RWJBarnabas HEALTH

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Via Electronic and Overnight

June 28, 2024

Mr. Michael Kennedy, J.D.
Executive Director
Certificate of Need and Licensing
New Jersey Department of Health, State of New Jersey
120 South Stockton Street, 3rd Floor
Trenton, NJ 08608

Re: Monmouth Medical Center
Certificate of Need #2024-04352-13;01

Dear Mr. Kennedy:

Thank you for reviewing our application for the relocation of select services to a new proposed second acute care campus. We have had an opportunity to review the completeness questions dated June 12, 2024, and our responses are provided in a questions and answer format as Attachment A. Enclosed in the overnight mailing are five (5) copies and a memory stick with a file copy.

We appreciate the Department's consideration of our application to enhance the existing services offered by MMC to the many communities seeking care at our facilities. We are also grateful for the many community organizations that have expressed support for our vision to upgrade our facilities including a new campus location. Enclosed additional letters of support are included as Attachment B. These are from the Brazilian Help Center of Long Branch, Chabad of the Shore in Long Branch and St. James' Episcopal Church of Long Branch.

Should you have any questions or require additional information, please do not hesitate to contact Mr. Carney or me directly at (732) 418-8054 or Tamara.Cunningham@rwjbh.org.

Sincerely,

Tamara Cunningham

cc: Jeff Kasko, Team Leader, DOH
Eric Carney, President and Chief Executive Officer,
Monmouth Medical Center and Monmouth Medical Center Southern Campus.

ATTACHMENT A: Questions and Responses

NAME OF APPLICANT: **Monmouth Medical Center**

CERTIFICATE OF NEED NUMBER: **2024-04352-13;01**

NAME OF REVIEWER: **Jeff Kasko**

REVIEWER'S TELEPHONE NUMBER: **(609) 292-6552**

REVIEWER'S EMAIL ADDRESS: **Jeff.Kasko@doh.nj.gov**

Below are the completeness questions and responses provided in Q & A format.

1) **Please provide the statutory and/or regulatory authority for establishing a new, general acute care hospital at Fort Monmouth that will not replace, but operate in addition to, the existing hospital in Long Branch. What statute or regulation do you believe permits the Department to approve the CN application as presented?**

Response:

Monmouth Medical Center ("MMC") has filed this application (the "Application") pursuant to N.J.A.C. § 8:33-3.1 et. al., which govern the certificate of need process. The Application covers the request by MMC to relocate certain beds and services from one physical location to another physical location within the same planning region in order to more efficiently and effectively promote increased quality, care and access to health care in the surrounding community.

Through enactment of N.J.S.A. § 26:2H-1 et al, the New Jersey legislature set the health care policy objectives for the State and delegated the certificate of need and health planning authorities to the New Jersey Department of Health (the "Department") and the New Jersey Commissioner of Health (the "Commissioner"). The Department is charged with the "central responsibility for the development and administration of the State's policy" with respect to health care facility matters subject to any specific regulations promulgated by the Commissioner. (N.J.S.A. § 26:2H-1). This authority includes the ability to recommend approval of an application for certificate of need to the Commissioner with respect to "the construction of a facility . . . if the facility is the subject of a health planning regulation adopted by the Department of Health", subject to certain exceptions to the certificate of need process. (N.J.S.A. § 26:2H-7(e); N.J.S.A. § 26:2H-5.8(b); N.J.A.C. § 8:33-3.1). In addition, the Department has oversight authority over the relocation of licensed beds and services within the same planning region (N.J.A.C. § 8:33-3.4; *see In re Certificate of Need Issues to Burris Post Acute Network/Wayne, LLC*, No. A-5772-12T2, 2014 WL 10213204 (N.J. Super. Aug. 13, 2015) (affirming the Department's approval of a relocation of certain licensed beds within the same health planning region)).

Thus, there is statutory, regulatory and case law authority that confirms that the Department has the requisite oversight authority to review and approve this Application.

I. The Application has Components that are Subject to the Certificate of Need Process.

The Application is for the relocation of certain beds and services and, as such, may be subject to full certificate of need review process unless it falls under certain exemptions or under the expedited review process.

A. Many (but not all) of the Services Covered in the Proposed Project are Exempt from the Certificate of Need Process.

As outlined in the narrative submitted with the Application ("Narrative"), MMC seeks to relocate the following services and associated beds: Medical/Surgical, Intensive Care/Critical Care, Obstetrical, Pediatric, Pediatric Intensive Care, and Neonatal Intensive Care. Some services, including Medical/Surgical, Intensive Care/Critical Care, Obstetrical, and Pediatric beds, are exempt from the certificate of need approval process (N.J.A.C. § 8:33-6.1(a); N.J.S.A. § 26:2H-7a; N.J.S.A. § 26:2H-7c). Others, such as Pediatric Intensive Care and Neonatal Intensive Care beds, require a full certificate of need review as they do not fall under specific exemptions. Despite this, the certificate of need requirements primarily address concerns about *increasing* bed counts. The Application does not seek to increase the number of licensed Pediatric Intensive Care and Neonatal Intensive Care beds, but rather to relocate them to a newly-constructed, modern facility, enhancing care for patients, their families, and hospital staff.

Regarding specific beds or service lines, although there will be a reduction in bed count, decreases in bed counts are exempt from certificate of need approval (N.J.A.C. § 8:33-3.2). This reduction aligns with public health goals of improving healthcare efficiencies and encouraging the use of modern, less invasive technologies (N.J.S.A. § 26:2H-1; N.J.S.A. § 26:2H-7.4). Thus because a reduction in bed count does not require certificate of need approval, it is not the focus of this Application.

B. This Application Should be Subject to Expedited Review.

To the extent not otherwise exempt from the certificate of need process, the proposed relocation of certain licensed beds and services should be subject to the expedited review process because it requests approval to relocate beds within the same planning region.

N.J.A.C. § 8:33-3.4 expressly promotes relocation of licensed beds and services within the same planning region by making relocations subject to an expedited review process:

> For services for which there is a specific licensed bed complement, ***the relocation of a portion of a facility's licensed beds or the entire service from one licensed facility (sending facility) to another (receiving facility) located within the same planning region . . . shall follow the expedited***

> ***review process, unless the beds or service at issue are otherwise exempt*** from the certificate of need requirements in accordance with these rules.

(N.J.A.C. § 8:33-3.4(a)(3); *see also* N.J.A.C. § 8:33-5.1(a)(11))[1]

This regulation applies to the proposed project described in the Application because MMC is both the sending and receiving facility – both the Long Branch location and the new Fort Monmouth location will be operated under the same Medicare and Medicaid provider numbers and the same Federal EIN and thus all services should be licensed under the same MMC license.

This interpretation aligns with public policy goals, as detailed below, because relocating licensed beds and services within the same planning region "will not have any measurable impact upon the health care delivery system as a whole." Therefore, it addresses the concerns the Legislature aims to safeguard against with the full certificate of need review process. (*In re Certificate of Need Issues to Burris Post Acute Network/Wayne, LLC*, No. A-5772-12T2, 2014 WL 10213204, at *6 (N.J. Super. Aug. 13, 2015)).

However, because certain beds and service lines in the proposed project are not exempt from the certificate of need review process (i.e., the Pediatric Intensive Care and Neonatal Intensive Care beds, as discussed in subpart I.A. above), and the Department determines that the Application should therefore not be subject to expedited review, MMC requests that the Department consider the Application under full review.

C. Certificate of Need Review of New Buildings

While the proposed project requests a relocation of select beds and services, those beds and services will be moved to a newly constructed, state-of-the-art building. N.J.A.C. § 8:33-3.5 (regarding buildings) calls for the establishment of a new health care facility to be subject to the full review process. In other words, under N.J.A.C. § 8:33-3.5(a)(1), a full certificate of need review is required, unless the proposed project either falls under: (i) an exemption to the certificate of need process (as set forth in N.J.S.A. § 26:2H-7a); or (ii) an expedited review process (as set forth in N.J.A.C. § 8:33-5.1(a)).

As discussed in subpart I.A. above, although many of the beds and services subject to this Application are not of the types of beds and services that are subject to the certificate of need review process, some of the beds and service lines in the proposed project are arguably still subject to the certificate of need process (even though the Application does not seek to increase these services or beds). Accordingly, if the Department determines that the Application requires review under the certificate of needs process, and that expedited review is not warranted, then a full review should be undertaken pursuant to N.J.A.C. § 8:33-3.5.

II. New Jersey Laws and Regulations Promote Approval of the Application.

[1] N.J.A.C. § 8:33-3.4(a)(3) and N.J.A.C. § 8:33-5.1(a)(11) use the identical language and discuss the same topic.

Relocating beds and services from one facility to another within the same county and planning region ensures continued access to care, while also improving efficiencies of care and quality of care by promoting the development of new state-of-the-art facilities equipped with modern health care technologies (discussed in greater detail in the Narrative). Therefore, the Application promotes the objectives of the certificate of need approval process.

A. This Application Promotes the Stated Policy Goals of the State.

In enacting the Certificate of Need Reform Act, the New Jersey legislature was clear in its intent. The stated public policy is to promote the highest quality of care, efficiently provided, and accessible at a reasonable cost for hospital and related health care services. The New Jersey legislature charged the Department with ensuring that such policy is appropriately implemented in accordance with applicable law. (N.J.S.A. § 26:2H-1; *In re Certificate of Need Issues to Burris Post Acute Network/Wayne, LLC*, No. A-5772-12T2, 2014 WL 10213204, at *3-4 (N.J. Super. Aug. 13, 2015)).

New Jersey legislature set forth formal legislative findings clarifying its intent with the Certificate of Need Reform Act, which include the following:

- The "development of new medical technologies and innovations in medical technology exposed the inefficiencies inherent in centralized health care planning."
- There have been "significant changes in the economics of the health care system" since the inception of the certificate of need review process.
- "Decisions as to health care services, the acquisition of medical technology, and the expansion of facilities can best be made by the health care provider based on [its] expertise in delivering health care services to the community [it] serves."
- "The appropriate role of the State . . . [is] to ensure quality of care."

(N.J.S.A. § 26:2H-6.1(c) – (g))

Based on the above findings, it is evident that the policy objectives aim to enhance efficiencies, promote the adoption and implementation of new medical technologies, and ensure continuous improvement in the quality of care for the communities served.

As discussed in the Narrative, the Application for relocating certain beds and services to a new MMC campus would enable MMC to better serve its community and patients with state-of-the-art technologies. As the first hospital established in Monmouth and Ocean counties nearly 140 years ago, Monmouth Medical Center's Long Branch campus presents significant challenges and inefficiencies for implementing the planned updates. Modernizing this facility would be considerably more costly and disruptive to patient care operations. Moreover, even extensive construction at the Long Branch campus would fall short of what MMC could achieve at a new site, which offers more space to enhance its licensed beds and services.

Approval of the Application would prevent MMC from becoming outdated in the medical care it provides, thus averting a decline in quality of care, potential financial distress, and possible closure. Conversely, approving the Application would support the stated goals of increasing efficiencies and quality of care, implementing modern technologies, and preserving access to healthcare.

Furthermore, the newly constructed, state-of-the-art facility with advanced technologies would bolster MMC's partnership with Rutgers Medical School, thereby attracting and retaining more physicians within the State.

B. There is Precedent for Approving a "Split" Medical Center Campus.

Support for similar relocations of certain beds and services, and separate medical center campuses, is found in previous approvals by Department. The Department's prior approvals permitted and recognized separate campuses for both acute and emergency services. For example:

- Monmouth Medical Center Southern Campus, operates its psychiatric beds at a Toms River location separate and apart from its Lakewood site (Hospital License #11502).
- Trinitas Regional Medical Center maintains its psychiatric beds at the New Point Campus located at 665 E. Jersey Street, whereas its other licensed services are located at 225 Williamson Street.
- In 2010, the Department provided a certificate of need approval (CN# ER 100506-07-01) for a proposed project in which Newark Beth Israel Medical Center would relocate a number of intermediate neonatal beds to the Christ Hospital campus and operate a remote unit.

On a final note, it should be noted that the Center for Medicare and Medicaid Services ("CMS") expressly approves of geographically separated hospital facilities in the same metropolitan area. In the CMS State Operations Manual, CMS sets forth Hospital Merger/Multiple Campus Criteria (Rev. 201, 06-19-20) in Chapter 2, providing that "when a hospital establishes an additional hospital facility, geographically separate but in the same metropolitan area, the SA determines whether the additional hospital facility will be certified as a separate hospital or whether it can be considered a single hospital."

In sum, there is compelling precedent and guidance supporting the approval of MMC's request to relocate certain beds and services to a new, advanced facility within the same health planning region.

2) Please confirm that all mandatory services at general hospitals, both inpatient and outpatient, as required by N.J.A.C. 8:43G-2.12, will be provided at both the Long Branch and Fort Monmouth locations.

Response:

Monmouth Medical Center will meet its obligations to provide mandatory services as identified at N.J.A.C. §8:43G-2.12 to serve each acute care campus. Outpatient service requirements will continue to be met through direct and/or service agreements such as the clinic services provided by FQHC as previously approved by the Department.

3) **The project summary mentions construction of a modern, technologically advanced, state-of-the-art facility at Fort Monmouth and upgrades at the older Long Branch facility (Section I, page 14). Please provide a description of the upgrades that are planned for the Long Branch hospital.**

Response:

The upgrades currently planned for the Long Branch campus include renovating space in the Todd Building, the newest inpatient hospital building on campus (1987) and best designed for renovation, to create a new state-of-the-art psychiatric facility. The psychiatric beds would be relocated from the Alexander Pavilion, a building constructed in 1968. Behavioral health is a top priority for upgrades based upon service need and demand.

Creation of state-of-the-art acuity adaptable beds is also being planned for the Todd Building. The hospital intends to build at least 12 beds of the planned 48 beds to ICU standards and operate as acuity adaptable patient rooms meeting any need for intensive care services and able to step down care to intermediate or general care as needed by the patient. The hospital plans to operate the Stanley ICU Unit (the Stanley Building was constructed in 1978), which contains 18 beds, as an acuity adaptable unit while phasing renovation work for 48 Medical Surgical / ICU beds in the Todd. Pharmacy will be upgraded and relocated to best serve the campus.

The Cranmer Surgical Pavilion (built in 1999 and connected to the Todd Building) will remain. Also, Lab and Radiology services will remain in current locations in the Stanley Building which is connected to the Todd Building.

4) **How long does MMC plan to operate the existing hospital in Long Branch? Are there any long-range plans to eventually relocate all MMC Long Branch services to the new Fort Monmouth hospital, or to eventually close or re-purpose its existing use as a general hospital?**

Response:

MMC is making a significant investment in the Long Branch site and there are no current plans to close or repurpose the Long Branch campus. The planning timeframe for this project spans a number of years and is based upon current knowledge and expected utilization of the site. As

future demand/needs for services may change, MMC would revisit planning to appropriately adapt either the Long Branch or Fort Monmouth campus.

5) Regardless of the answer to #4 above, will the planned Fort Monmouth facility have the ability to expand its physical plant and services in the future, if necessary?

Response:

One of the planned towers to be constructed at the Fort Monmouth campus is expandable vertically by a floor. The Long Branch campus would retain capability of expansion as well. There is the flexibility to expand.

6) Please confirm MMC understands that its plans to relocate and expand the number of neonatal intensive care unit (NICU) beds licensed to MMC (Section I, page 14 and page 23) are being done without the required CN approval for additional NICU beds and that construction of additional NICU space at the Fort Monmouth hospital assumes the risk that a future CN Call or future awarding of additional NICU beds to MMC is not guaranteed.

Response:

The applicant understands. This was also noted in the application narrative on page 21. MMC is currently approved and licensed for 31 NICU beds. The plan calls for a combined unit of level II and level III beds which will be operated at the current licensed levels until the next CN call for NICU beds, at which time an additional nine (9) beds will be requested in the application submitted at time of a future call. It is noted that a limited call was issued in February 2019 and subsequently cancelled by the Department after applications were submitted.

Capital construction is expensive and given the past growth in obstetrical and neonatal services, the hospital wants to be best situated to meet the care demand.

7) Please explain why no changes in hospital admissions are projected over the next two years (Section I, page 16) and how you arrived at these projections.

Response:

The projections provided are based on two factors: current utilization trends as experienced by the hospital over the last several years; and, from analysis of five (5) and ten (10) year projection of

our service area's utilization made by outside consultancy experts in healthcare. Inpatient admissions were 22,653 in 2021, and 22,895 in 2023 (less than a 1% change). The consultancy estimates also place volume at a stable level, therefore the constant volume project methodology was selected.

One of the "Think Tank" consultancies of which estimates were reviewed was from the Health Care Advisory Board ("HCAB"), a consultancy organization with over 4,500 members and over 200 employed experts that has worked in healthcare for over 40 years. HCAB conducts research, monitors industry and political trends as well as developing information and data tools to assist organizations in navigating a changing healthcare landscape. The other consultancy think tank is Sg2, a Vizient Company, that serves more than 1,700 members across multiple segments, including academic medical centers (AMCs), life sciences/suppliers and integrated delivery networks (IDNs). Sg2 staff include a team of seasoned thought leaders (e.g., strategists, former healthcare executives and service line leaders, physicians and nurses, data scientists, and entrepreneurs) who offer a future-focused perspective and enterprise-wide expertise in areas such as strategic planning and prioritization, value-based care, physician alignment, and virtual health. The application identified Sg2 trends in more detail so more information on the HCAB forecast methodology is provided below.

HCAB convenes a team of experts annually to forecast inpatient and outpatient volumes for the next five and ten years using a Delphi method along with detail examination of historical utilization and use rates (population changes). The anticipated future changes, are grouped into six categories along with population change forecasts and tools allow application to specific markets with projected population changes. The six groups and general impact are:

- Population changes and demographic shifts will have positive impacts (increase in utilization) due to the growth and aging of the population.
- Insurance changes have a negative impact in both inpatient and outpatient settings. Expectations are for continued expansion of insurance coverage. However, payer steerage, cost sharing through high-deductible health plans, and tactics like preauthorization will continue to hold back utilization and shift to least cost settings.
- Disease prevalence drives increased utilization. More utilization is expected per person because of increased prevalence of chronic conditions and patient multi-morbidity.
- Technology adoption will decrease inpatient utilization but have a positive impact for outpatient utilization. That's largely the result of minimally invasive techniques that continue to shift care to outpatient settings, in addition to telehealth shifting the care to the patient's home.
- Readmission efforts will decrease inpatient utilization as hospitals continue to prioritize avoiding readmissions and shifting appropriate patients to observation status.
- Care management will continue to result in improved management of chronic conditions, reducing and delaying hospitalizations. A focus on delivering care in the most appropriate settings will further reduce inpatient

utilization. These trends will lead to reduced inpatient utilization but increased outpatient utilization.

Applying the HCAB expected national changes to the MMC population suggests an adult inpatient utilization will decrease 1.1% over the next 5 years, and have a slight 0.3% increase over the next 10 years. The HCAB projected decreases in pediatric inpatient volumes of 10% over five years growing to 15% in ten years.

The Sg2 projection, as detailed in the application narrative, projects a modest increase of less than half a percent (0.5%) growth for adult inpatient utilization over the ten-year timeframe and a more modest decline of 0.3% in pediatric cases. The Sg2 forecasting tool has been adjusted by the Sg2 to reflect regional nuances and expectations.

Both HCAB and Sg2 place volume at a comparative stable level, therefore the constant volume project methodology was confirmed as keeping with utilization trends and expert projections.

8) Please explain why no changes in visits to the Emergency Room or Clinic(s) are projected over the next two years (Section I, page 17) and how you arrived at these projections.

Response:

The gross ED visits at MMC decreased from 46,423 visits in 2022, to 45,515 visits in 2023. As part of our strategy to reduce non-emergent cases from the ED and expand access to outpatient services, we have increased the availability of primary and specialty care services throughout the service area with sites available on the hospital campus, at our Wellness Center in Eatontown which includes urgent care, and in Neptune. Another center will soon open in Tinton Falls as part of Phase I of the Vogel Medical Campus.

The sites are staffed with Barnabas Health Medical Group physicians who accept both Medicaid and Medicaid managed care and provide access to medically under insured patients. In addition, our clinic volumes have not increased at our specialty clinics. All primary care, obstetrical and pediatric care services will continue to be provided under an agreement with the Monmouth Family Health Center.

Most recent utilization and these initiatives underscore our rationale for projecting stable volume in the ED and specialty clinics.

9) Please explain why the projected admissions table (Section I, page 16) lists no increases for NICU admissions, but the project summary lists increased demand and plans to offer an increased number of NICU beds from 23 to 40 (subject to a CN Call) at the Fort Monmouth facility.

Response:

As a Regional Perinatal Center that provides care to high need communities, MMC needs to assure sufficient capacity to meet the ebbs and flows of expressed demand for services. Lakewood is the origin of the highest number of births and neonates in the State and over 50% of obstetrical care for this community is provided at MMC.

Current NICU utilization, unlike medical surgical volumes, has experienced high occupancies and has not been comfortably met in its current licensed bed complement of 31 beds. For example, in 1st Quarter 2023, the occupancy for our NICU was over 80% and most recently, the hospital has experienced even greater occupancy. The hospital recently submitted an occupancy surge waiver. In February 2024, there were more than ten days of occupancy at 30 or more beds. The hospital would be remiss not to address its past and current capacity needs.

10) Please confirm that the current/future licensed beds table (Section II, page 27) lists current NICU beds (intensive and intermediate) but does not list proposed beds being located at either the Long Branch or Fort Monmouth locations.

Response:

The NICU beds are identified in the third column in Table 2.1 for the proposed beds at Fort Monmouth. The line is NICU with 40 beds identified to reflect the intent to construct 40 Level III capable beds and to serve both intensive and intermediate care needs and secure approval for operation as acuity adaptable. The licensed capacity is currently 23 Intensive and 8 Intermediate beds as identified in the first column.

11) Please provide further explanation (project summary and Section II, page 27 chart) for plans to not provide any adult intensive/critical care unit (ICU/CCU beds at the Long Branch facility and how ICU/CCU patients at that hospital will be care for.

Response:

As discussed in the response to question 3, the applicant intends to renovate units in the Todd Building and phase up to 48 beds. At least 12 of the 48 rooms will be built to ICU standards to assure highest acuity care can be rendered. The facility can license a number of these 12 beds as ICU and work with the Department to secure approval to operate as acuity adaptable beds. The 18-bed ICU unit in the Stanley Building will remain open as an acuity adaptable unit until the Todd renovations are completed.

12) Please provide a more detailed explanation for the need to hire increased staff in certain areas (engineering, environmental services, security, outpatient services, and ancillary services) but not staff in other areas involving medical, nursing, or inpatient services.

Response:

The proposed project splits services amongst two campuses. Both campuses will require support services (engineering, environmental, security, dietary) and this is reflected in expected FTE additions. Overall, there is a planned increase of 326 FTEs. Most of these are clinical professionals identified by service area and not by specific job class. Operating two EDs will increase medical and nursing staff working in this critical service area as well as clinical professionals working in the OR (+20) and SDS (+23 FTEs) programs at both campuses. The plans also include a 36 FTE increase for inpatient medical-surgical services, a 4 FTE increase in nursing supervisors and an increase in Pharmacy (+15). These are identified in detail in Exhibit D, pages 51 – 54.

13) Please provide an explanation for the patient utilization projections table (Section II, page 39, table 4.1), which shows a constant volume (no changes) of projected admissions for all categories for the next seven years, and how you arrived at these projections.

Response:

The historical pattern and projections examined are discussed in the response to question 7. Capacity is assured based upon historical experience with adjustments to OB and NICU capacity that is based upon historic and most recent utilization. The hospital reviewed several methods and discussed within the application, the estimates generated through the Sg2 methodology. More reliance was placed on the Sg2 method as the consultants had applied regional trends to provide a more hyper-localized forecast of patient demand. In question 7, we reviewed the HCAB methodology. Below we detail the Sg2 methodology.

The estimates relied upon expected changes in population growth/decline, the disease burden for the service area, medical and technological advancements in care, as well as the impact of changing reimbursement policies and insurance coverage. Because these issues will continue to exert an impact on the use of inpatient and outpatient services into the future, the analysis utilized the bed demand for casting tool, the Market Demand Forecaster ("MDF") version 2023, developed by Sg2. The MDF projects volume and patient days by service lines for planning purposes.

Sg2's forecasting tool starts with trends in the prevalence and incidence of underlying health conditions. The disease-based model, impact of Change®, analyzes patient level local market

trends to project demand across inpatient and outpatient services. The Sg2 model incorporates local market assumptions to generate more regionalized projections.

The MDF tool generates estimates and projections based upon select factors that impact volume. The MDF national demand models are constructed from several data sources, including: HCUP National Inpatient Sample (NIS); Healthcare Cost and Utilization project (HCUP) 2019; Agency for Healthcare Research and Quality, Rockville, MD; Proprietary Sg2 All-Payer Claims Data Set, 2021;41 the following 2021 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2023; and Sg2 Analysis, 2023.

The Sg2 Impact of Change (IoC) methodology considers various interconnected factors that influence utilization across inpatient and outpatient services. Its key aspects are:

1. Disease-Based Forecasting:
    - Begins by analyzing trends in the prevalence and incidence of underlying health conditions.
    - Patient-level data and local market trends are evaluated to project demand for healthcare services.
    - Focusing on specific disease groupings and procedures, the model provides insights into future volumes.
2. Impact Factors:
    - Sg2's experts annually assess and update a series of impact factors.
    - These factors reflect trends specific to disease categories and procedures.
    - It is used to forecast how variables such as patient acuity, site of care shifts, and alternative care models will influence healthcare volumes.
3. Site of Care Shifts:
    - Rising patient acuity and evolving care models drive changes in where healthcare services are delivered.
    - The forecast considers virtual care settings, urgent care, retail clinics, offices and homes. Approximately 26% of all evaluation and management (E&M) visits are projected to occur in virtual care settings by 2033.
4. Utilization Trends:
    - Inpatient volumes are expected to experience modest increases due to rising patient acuity.
    - Outpatient demand is likely to outpace population-based projections.
    - Utilization patterns vary across different service lines.

The impact forecast for MMC in its entirety is a modest increase of less than half a percent with an increase of 84 cases. The growth is in OB, neonatal and Behavioral Health. The Sg2 forecasts specific to its primary and secondary service area is slightly higher at 130 cases, a 0.7% increase, due to a drop in the decrease expected from the out of area market. The service area represents 83% of MMC's total discharges.

The Sg2 IoC methodology projections for 2023-2033 projects increasing utilization in the outpatient procedures across all markets, including MMC. The Sg2 outpatient projection by service line for MMC's service area shows a 18.5% growth expectation. The Sg2 outpatient projection by site of service for MMC's service area shows hospital outpatient/ambulatory surgery expected to grow 10.8%, the major procedure growth at 19.2% and minor at 12.2%. For all sites of care, outpatient volumes are expected to increase significantly.

The Sg2 projections were cross checked with volume projections for MMC's service area generated by the Health Care Advisory Board ("HCAB"), another national healthcare consultancy firm and think tank. Both were similar directionally with HCAB indicating a decline of 1.1% over the next 5 years and a growth of 0.3% over the next 10 years in the adult population with declines in the pediatric patient population. SG2 projected a mere decline of 0.3% in pediatric cases but had a lower base starting point. In both cases, projections tended to be in line with recent experience. These changes essentially place future inpatient volume at a stable level.

Patient days will be influenced by a number of factors which will increase patient days, including aging service area population with increased comorbidities, increased acuity and length of stay, increased number of patients with infections, and growth in neuroscience and behavioral health service lines. Factors influencing declines in patient days will include value-based measures focusing on reducing LOS and readmissions, vaccine usage, enhanced technology in the home setting, increase in community-based care, consumerism and pricing incentives, use of artificial intelligence, virtual healthcare, improved transitions in care, increased use of non-physician advanced practitioners and payers/insurers channeling patients to the lowest cost settings.

These trends are expected to increase ICU utilization. An aging population and the shift in sites of care for lower-acuity patients will increase the complexity of cases, further shifting the distribution of ICU and med/surg beds. In addition to rising acuity levels of patients, hospitals can expect to see increasing emergency cases and increasing utilization of behavioral health patients which will continue to place stress on the throughput of the emergency department. Hospital outpatient department short stays and observation cases will contribute to an increased proportion of hospital activity. Observation cases will have an evolving role within the footprint of the hospital campus. The use of acuity adaptable beds design will assure capacity to meet the highest acuity needs while building an infrastructure that is expected to operate more effectively and efficiently. Acuity adaptable beds, provision of med/surg observation beds and the fact that all beds are private and not gender dependent, will ensure sufficient capacity to meet our patients' current and future demands for services.

The projection models were used as guidelines in developing plans for the new facility. Also considered were factors increasing the use of ICU beds including the increased number of patients

with cardiac disease who need step down or intermediate care, as well as the growth in robotic and other sophisticated surgical procedures and the impact these trends will have on ICU/intermediate care utilization over time. Long Branch will maintain 48 Medical/Surgical/observation licensed beds and at least 12 acuity adaptable rooms meeting ICU standards to provide intensive care capacity promoting care access for Long Branch residents. Psychiatric beds will also remain on the Long Branch campus and the hospital will continue to pursue enhanced quality and Center of Excellence status for psychiatric services. There will be no diminishment in the number of psychiatric beds as these are governed by specific Certificate of Need rules. Medical surgical beds will be reduced from 318 beds to a total of 138 beds: 90 on the Vogel campus and 48 observation/med/surgical/ICU beds on the Long Branch campus. Obstetrical beds will increase from 54 beds to 70 beds (64 post-partum and 6 antepartum beds). A 16 Bed Pediatric Unit with acuity adaptable beds will be provided with licensed pediatrics beds reduced from 15 beds to 11 beds and sustaining 5 licensed PICU beds.

14) Please explain why the mention of expected inpatient volume increases (Section II, page 41) does not appear to match the projections mentioned above (Section II, page 39, table 4.1).

Response:

The slight increase projected by Sg2 relates to the projection calculated from the PSA/SSA. This increase was offset by decreases in cases anticipated to come from the 17% of patients who come from out of area. Additionally, two sources were consulted in developing these projections and the HCAB projection methodology would have resulted in a small decrease overall. Given these factors it seemed prudent to assume that volumes would remain stable.

15) Please explain how the projected market demand increases in the MMC service area for selected hospital services (Section II, page 44, table 2.8) does not coincide with the projected admissions for the next seven years (Section II, page 39, table 4.1).

Response:

As with our above responses, much of the increase anticipated in the primary service area is projected to be offset by decreases in admissions from out of area patients. Additionally, with MMC's development of multiple outpatient sites throughout the service area, it is expected that any growth will be attributed to these sites rather than to the hospital.

16) Please provide additional information, including planned days, hours, and/or contracted services, to provide transportation services between the Long Branch and Fort Monmouth hospital sites for patients, visitors, support persons, staff, etc.

Response:

Our current plans are to provide non-medical transportation assistance between the Long Branch and Fort Monmouth campuses daily between the hours of 7 am and 7 pm. We envision the service to operate on a demand basis with scheduled pick-ups and drop-offs.

ATTACHMENT B: Letters of Support

BR Center
489 Broadway
Long Branch NJ 07740
brhelpcenter@gmail.com
Phone: (732) 263-1100 Fax: (732)263-1102

Long Branch, April 09, 2024

Kaitlan Baston, M.D.
Commissioner of Health
P.O. Box 360
Trenton, NJ 08625-0360

As the Director of the Brazilian Help Center in Long Branch, I am pleased to offer my support for Monmouth Medical Center's (MMC's) project to expand acute care services at the Tinton Falls site. Although this expansion will relocate some acute care services, I believe that the move will result in far more lasting benefits for the community. Moreover, critical services, including emergency department, inpatient/observation medical beds, inpatient and outpatient behavioral health services, specialty clinics, and outpatient services, will all continue to be available at the current site. MMC has a proven track record of providing high quality health care services. I urge you to approve their request to expand the acute care services.

I am aware of the Medical Center's commitment to the Long Branch community and the residents of Monmouth County. I believe that the new site will provide residents with a new state-of-the-art medical facility and provide the latest innovations in medical technology and infection control. In addition, the Long Branch campus will remain a vibrant health care facility that will continually evolve to meet the unique needs of the Long Branch community. Both campuses will ensure that future generations continue to have access to the quality patient care from a trusted and respected medical provider.

Residents of this area have long relied on Monmouth Medical Center to provide quality emergency, inpatient, and outpatient care. MMC is also committed to continuing partnerships with many local non-profit and religious organizations to achieve our collective mission to keep the residents of our City well. Together, the Long Branch campus, with the new campus and MMC's various outpatient sites, will ensure optimal access to health care services throughout the County.

Sincerely,

Luciana Silva
President

בס"ד

CHABAD
OF THE SHORE

April 3, 2024

Dear Commissioner Baston,

As the Rabbi at Chabad of the Shore in Long Branch, I am pleased to offer my support for Monmouth Medical Center's (MMC's) project to expand acute care services at the Tinton Falls site. Although this expansion will relocate some acute care services, I believe that the move will result in far more lasting benefits for the community. Moreover, critical services including the emergency department, inpatient/observation medical beds, inpatient and outpatient behavioral health services and surgical services, specialty clinics and outpatient services will all continue to be available at the current site. MMC has a proven track record of providing high quality health care services. I urge you to approve their request to expand their acute care services.

I have first-hand knowledge of MMC's commitment to the Long Branch community and the residents of Monmouth County. I believe that the new site will provide residents with a new state-of-the-art medical facility that offers the latest innovations in medical technology and infection control. In addition, the Long Branch campus will remain a vibrant heath care facility that will continually evolve to meet the unique needs of the Long Branch community. Both campuses will ensure that future generations continue to have access to high quality patient care from a trusted and respected medical provider.

Residents of this area have long relied on MMC to provide quality emergency, inpatient and outpatient care. MMC is also committed to continuing partnerships with many local non-profit and religious organizations to achieve our collective mission to keep the residents of our city well. Together, the Long Branch campus, with the new Tinton Falls campus and MMC's various outpatient sites, will ensure optimal access to health care services throughout the county.

Sincerely,

Rabbi Yaakov Greenberg

620 Ocean Avenue
Long Branch, NJ 07740
732-229-2424
info@chabadshore.com
Chabadshore.com

CHABAD Young Jewish Professionals JTEEN

ST. JAMES'
EPISCOPAL CHURCH
300 Broadway, Long Branch, NJ 07740
administrator@stjames-longbranch.org
732-222-1411

March 29, 2024

Kaitlan Baston, M.D.
Acting Commissioner of Health
P.O. Box 360
Trenton, NJ 08625-0360

Dear Commissioner Baston,

As the Junior Warden of the Vestry at St. James' Church in Long Branch, I am pleased to offer my support for Monmouth Medical Center's (MMC's) project to expand acute care services at the Tinton Falls site. Although this expansion will relocate some acute care services, I believe that the move will result in far more lasting benefits for the community. Moreover, critical services including the emergency department, inpatient/observation medical beds, inpatient and outpatient behavioral health services and surgical services, specialty clinics and outpatient services will all continue to be available at the current site. MMC has a proven track record of providing high quality health care services. I urge you to approve their request to expand their acute care services.

I have first-hand knowledge of MMC's commitment to the Long Branch community through their support of our food pantry, St. Brigid's pantry and kitchen, and the residents of Monmouth County. I believe that the new site will provide residents with a new state-of-the-art medical facility that offers the latest innovations in medical technology and infection control. In addition, the Long Branch campus will remain a vibrant heath care facility that will continually evolve to meet the unique needs of the Long Branch community. Both campuses will ensure that future generations continue to have access to high quality patient care from a trusted and respected medical provider.

Residents of this area have long relied on MMC to provide quality emergency, inpatient and outpatient care. MMC is also committed to continuing partnerships with many local non-profit and religious organizations to achieve our collective mission to keep the residents of our city well. Together, the Long Branch campus, with the new Tinton Falls campus and MMC's various outpatient sites, will ensure optimal access to health care services throughout the county.

Sincerely,

Nancy Francese

Nancy Francese
Jr. Warden
St. James' Episcopal Church