy Aging Data Report stated that the population of older adults in Massachusetts will increase from 15% in 2015 to 21% in 2030.[4] The Applicant cites a report from the UMass Donohue Institute stating that the 65 and older population in the Northeast region of Massachusetts, comprised of the four communities of the Greater Lowell Cluster, will increase from 14% as reported by the U.S. Census in 2010 to 25% in 2035.[5] The Applicant states that, in general, older populations suffer from heart-related chronic diseases which, in turn contribute significantly to re-hospitalization rates. The National Center for Health Statistics reported that in 2014, heart disease was one of the 10 leading causes of death, accounting for 23% of all of deaths in the United States.[6,7] LGH/Circle Health, the Applicant's acute care programmatic partner, estimates a 12.85% growth in its cardiac service line for male inpatients 65 and older and a 9.1% growth for female inpatients 65 or older over the next 10 years. This growth translates to an increase of 2,000 seniors per year for LGH/Circle Health through 2026.

SunBridge also looked to data from the Lowell General Hospital (LGH) Community Health Needs Assessment (CHNA) to understand the needs of its potential patient panel. Lowell represents 37% of the patient panel. The demographic profiles presented in the CHNA show that Lowell has a higher (25.2%) than state average (15.3%) foreign born population, higher rates of poverty and unemployment compared to surrounding communities, and a lower than average median household income when compared to surrounding communities and to the state.[8]

In 2014, the Massachusetts Healthy Aging Collaborative stated that the City of Lowell's profile is characterized as having challenges related to the social determinants of health (SDoH), a higher than state average percentage of adults dually eligible for Medicare and Medicaid, and a higher percentage of older adults reported fair or poor health compared to the state average.[9] SunBridge cited data from CHNA reporting that in 2012, emergency department (ED) visits and hospitalizations for all circulatory system diseases were higher in Lowell (685.94 per 100,000) compared to Massachusetts (567.36 per 100,000); in addition, individuals in Lowell experienced higher ED visits for hypertension (201.27 per 100,00) compared to the rest of Massachusetts (128.51 per 100,000).

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[4] *Highlights from the Massachusetts Healthy Aging Data Report: Community Profiles 2015* (Rep.). (2015). Retrieved March, 2018, from Tufts Health Plan Foundation website: http://mahealthyagingcollaborative.org/wp-content/uploads/2014/01/MA_HealthyAgingDataReport_Highlights_2015.pdf

[5] Renski, H., & Strate, S. (2015, March). *Long-term Population Projections for Massachusetts Regions and Municipalities* (Rep.). Retrieved Feb. & march, 2018, from UMass Donahue Institute website: http://pep.donahue-institute.org/downloads/2015/new/UMDI_LongTermPopulationProjectionsReport_2015%2004%20_29.pdf

[6] Chronic Disease Overview. (2017, June 28). Retrieved March, 2018, from https://www.cdc.gov/chronicdisease/overview/index.htm

[7] *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*(Rep.). (2015). Retrieved March, 2018, from National Center for Health Statistics website: https://www.cdc.gov/nchs/data/hus/hus15.pdf#019

[8] *Greater Lowell Community Health Needs Assessment* (Rep.). (2016). Retrieved December, 2017, from https://www.greaterlowellhealthalliance.org/wp content/uploads/2016/09/2016_GL_Comm_Health_Needs_Web.pdf

[9] *Community Profiles 2014* (Rep.). (2014). Retrieved February, 2018, from Massachusetts Healthy Aging Collaborative website: http://www.mass.gov/eohhs/docs/dph/com-health/chronic-disease/healthy-aging-data-report.pdf

Public Health Value

Public Health Value, for the purposes of DoN, requires that the project have an evidence base, be outcome oriented, and address health inequities. Staff examined the impact of the transaction on improved coordination of care and patient access to care as well as the impact upon outcomes and quality of life.

SunBridge proposes to operate and develop the Merrimack along with its programmatic partners, UMA and LGH/Circle Health, in order to offer short-term and long-term care in a teaching environment. The Applicant states that the Merrimack will provide high-level skilled care that will improve access to services and programming across the continuum of care for a patient panel that is growing in size and need for highly skilled health care services at a lower cost. Below, staff reviews how the project, as described by the Applicant, is designed to improve health outcomes, the resident experience, and increase the geriatric care capacity within the health care workforce while reducing such costs.

Interprofessional Education

SunBridge proposes to work with the UMA Gerontological Nurse Practitioner Program to develop and incorporate a structured Interprofessional Education (IPE) program into care delivery at the Merrimack; this IPE will incorporate nursing students and other health care professionals in training. The Applicant points to research from the Institute of Medicine (IOM) and the World Health Organization (WHO) in support of IPE as a model that can improve quality of care, lower costs, decrease length of stay (LOS), reduce medical errors, and address social determinants of health.[10] Additional research states that IPE is important for addressing the health needs of a growing aging population that requires care from multiple providers. [11]

SunBridge asserts that IPE will support the growth and development of geriatric care professionals to support physicians treating the patient panel, which will, in turn, transform patient clinical care in the Greater Lowell Area. IPE students will serve a rotation through the Facility and these rotations will allow students to work with residents at all levels of care and through various stages of care.

All the resident rooms will be private and large enough to facilitate the educational component. The Applicant states that the clinical and psychosocial benefits of a new physical plant and private rooms will support resident-centered care and accommodate privacy and resident

[10] "Cross-sectoral Interprofessional collaboration between health and related sectors is also important because it helps achieve the broader determinants of health such as better housing, clean water, food security, education and a violence-free society" *Framework for Action on Interprofessional Education & Collaborative Practice* (Rep.). (2010). Retrieved January, 2018, from World Health Organization website: http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf?ua=1

[11] Darlow, B., Coleman, K., Mckinlay, E., Donovan, S., Beckingsale, L., Gray, B., . . . Pullon, S. (2015). The positive impact of interprofessional education: a controlled trial to evaluate a programme for health professional students. *BMC Medical Education, 15*(1). doi:10.1186/s12909-015-0385-3

preferences. The Applicant asserts that private rooms reduce the risk of health care associated infection,[12] can result in better sleep patterns, and improve resident outcomes.

Integrated Cardiac Management and Post-Acute Care

LGH is the acute care component of Circle Health, founded in 2012 through a partnership of LGH, Circle Home, the Lowell Community Health Center, and 700 local physicians. LGH serves the Greater Lowell area and surrounding communities with two campuses in Lowell. Circle Health describes itself as designed to provide individuals with care along the care continuum of prevention to treatment and recovery, while expanding access to healthcare with a focus on vulnerable populations.[13] According to the Applicant, LGH/Circle Health "identified developing a skilled extension of cardiac services integrated with the acute cardiac management and cardiac rehabilitation programs at the hospital as an area of need."[14]

SunBridge proposes a 12-bed telemetry unit[15] to support the LGH cardiac rehabilitation and cardiac management programs. Telemetry will allow hospital patients to transition quickly from an acute care hospital setting to a lower cost skilled nursing setting. The Applicant states that the telemetry equipment and staff training at the Merrimack will be the same as that which is employed at LGH to support seamless collaborative monitoring. Monitoring will occur at both the Facility and at LGH allowing cardiology staff to be updated in real-time. The Applicant asserts that the Merrimack will be able to monitor and manage clinically complex patients including those with symptoms associated with heart failure, and may minimize the number and impact of transfers from the Merrimack back to the ED.

SunBridge asserts that the implementation of telemetry and the improved capacity to care for more critical residents at the Merrimack will facilitate decreased lengths of stay at hospitals. The Applicant cites research supporting the correlation between a reduction in a patient's acute care length of stay and a reduction in readmissions.[16] These improvements may be attributed to lowered risks for health care associated infection.

[12] According to the CDC, the most common pathogens that cause nosocomial infections are Staphylococcus aureus, Pseudomonas aeruginosa, and E. coli. Some of the common nosocomial infections are urinary tract infections, respiratory pneumonia, surgical site wound infections, bacteremia, gastrointestinal and skin infections

[13] *The Power of Partnership Annual Report 2016* (Rep.). (2016). Retrieved February, 2018, from Circle Health website: https://www.lowellgeneral.org/files/lghPublication/documentFile/LGH_Annual2016_web.pdf

[14] DoN Application 17112412, at page 24.

[15] Telemetry will offer continuous monitoring of residents, a quick response from trained staff, and serves as a helpful diagnostic and treatment tool. Telemetry will be for residents at risk of heart events, residents with ongoing heart problems, or residents recovering from heart events. A transmitter will send signals to a monitoring station which will be watched by nurses and cardiologists. Residents will wear portable transmitters to permit mobility. Telemetry will monitor changes in heart rhythms and associated complications, which the Applicant states is important for post-operative patients that generally all have a similar risk of complications including pneumonia and infection.

[16] Kaboli, P. J., Go, J. T., Hockenberry, J., Glaslow, J. M., Johnson, S. R., Rosenthal, G. E., Vaughn-Sarrazin, M. (n.d.). Associations Between Reduced Hospital Length of Stay and 30-Day Readmission Rate and Mortality: 14-Year Experience in 129 Veterans Affairs Hospitals. *Annals of Internal Medicine, 157*(12), 837-845.

SunBridge states that at this time, the monitoring and cardiac care provided through telemetry is only available in the hospital setting. If approved and implemented, the Merrimack would be the first SNF with telemetry capacity. SunBridge asserts that the Merrimack's design and programming will accommodate a changing array of clinical therapies and services for seniors and will assist residents' transition from acute care to home or a home-like setting.

Care Coordination

Transitions in care, leaving one setting and moving to another, are common for older patients and those with chronic conditions.[17] "Problematic transitions occur from and to virtually every type of health care setting, but especially when patients leave the hospital to receive care in another setting or at home."[18] Poor communication during care transitions is costly to patients and the health care system, can reduce quality of care, and leads to patient and family caregiver dissatisfaction with the health care system.[19,20]

SunBridge points to the Genesis Transitions of Care Program as an example of how it will focus on the development of care coordination including physician input that aligns with the Triple Aim of Healthcare.[21] The Transitions of Care Program is initiated for all residents prior to admission; manages transitions between settings; includes participation by an inter-professional team led by the Executive Director; and supports the transition of residents within the continuum of care. SunBridge will utilize a Risk for Readmission Evaluation Tool for all residents to determine appropriate patient engagement and assess the likelihood for re-hospitalization. A post-admission patient/family conference will be conducted within 72 hours of admission to identify patient goals, inter-professional team goals, and what, if any services were used prior to admission. Contact with the patient's primary care physician (PCP) will be maintained throughout this process. By incorporating PCPs in the care development process, the Applicant will, with its collaborators, develop care paths and services to support community reintegration and reduce re-hospitalization. The Applicant intends to integrate social services and community-based expertise into patient care coordination from admission to discharge as well as within and between settings along the continuum of care. The Applicant provided a list of health care and community-based resources with which it will work to coordinate patient care.

[17] *Improving Transitions of Care* (Rep.). (2010). Retrieved February, 2018, from National Transitions of Care Coalition website: http://www.ntocc.org/Portals/0/PDF/Resources/NTOCCIssueBriefs.pdf
[18] *Transitions of Care: The need for a more effective approach to continuing patient care* (Rep.). (2012). Retrieved February, 2018, from https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf
[19] *Improving Transitions of Care* (Rep.). (2010). Retrieved February, 2018, from National Transitions of Care Coalition website: http://www.ntocc.org/Portals/0/PDF/Resources/NTOCCIssueBriefs.pdf
[20] Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The Importance Of Transitional Care In Achieving Health Reform. *Health Affairs, 30*(4), 746-754. Retrieved February, 2018, from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2011.0041.
[21] The IHI Triple Aim. (2018). Retrieved February, 2018, from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Equity

The Applicant asserts that the Genesis Healthcare Policies support access to care and offer tools to ensure "meaningful access and an equal opportunity to participate in the services, activities, programs, and other benefits."[22] These policies ensure access to Auxiliary Aids and Services for persons with Disabilities.[23] SunBridge commits to provide – and the standard conditions to all DoNs require - culturally and linguistically appropriate services and to hire and to train staff in cultural competence.

Measurement

The Affordable Care Act of 2012 made QAPI a requirement for nursing homes. QAPI contains two components: Quality Assurance (QA), and Performance Improvement (PI). According to reporting from the Centers for Medicare and Medicaid Services, QAPI "ensure[s] a systematic, comprehensive, data-driven approach to care," the benefits of which include prevention of adverse events, promotion of safety and quality, and a reduction in risk to residents and caregivers. [24]

The Genesis QAPI process involves all members of the organization.[25] Each Genesis facility sets individual annual targets for performance, which are incorporated into the QAPI performance plan and conducts ongoing reports to track process. Staff participation includes focused rounds, clinical huddles, and an Interdisciplinary Team for quality assurance and improvement. The Applicant reports that QAPI teams use problem solving tools to enhance targeted areas and improve outcomes and cost-containment goals. The Applicant states that these tools will give the Merrimack the ability to identify, implement and sustain improvement in outcomes and cost containment goals.

Health information technology will support internal measurements of quality outcomes at the Merrimack. Electronic health records already track patient medication and lab results in other Genesis facilities. The Applicant reports that some Genesis facilities have enhanced electronic processes that have allowed care teams to receive information in advance of the resident's transfer to a facility. This has, the Applicant asserts, helped to increase operational efficiencies, decrease reporting lag times, reduce transcription errors, and eliminate workflow redundancies. The Applicant states that the Facility will advance the transfer of patient health information between providers through virtual Health Information Exchange to support patient care.

[22] DoN Application 17112414, at page 147.
[23] DoN Application 17112414 Attachments, at page 152.
[24] *QAPI At A Glance* (Rep.). (n.d.). Retrieved February, 2018, from CMS website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf
[25] See, generally *QAPI At A Glance* (Rep.). (n.d). Retrieved February, 2018, from CMS website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf

Patient experience will be measured in an annual Resident Experience Survey, Family Experience Survey and Former Patient Satisfaction Survey administered to residents who have returned home. Attachment 1 lists the Genesis performance measures that will be implemented at the Merrimack. As well, the Applicant asserts that with input from its collaborative partner LGH/Circle Health, reducing length of stay in an acute care hospital will improve health outcomes and patient quality of life. The Applicant commits to ongoing monitoring and evaluation with collaborative partners to support improved patient outcomes.

Community Engagement

The Applicant used the Continuum of Community Engagement adapted from the International Association for Public Participation (IAP2) to guide the community engagement process.[26,27] The Applicant engaged representatives of the patient panel and community health leadership in the planning process. The Lowell General Hospital CHNA helped to identify both the health needs of the patient panel and the need for additional professionals trained in geriatrics. Community providers, consumers and local and state officials through the Greater Lowell Health Alliance (GLHA) helped affirm the needs of the older population. The Applicant received feedback from community focus groups and key informant interviews, and engaged in discussion with the Lowell Community Health Center, and physicians and pharmacy groups.

The Applicant states that throughout the planning process, the community has been "informed, consulted, involved, and collaborated."[28]

Finding - Factors 1 and 2

Based upon a review of the materials submitted, Staff finds that SunBridge will employ a patient-centered approach to care at the Merrimack that addresses the identified health needs of the patient panel. The Applicant has committed to ensuring care coordination upon discharge. The proposed project, with a focus on inter-professional education and high-level skilled nursing care, will fill a gap in the care continuum for older populations; and the hybrid SNF with IPE component is likely to reduce acute care stays and costs, which is in keeping with the Commonwealth's goals for cost containment, delivery system transformation, and improved outcomes, thus meeting each of factors 1 and 2.

Factor 3

Factor 3 requires compliance with relevant licensure, certification, or other regulatory oversight. The Applicant provided sufficient information in the form of its Affidavit of Compliance and other relevant documentation.

[26] IAP2 is an international association of members who seek to promote and improve the practice of public participation in relation to individuals, governments, institutions, and other entities that affect the public interest in nations throughout the world. About IAP2. (n.d.). Retrieved February, 2018, from https://www.iap2.org/?page=A3

[27] The Department has adapted and adopted the International Association of Public Participation's (IAP2) Spectrum of Public Participation for use in its Community Engagement Guidelines.

[28] DoN Application 17112414, at page 14.

Factor 4

The DoN regulation at 105 CMR 100.210(A)(4) requires that an Applicant for a DoN provide "sufficient documentation of the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel and that the Proposed Project is financially feasible and within the financial capability of the Applicant." Factor 4 requires that the documentation provided in support of the Department's finding shall include an analysis of the Applicant's finances, completed by an independent Certified Public Accountant (CPA Report).

The Analysis prepared by Bernard L. Donohue (Donohue) and dated January 26, 2018 included an analysis of five-year financial projections prepared by Genesis for operation of the Merrimack and supporting documentation obtained from the DoN Application and relevant websites to render an opinion as to the reasonableness of assumptions used in the preparation and feasibility of the Projections. Donohue calculated liquidity ratios to measure the quality and adequacy of assets to meet current obligations and operating ratios to evaluate management performance and efficient utilization of resources for the fiscal years 2019 through 2023.

Revenue analysis reviewed reasonableness of reimbursement rates based on private pay at existing Genesis facilities, Medicaid and Medicare rates, and expected government Managed Care rates, the payer mix at a facility with short-term rehabilitation, long-term care, and a telemetry unit, and the projected volume of the facility (93.3% occupancy level for years 2 through 5). Donohue predicted an increase in traditional Medicare residents, Medicare Advantage Plan residents, and other Managed care residents due to the telemetry unit and short-term rehabilitation residents. Donohue cited Medicare predictions of an 18.6% increase in the Medicare eligible population the Facility's catchment area in the next 5 years, and predicted a reimbursement rate increase of 2.5% in succeeding years. Donohue states that revenue projected reflects a reasonable estimate of future revenue.

Donohue analyzed expenses and found the projections to be in line with those selected for comparison, but noted higher ancillary (therapy, pharmacy, radiology, laboratory, telemetry services) expense due to the cardiac unit and short-term sub-acute care, which the report states are in line with the scope of the project. Expenses are projected to increase 2.5% per year and are reasonable in nature.

Donohue reviewed the lease agreement and cash flow to determine if sufficient funds would be available to support the lease and continued operations. Development Group LLC, a Genesis subsidiary, and WS Property Group formed a joint venture that will own the Facility and develop it for use as a skilled nursing facility. The joint venture will lease the Facility to SunBridge and SunBridge will operate the Facility. Donohue found that the pro-forma capital expenditures and resulting impact on cash flows of the Merrimack were reasonable.

The CPA Report concludes that "the project and continued operating surplus are reasonable expectations and are based upon feasible financial information" and that "the Projections are feasible and sustainable and not likely to have a negative impact on the patient panel or result in liquidation of assets of the Merrimack."[29]

Finding - Factor 4

There is sufficient evidence that the project, including construction and operation of the Facility, is within the financial capabilities of the Applicant and in that context, will not have a negative impact on the patient panel.

Factor 5

Factor 5 requires an assessment of the relative merit of the proposed project compared to alternative methods for meeting the patient panel needs. In this context, the Applicant's decision to pursue the proposed project was based on an assessment of what would offer optimal operational efficiency, capital investment, and design to support the needs of the patient panel.

Genesis considered demolition and renovation of an existing facility in the Genesis Lowell Cluster to implement the hybrid program, but stated that this option would be inefficient and required a costlier design given severe site constraints.[30] The Applicant notes that direct care costs would be higher if the programming were implemented at an existing renovated facility because staffing would be required to cover four floors compared to three floors at the Merrimack. The cost of this alternative was $34,654,250.00, which is $8.5 million higher than the proposed project. The Applicant rejected this alternative based on development costs and building inefficiencies.

The Applicant states that the selected site will allow 40-bed nursing units on each floor and private rooms large enough to accommodate implementation of the IPE program. The Applicant reports that ancillary and support services will be adequately accommodated to promote maximum efficiency.

The Applicant states that the Merrimack will be easily accessible by car and through the Lowell Regional Transit Authority and that the site will have 124 parking spaces, and multiple entrances to support accessibility for staff and visitors, which SunBridge argues makes the Facility more easily accessible than re-use of an existing site. The Applicant cites the proximity of the LGH Outpatient space to the project as a benefit of the location that will serve as an option for care for long-term care residents when needed. The Facility is adjacent to a planned project creating 27,000 square feet of LGH office space which includes urgent care, a Patient

[29] CPA report, at page 6.

[30] The Applicant asserts that the site restricted implementation of the innovative programming and state-of-the-art technologies. Design included reconfigured four nursing units over four floors, three floors with 35 beds and one floor with 15 beds which is a non-traditional and less efficient staffing pattern. The design also lacked a loading dock or a loading area.

Service Center (including Phlebotomy, X-Ray, and Ultrasound), a Diabetes clinic, Endocrinology, and Primary Care, and the Facility borders Arbors Assisted Living in Dracut which opened in July 2017.

Finding - Factor 5

The Applicant determined that the proposed project allowed for construction of a nursing facility with technological and programmatic features that most adequately addressed the needs of the patient panel.

Factor 6

In compliance with Factor 6 of the regulations, as a condition of approval, the Applicant will make payment in the amount of $790,469.76 to the Community Health Initiative (CHI) Healthy Aging Fund pursuant to 105 CMR 100.210(6), 105 CMR 100.715(B)(1), and the *Determination of Need Community Health Initiative Planning Guideline*. Projects on behalf of a long-term care facility are directed to fulfill their CHI requirements by contributing 3% of the Total Capital Expenditure of the Proposed Project to the Healthy Aging Fund.

Recommendation

Based upon a review of the materials submitted, Staff finds that SunBridge Healthcare has met each DoN factor and recommends that the Department approve this Determination of Need application for the construction of a new skilled nursing facility subject to all standard conditions (105 CMR 100.310), and subject to the other conditions set out below, pursuant to 105 CMR 100.360.

Other Conditions

1. SunBridge will activate and operate 120 beds from the recently closed Heritage Nursing Care Center, and will relinquish the remaining 22 beds, leading to a decrease in the number of licensed long-term care beds in the area.

2. In its first report mandated by 105 CMR 100.310(L), and as one of the measures that reflects the Project's achievement of the DoN factors, the Holder will include a description, including metrics that support the assertions, of how the provision of post-acute care in the Facility has decreased costs and improved the quality of and access to care as well as care continuity for the patient panel.

3. In its first report mandated by 105 CMR 100.310(L), the Holder will provide the following:

a. A description of the current payer mix of the Merrimack, reported by each of the health insurance coverage categories reported on by CHIA.[31]
   i. Private Commercial – Overall
   ii. Private Commercial – MA Health Connector QHPs (Subsidized and Unsubsidized)
   iii. MassHealth – Overall
   iv. MassHealth – Temporary
   v. MassHealth – Managed Care Organizations (MCO)
   vi. Senior Care Options, One Care, PACE
   vii. Medicare Fee-for-Service (Parts A and B)
   viii. Medicare Advantage

4. For the duration of the reporting period mandated by 105 CMR 100.310 (L), the Holder will provide the following:
   a. Updates on the payer mix of the Merrimack as outlined in condition 3.
   b. A report on the measures set out in Attachment 1.
   c. Updates on the impact of the project on savings and resident outcomes as initially reported in condition 2.

5. In addition to the Holder's obligation to participate in MassHealth as mandated by 105 CMR 100.310(K), the Holder will comply with any conditions or reporting requirements imposed by MassHealth related to MassHealth's approval of reimbursement rates for services provided to MassHealth beneficiaries. Should the Holder not comply with any such conditions or reporting requirements, MassHealth will notify the Department, after which the Holder shall report to the Department on why it should find that the Holder is still in compliance with the terms and conditions of this DoN.

[31] *Enrollment Trends Technical Appendix* (Rep.). (2018, February). Retrieved February, 2018, from CHIA website: http://www.chiamass.gov/assets/Uploads/enrollment/2018-feb/Enrollment-Trends-Technical-Appendix-.pdf

Attachment 1

Genesis performance measures that will be implemented in the Merrimack Valley Center.

1. Reducing Re-hospitalizations
2. Reducing Anti-psychotic Use
3. Maintaining Skin Integrity
4. Minimizing Falls with Injury
5. Infection Prevention and Control
6. Employee Engagement and Enablement
7. 5-Star Performance
8. Discharge Customer Satisfaction
9. Family and Resident Satisfaction

Other measures proposed by the Applicant

1. Hospitalizations
2. Hospital Length of Stay
3. Emergency Room Direction

Attachment 2

100.310: Standard Conditions

Unless otherwise expressly specified within 105 CMR 100.000, each Notice of Determination of Need issued by the Department shall be subject to the following Conditions. The Commissioner may specify additional Standard Conditions within Guideline which shall be attached to all Notices of Determination of Need, unless otherwise specified, and which shall be determined by the Commissioner as advancing the objectives of 105 CMR 100.000. Prior to issuance, such Guideline shall be developed through a public process consistent with 105 CMR 100.440 and in consultation with applicable Government Agencies, community-based organizations, relevant stakeholders, and the Public Health Council.

(A) The Notice of Determination of Need shall be subject to administrative review by the Health Facilities Appeals Board and may be stayed by the Health Facilities Appeals Board. If the Health Facilities Appeals Board is not constituted on the date of issuance of the Notice of Determination of Need, the Notice shall be considered a Final Action subject to review under M.G.L. c. 30A.

(B) The Notice of Determination of Need shall go into effect upon the Department's issuance of a written notification made pursuant to 105 CMR 100.625(A). The Holder shall submit an acknowledgment of receipt to the Department within 30 days of the written notification, documented in the form of an attestation, signed by the Holder's chief executive officer and board chair, and returned to the Department and all Parties of Record. Unless extended for Good Cause Related to Project Implementation, or as a result of an approved amendment to a previously issued Notice of Determination of Need, the Notice of Determination of Need shall constitute a valid authorization for a period of not more than three years following the approval of the Department, unless otherwise expressly noted as an Other Condition, and shall only be for the purposes of the approved project, including for the identified and approved treatments and/or patient populations. No Notice of Determination of Need shall remain in authorization unless the Holder complies with all prescribed terms and Conditions as set forth by the Department.

(C) Unless extended for Good Cause Related to Project Implementation, or as a result of an approved amendment to a previously issued Notice of Determination of Need, the Notice of Determination of Need shall constitute a valid authorization only for the Proposed Project for which the Notice of Determination of Need is made, and for only the total Capital Expenditure approved.

(D) The Notice of Determination of Need shall constitute a valid authorization only for the Person to whom it is issued and may be transferred only upon the expressed written permission of the Department pursuant to 105 CMR 100.635(A)(3), except that a Notice of Determination of Need issued for an Original License pursuant to 105 CMR 100.730 and a Notice of Determination of Need for a Transfer of Ownership pursuant to 105 CMR 100.735 shall not be transferable.

(E) The authorization for the Notice of Determination of Need shall expire if the Department determines that Substantial and Continuing Progress is not made, or if not duly extended by the Department for Good Cause Related to Project Implementation shown. Any request for an extension must be filed by the Holder within the period of authorization for the Notice of Determination of Need. In the event an appeal filed with the Health Facilities Appeals Board, the period of authorization of the Notice of Determination of Need shall be extended during such time that any stay is in effect.

(F) (1) Notwithstanding the period of authorization of the Notice of Determination of Need, if the Holder is subject to the requirements of filing final architectural plans and specifications pursuant to M.G.L. c. 111, § 51 or § 71, and if any Construction or renovation is involved, the Notice of Determination of Need shall not remain in force longer than 12 months, unless within said 12 months, the Holder has filed such final architectural plans and specifications; provided that the Commissioner may approve a written schedule for the phased submission of such plans beyond that period for any project involving Construction having an authorized Capital Expenditure in excess of an amount equal to the Expenditure Minimum with respect to Substantial Capital Expenditures with respect to Hospitals. In the event a written schedule for phased submission of such plans is approved, each portion of the project to which a submission relates shall be consistent with the overall project as approved by the Department and shall not exceed the proportional share of the total approved project cost.

(2) Failure to submit final and complete architectural plans and specifications plans by the date specified by the Department, or by an approved schedule for plan submission pursuant to 105 CMR 100.310(F)(1), may result in:

(a) the initiation of revocation procedures pursuant to 105 CMR 100.640; or

(b) the disallowance of inflation calculated pursuant to 105 CMR 100.310(I) for the amount of time equal to the time period between the due date for submission of final plans as prescribed by the Department, and the date of actual submission by the Holder. The disallowance of inflation for this time period shall be calculated as if the time period occurred immediately preceding the commencement of Construction.

(3) No Construction may begin pursuant to a Notice of Determination of Need until the Holder has met all applicable Department and other Government Agency licensure requirements, including plan review. Part 1 Plan Review by the Department may coincide, as is reasonably feasible, with Department consideration of a Proposed Project pursuant to 105 CMR 100.000.

(4) The Holder shall ensure Construction of any new building or the complete rehabilitation of a building implemented pursuant to a Notice of Determination of Need shall meet all Prerequisites and meet or exceed certifiable "silver level", or equivalent, of the Leadership in Energy and Environmental Design-Health Care (LEED-HC) Green Guide for Healthcare (GGHC), or an equivalent nationally recognized best practice standard, as approved by the Department

(G) The written schedule for the phased submission of architectural plans and specifications submitted by the Holder pursuant to 105 CMR 100.310(F) shall be used to measure continuing progress toward completion of the project for which a Notice of Determination of Need has been issued.

(H) The Government Agency license of the Health Care Facility or Health Care Facilities for which, and on behalf of, the Holder possesses a valid Notice of Determination of Need, shall be conditioned with all Standard and Other Conditions attached to the Notice of Determination of Need.

(I) Unless extended for Good Cause Related to Project Implementation, the Department shall receive from the Holder firm, itemized figures specifying the final project costs, or current phase thereof, which shall not be greater than those approved by the Department pursuant to the issued Notice for Determination of Need plus any increase in cost due to the allowable rate of inflation. This submission shall occur within six months following the receipt of written final approval of architectural plans and specifications by the Department or other applicable Government Agency; or, in the case of projects for which a schedule of phased plan submission has been approved, each phase submitted. The Holder shall submit the final project costs in a format specified by the Commissioner. No additional increases in the maximum Capital Expenditure, inflationary or otherwise, shall be approved beyond 12 months after the

initial licensure of beds and opening of the facility or service. The final approved project costs shall be submitted by the Commissioner to all Parties of Record. Should the Holder fail to submit final project costs pursuant to 105 CMR 100.310(I)(1), the Holder shall be subject to enforcement actions as set forth within the Notice of Determination of Need's Standard and Other Conditions.

(J) Unless explicitly exempted within 105 CMR 100.000, the terms and Conditions shall include descriptions of project(s), mutually agreed upon and approved by the Department, documenting the Holder's obligations pursuant to 105 CMR 100.210(A)(6). Said plan shall require the Holder to expend, over a five-year period, or any other period as specified by the Commissioner, an amount which in total shall be greater than or equal to 5% of the total Capital Expenditure of the approved project, except in cases where exemptions within 105 CMR
100.000 may apply. Said projects shall address one or more of the Health Priorities set out in Department Guidelines.

(K) If the Health Care Facility or Heath Care Facilities for which the Notice of Determination of Need has been issued is eligible, the Holder shall provide written attestation on behalf of the Health Care Facility or Heath Care Facilities, under the pains and penalties of perjury, of participation, or their intent to participate, in MassHealth pursuant to 130 CMR 400.000 through 499.000.

(L) The Holder shall report to the Department, at a minimum on an annual basis, and in a form, manner, and frequency as specified by the Commissioner. At a minimum, said reporting shall include, but not be limited to, the reporting of measures related to the project's achievement of the Determination of Need Factors, as directed by the Department pursuant to105 CMR 100.210.

(M) If it is determined by the Department that the Holder has failed to sufficiently demonstrate compliance with one or more Conditions, the Holder shall fund projects which address one or more of the Health Priorities set out in Department Guideline, as approved by the Department, which in total, shall equal up to 2.5% of the total Capital Expenditure of the approved project. Said projects shall address one or more of the Health Priorities set out in Department Guideline, and shall be in addition to those projects approved by the Department in fulfillment of 105 CMR 100.210(A)(6). In making such determination, the Department shall provide written notification to the Holder at least 30 days prior to requiring such funding, and shall provide the Holder the opportunity to appear before the Department. The Department shall consider circumstances external to the Holder that may impact the Holder's ability to demonstrate compliance.

(N) The Holder shall provide to Department Staff a plan for approval by the Office of Health Equity for the development and improvement of language access and assistive services provided to individuals with disabilities, non-English speaking, Limited English Proficiency (LEP), and American Sign Language (ASL) patients.

(O) The Holder shall provide for interpreter services to the Holder's Patient Panel. The Holder shall ensure that all medical and non-medical interpreters, inclusive of staff, contractors, and volunteers providing interpreter services to the Holder's Patient Panel maintain current multilingual proficiency and have sufficient relevant training. Training for non-medical interpreters should include, at a minimum:

(1) the skills and ethics of interpretation; and
(2) cultural health beliefs systems and concepts relevant to non-clinical encounters.
(3) Training for medical interpreters should include, at a minimum:
    (a) the skills and ethics of interpretation; and

(b) multilingual knowledge of specialized terms, including medical terminology, competency in specialized settings, continuing education, and concepts relevant to clinical and non-clinical encounters.

(P) The Holder shall require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically appropriate services (CLAS), including, but not limited to, patient cultural and health belief systems and effective utilization of available interpreter services.

(Q) All Standard and Other Conditions attached to the Notice of Determination of Need shall remain in effect for a period of five years following completion of the project for which the Notice of Determination of Need was issued, unless otherwise expressly specified within one or more Condition.