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May 23, 2012

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VIA E-MAIL

Suellen Wideman, Esquire
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Md. 21215-2299

Re: In the Matter of Proposed New Hospital in Montgomery County
 Holy Cross Hospital of Silver Spring (Docket No 08-15-2286)
 Clarksburg Community Hospital (Docket No. 09-15-2294)
 Before The Maryland Health Care Commission

Dear Suellen:

In accordance with the schedule established by Dr. Moon in this matter, attached is an e-mailed copy of Adventist's Exceptions To The Recommended Supplemental Decision and Adventist's Exhibits which accompany its Exceptions. These items are being sent to the Maryland Health Care Commission prior to noon on May 23rd.

In keeping with the schedule established by Dr. Moon, 30 copies of these Exceptions, and the Exhibits thereto, will be delivered to the Maryland Health Care Commission on May 24th.

Regards,



Diane Festino Schmitt

DFS/pad
Attachments

Suellen Wideman, Esquire

May 23, 2012

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cc: Howard L. Sollins, Esquire
Lisa D. Stevenson, Esquire
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IN THE MATTER OF	*	BEFORE THE
PROPOSED NEW HOSPITALS	*	MARYLAND HEALTH CARE
IN MONTGOMERY COUNTY	*	COMMISSION
Holy Cross Hospital of Silver Spring Docket No. 08-15-2286	*	
	*	
Clarksburg Community Hospital Docket No. 09-15-2294	*	
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**ADVENTIST’S EXCEPTIONS TO THE RECOMMENDED SUPPLEMENTAL
DECISION**

Clarksburg Community Hospital, Inc. (“CCH”) and Adventist HealthCare, Inc. (“AHC”) d/b/a Shady Grove Adventist Hospital (“SGAH”), which is also the owner and operator of Shady Grove Adventist Germantown Emergency Center (“GEC”) (collectively “Adventist”), through undersigned counsel, hereby submits its exceptions, pursuant to COMAR 10.24.01.09B to the Recommended Supplemental Decision rendered by Commissioner Marilyn Moon Ph.D, on May 15, 2012 (the “Recommended Supplemental Decision”).

The Recommended Supplemental Decision is, as Yogi Berra would say, “déjà vu all over again.” In 2011, the Maryland Health Care Commission (“MHCC”) awarded Holy Cross Hospital of Silver Spring, Inc. (“Holy Cross”) a Certificate of Need (“CON”) to construct a new 93-bed acute care hospital in Germantown, Maryland. That CON, however, was based on miscalculations, errors, and overstatements of the need for, and financial viability of the proposed new hospital. When Adventist realized that the 2011 Holy Cross Germantown CON had been improvidently granted, and had been based on evidence that Adventist had no opportunity to question, analyze or comment on, Adventist appealed.

Adventist won its appeal, and the Appeal Court took the extraordinary step of reversing, and revoking the 2011 Holy Cross CON. The Appeal Court also sent the case back to the MHCC drawing board, so that this time, any decision on whether to award a CON for the first new hospital in Maryland in 30 years would be based on a rigorous assessment of the evidence the MHCC relied on.

Following the Appeal Court's remand, Adventist received an opportunity to analyze and comment on all the population and projection evidence that supported the MHCC's findings in 2011. Adventist's analysis showed that the MHCC's calculations were fundamentally flawed and could not possibly prove either that there was a need for a 93-bed acute care hospital in Germantown, or that the proposed hospital would be financial feasible. Absent proof of both of these mandatory elements, no CON can be awarded to Holy Cross.

Adventist set forth its analysis in Comments filed with the MHCC on May 4, 2012. What was the response to the fact that Adventist demonstrated that the MHCC's 2011 Holy Cross Germantown project bed need findings were rife with errors, mistakes, miscalculations, and overstatements of need which also led to an incorrect finding of financial feasibility? The response was a Recommended Supplemental Decision which acknowledged that Adventist was right. Specifically, it admitted that:

- the 2011 CON Decision “contained miscalculations of MSGA bed need for HCH-G’s expected service area;”
- Adventist “found errors in the projection of bed need in the [CON] Decision;”
- Adventist “correctly pointed out two errors that occurred in the analysis of service area bed need in the Decision;”
- the MHCC’s “overstated base year use rate affected the range of use rates employed in projecting demand in the target year, ten years after the base year;” and

- “the Decision’s missteps in adapting the SHP methodology to adjust ALOS resulted in an inappropriately high range of ALOS for both the Medicare and non-Medicare patient population.”

Holy Cross, however – which did not even try to rebut the errors Adventist carefully and correctly documented – once again was handed a recommendation that the MHCC approve a CON to build a 93-bed hospital in Germantown, even though that recommendation is founded on improper assumptions, erroneous math, and carefully calibrated formulae that backs into its desired result.

Adventist respectfully requests that the MHCC decline to approve a second unsubstantiated CON for Holy Cross. The first new hospital in Maryland in 30 years should not be constructed on a foundation of faulty math and selective data analysis.

I. BACKGROUND

A. **The Baltimore City Circuit Court Reversed The 2011 CON Award For Holy Because The Decision Relied On Evidence The MHCC Did Not Put Into The Record Or Make Available To The Parties.**

This CON review goes back to 2008 when two hospitals separately sought approval from the MHCC to build the first new hospital in Montgomery County in 30 years. Montgomery County is Maryland’s most populous jurisdiction and a decision on a new hospital in that County will affect how health care is delivered to millions of Marylanders for years to come.

Initially, Holy Cross filed a Letter of Intent to build a new 93-bed acute care hospital in Germantown Maryland in a service area already served by numerous existing hospitals and located one mile from the Shady Grove Adventist Germantown Emergency Center. (See Exhibit

1 hereto, Excerpts of 2011 CON Decision, Appendix A at p. 27).¹ CCH then submitted its Letter of Intent to build a new 86-bed general acute care hospital in Clarksburg, Maryland.

Because the stakes were so high, both applicants requested that MHCC Chair Dr. Marilyn Moon, who had been appointed to comparatively review the two CON applications, conduct an evidentiary hearing. Dr. Moon agreed and decided to receive testimony on three State Health Plan Acute Care Hospital review criteria which must be satisfied before any new Maryland hospital can be constructed: (1) access to the proposed hospital, (2) need/cost and effectiveness of the proposed project and (3) the financial viability of the proposed hospital. (Appx. A to Ex. 1 at p. 7).

CCH and Holy Cross submitted the pre-filed testimony of their respective fact and expert witnesses. Some of the prefiled testimony discussed historical zip code and population data and projected that historical data forward to substantiate the “need” for a new hospital in the expected new hospital service areas. An evidentiary hearing commenced on these three issues on August 30, 2010. For six days, both applicants questioned each other’s data and the witnesses who championed that data. The hearing concluded on September 16, 2010 when the Reviewer heard rebuttal testimony and closing arguments.

In December, 2010, Dr. Moon issued a 181 page single-spaced Recommended Decision proposing that the Commission approve the Holy Cross CON to establish a new 93-bed general acute care hospital in Germantown and deny the CCH CON to establish a new 86-bed general acute care hospital in Clarksburg. (See Exhibit 1 at pp. 169-70). In reaching this conclusion, the Reviewer evaluated the substantial information already in the record, applied the expertise of the MHCC Staff, and expressly found that a 10% market share penetration for the Holy Cross

¹ For the MHCC’s convenience, Adventist files herewith copies of materials it references in these Exceptions. All the Exhibits attached hereto are part of the Administrative Record in this case.

Germantown project expected service area was “realistic” and “reasonable.” (Id. at p. 42 and p. 169). The Reviewer also used this 10% market share to establish there was a need for the Holy Cross hospital, and establish that the hospital would be financially feasible within 5 years. (Id.).

The Recommended Decision was replete with tables, charts, maps, and analyses that referenced Montgomery County’s historical population, Montgomery County’s existing hospitals’ historic patient origin and service areas, and that referenced Montgomery County’s historical population change rates. These historical figures predicated the Reviewer’s projections about the need for future Montgomery County hospital beds, and predicated the Reviewer’s conclusion that Holy Cross had satisfied the “need” requirement assuming 10% market penetration.

Many of these referenced data, however, were from sources that neither Holy Cross nor Adventist used or saw during the comparative review. Instead, these referenced data came from sources the MHCC obtained and then used to derive its projections of need and financial feasibility. Adventist realized that certain of this data that the MHCC referenced, relied on and cited in the Recommended Decision, was not given to the parties or made a part of the record prior to Recommended Decision which meant there had been no rigorous analysis of this data or cross-examination about it during the evidentiary phase of the proceedings.

Adventist filed Exceptions to the Recommended Decision, asking the full Commission to deny a Holy Cross CON based on improper evidence. Essentially, Adventist asked the MHCC to hit the pause button so that any decision on a new hospital in Montgomery County, would be based on sound data, and would be supported by evidence that had been rigorously and fully evaluated. (See Exhibit 2 hereto; excerpts of Adventist’s January, 2011 Exceptions). The MHCC rejected Adventist’s Exceptions, and decided on January 20, 2011 to award Holy Cross a CON and deny CCH a CON. (Exhibit 1 at pp. 168-69).

Adventist appealed to the Circuit Court for Baltimore City.² On appeal, Judge J. Michel Pierson agreed with Adventist that the 2011 CON Decision was improvidently granted. He issued a Memorandum Opinion and Related Orders (collectively the “Pierson Ruling”) which took the extraordinary step of reversing the CON Decision and thereby vitiating the 2011 Holy Cross CON. (Exhibit 3 hereto). Judge Pierson recognized that Maryland law compels any CON for a new hospital to be predicated on evidence to which all parties have had a meaningful opportunity to respond. This “meaningful opportunity to respond” ensures that agency decisions are based on evidence that has been thoroughly vetted, considered and analyzed. In particular, he held that:

The court’s review of the record convinces it that [Adventist was] not presented with a meaningful opportunity to contest the data relied upon by the reviewer. ...the significance of this information relates to the bed need standard. That standard permits an applicant to justify an increase in beds by application of projection methodology, assumptions and targets.... the Decision must be reversed to permit [Adventist] the opportunity to contest the facts noticed by the Commission after the closing of the record. The Commission must comply with the provisions of section 10-213 [of the Md. Administrative Procedures Act] by giving the parties a meaningful opportunity to contest the facts of which it took official notice. Whether [Adventist was] prejudiced by use of the information in ineluctably linked to an analysis of what part that information plays in the findings that were the foundation of the decision.

(See Exhibit 3; Pierson Ruling at pp. 2, 5-6).

B. After Analyzing The Additional Evidence, Adventist Proved That The 2011 CON Decision’s Findings Of “Need” And “Financial Feasibility” Were Based On Errors And Overstatements.

As mandated by the Pierson Ruling, the case came back to the MHCC so Adventist could have “meaningful opportunity to contest” the extra record data. (Exhibit 3 at p. 8).

² Adventist appealed the grant of a CON to Holy Cross but did not appeal the MHCC’s denial of the CCH CON.

Immediately, on March 2, 2012, Dr. Moon directed that Adventist be allowed to only “file comments” on the extra record evidence by April 2, 2012. At no time did Dr. Moon invite the parties to challenge MHCC findings in the 2011 CON Decision that had not been appealed. To the contrary, she said “I want to note that the issue on remand is limited to the use of specific data in the Commission’s decision. Parties are cautioned not to attempt to raise other issues that were or could have been raised in earlier filings before the Commission or the Circuit Court.” (Exhibit 4 hereto, March 2, 2012 Letter) (emphasis supplied).

Dr. Moon also said that after Holy Cross responded to Adventist’s comments, she “will determine whether additional filings or oral argument will be helpful to me.” (Id.). Dr. Moon’s first post-remand communication also stated that she would be issuing a Recommended Supplemental Decision – not issuing a new CON Decision – even though the 2011 CON Decision had been reversed.

Because Adventist still did not know the extent of the extra record data the MHCC had “used, reviewed and considered” when the MHCC filed the faulty 2011 CON Decision, Adventist asked that the MHCC compile that evidence and enter it into the MHCC administrative record. Then Adventist could analyze of all the information used to approve a CON for a new Holy Cross Hospital and could provide its analysis to the MHCC. (Exhibit 5 hereto; March 7, 2012 Letter).

On March 28, 2012, counsel for MHCC sent an e-mail, which identified, for the first time, the sum and substance of the extra record evidence. It said that “the data Ober|Kaler received in January of 2011 is all the extra record data. There are no additional data, assumptions, documents, etc. There simply is nothing else.”³ That e-mail further said that the

³ The MHCC gave Adventist some data in late January 2011, at a time after the 2011 CON Decision was filed, and at a time when Adventist had no ability to present its findings to the

documents “will be downloaded to a thumb drive and placed in the record.” On March 29, 2012, that occurred, and Adventist picked up the thumb drive – which contained 152 megabytes of data (the “Additional Evidence”). (Exhibit 6 hereto; March 28, 2012 E-mail).

When Adventist thoroughly analyzed the 152 megabytes of data, it determined that the bed need projections the MHCC used in 2011 were miscalculated and overstated. This, in turn meant that the Holy Cross CON application did not and could not satisfy either the MHCC’s bed need or financial feasibility requirements.

Adventist carefully described its position in Comments on the Additional Evidence Adventist filed on May 4, 2012 (Exhibit 7 hereto; “Adventist’s Comments”). Therein, Adventist showed how its analysis of the Additional Evidence manifested and highlighted two obvious errors in the 2011 CON Decision. The first error the MHCC made was using the wrong 2008 base year rate for MSGA Non-Medicare discharges. Specifically, Adventist’s Comments demonstrated that the 2011 CON Decision used 66.51 as a baseline patient discharge rate when it should have used the much lower figure of 47.29. Adventist’s comments also demonstrated that the CON Decision used an overstated average length of stay (“ALOS”) when calculating bed need. (Compare Ex. 1 2011 CON Decision at pp. 39-40 to Ex. 7 Adventist’s Comments at pp. 10-16).

The fact the 2011 CON Decision used the wrong baseline discharge and wrong ALOS calculations rate skewed and overstated the forecast of MSGA bed need for Montgomery County in 2018. (Exhibit 7 at pp. 15-16). This, in turn, necessarily means that 2011 CON Decision’s erroneous 2018 MSGA bed need projections cannot possibly support the MHCC’s finding of

MHCC about that data. On appeal, Holy Cross and the MHCC both argued strenuously to Judge Pierson that giving data to Adventist in January 2011 satisfied the law. Judge Pierson did not agree and remanded the to the MHCC to give Adventist a “meaningful opportunity” to present its findings about that evidence directly to the MHCC. (See Exhibit 3 at pp. 4-6).

“need” for the 75 MSGA beds proposed for the Holy Cross Germantown project. (Compare Ex. 7 Adventist’s Comments at p. 15 to Ex. 1 2011 CON Decision at p. 42).

Adventist’s Comments also recalculated the MSGA Gross Bed need for the residents of the Holy Cross Germantown Expected Service Area for 2018 using the more accurate rate Richard J. Coughlan, an Adventist witness and the former director of Maryland’s CON program, had derived from the Additional Evidence. Mr. Coughlan combined this new, more accurate rate with the CON’s endorsed 10% market share for the Holy Cross Expected Service Area. (Exhibit 7 at pp. 14-15). This more accurate Coughlan rate calculation led inexorably to the conclusion that the bed need projected in the 2011 CON Decision of 75 MSGA beds at an average length of stay (“ALOS”) of 4.56 was also wrong, at nearly one half day higher per MSGA case than is reasonably forecasted to be needed. (Id. at p. 15; see also comparison of Ex. 7 Adventist’s Comments at p. 12 to Ex. 1 2011 CON Decision at Tables 30 and 31).

Adventist’s Comments further explained that the MHCC’s miscalculations of base year discharge and ALOS also gutted the 2011 CON Decision’s finding that the proposed Holy Cross project was “financially viable.” (Exhibit 7 at p. 20). Indeed, Adventist’s Comments demonstrated that because the MSGA discharge rate for the Holy Cross Expected Service Area population was significantly overstated, the proposed Holy Cross Germantown project will not have sufficient revenue to be financially feasible. (Id. at pp. 17-21).

Holy Cross filed its Response to Adventist’s Comments on May 9, 2012. (Exhibit 8 hereto; the “Holy Cross Response”). Notably, Holy Cross did not even bother to refute Adventist’s findings that the CON Decision used erroneous calculations and projections to justify the need and financial feasibility for the Holy Cross Hospital. On this point, Holy Cross said only that:

The Commission is best able to assess the information related in the Coughlan Affidavit. The Commission and Staff must determine first if there was a mistake in the use rate for non-Medicare MAGA discharges for residents of Montgomery County, as AHC alleges. The Commission and its Staff must next determine the materiality of any such mistake on the five and ten-year trend adjustment in the Commission's need methodology, if the discharge rate in question that appears in Table 29 on Page 40 of the Decision is erroneous. (Exhibit 8 at p. 3).

Holy Cross continued to claim that its project was needed and remained financially viable even in the face of the mistakes and errors Adventist uncovered. To that end, Holy Cross did a quick switch to say it would achieve a 14.9% market share (even though Holy Cross had never objected to or complained about the 10% market share findings at the heart of the 2011 CON Decision). Rather, Holy Cross said merely that the MHCC's CON Decision's 10% market share was not "a ceiling." (*Id.* at p. 6).

C. The Recommended Supplemental Decision Readily Admits That Adventist Correctly Established That The MHCC Made Numerous And Pervasive Errors And Miscalculations In Projecting Need For The Holy Cross Project. Nonetheless, The Recommended Supplemental Decision Proposes To Again Award A CON For The Holy Cross Project.

After the Holy Cross Response, Dr. Moon wrote to the parties on May 11, 2012 stating that "I have reviewed the parties' filings and have determined that I do not desire additional filings, evidence, or oral arguments in this matter." (Exhibit 9 hereto; Letter, May 11, 2012 Letter). Thus, even though Adventist had pointed out significant and pervasive flaws in the foundation of the CON Decision – and even though Holy Cross proposed a change to the CON Decision's 10% market share findings without stating a single reason why those market share findings should now be reopened – the parties were not afforded a chance to present further information to the MHCC on the crucial issues of market share, need, and the financial feasibility of a new Holy Cross Germantown Hospital. Similarly, the parties were given no

opportunity to cross examine or rebut the witnesses who prepared and compiled the Additional Evidence.⁴

On May 15, 2012, the Recommended Supplemental Decision was filed. It proposed that the MHCC “approve the application of Holy Cross Hospital of Silver Spring for a Certificate of Need to establish a 93-bed general acute care hospital in Germantown.” (Exhibit 10 hereto). The recommendation was made despite the acknowledgement that the MHCC’s 2011 CON Decision was based on the very mathematical errors and miscalculations that Adventist found from the Additional Evidence. Specifically, the Recommended Supplemental Decision references the fact that the 2011 CON Decision “contained miscalculations of MSGA bed need for HCH-G’s expected service area,” (Exhibit 10 cover letter); contained “errors in the projection of bed need in the [CON] Decision ... [and] in the analysis of service area bed need” (Exhibit 10 at p. 2); “overstated base year use rate affected the range of use rates employed in projecting demand in the target year, ten years after the base year” (*Id.* at p. 3); and that “the Decision’s missteps in adapting the SHP methodology to adjust ALOS resulted in an inappropriately high range of ALOS for both the Medicare and non-Medicare patient population.” (*Id.* at p. 4).

The Recommended Supplemental Decision concludes that “Despite the miscalculations in the [2011 CON] Decision’s MSGA bed need projection that were noted by the Adventist Entities, the corrected bed need projection still supports a finding of need for the complement of 75 MSGA beds proposed for the HCH-G project.” (*Id.* at p. 6). The Recommended Supplemental Decision does this by determining that “HCH-G would still achieve approximately

⁴ Recall that Judge Pierson expressly held that the data withheld was the cornerstone of the 2011 CON Decision’s finding of bed need: “the significance of this information relates to the bed need standard ... Whether [Adventist was] prejudiced by the use of the information is ineluctably linked to an analysis of what part that information plays in the findings that were the foundation of the Decision.” (Exhibit 3 at pp. 2, 5-6).

the same level of bed use in 2018 by capturing a 15 percent share of the MSGA demand in its expected service area.” (Id. at p. 8).

In this fashion, the Recommended Supplemental Decision forsakes the 2011 CON Decision’s pronouncement that Holy Cross would achieve a 10% market share, which, was “reasonable, given the observed experience of existing hospitals.” (Exhibit 1 at p. 169). In lieu of what was “reasonable” in 2011, the Recommended Supplemental Decision now concludes in 2012 that Holy Cross should be able to pull off a market share of 15%, which is 50% higher than the share the MHCC previously found Holy Cross could obtain.

The Recommended Supplemental Decision also concludes, without any further analysis, that the Holy Cross project will be financially feasible because “[t]here is sufficient bed need in HCH-G’s expected service area for this new hospital to support a revenue base that will result in the profitable operation of the hospital. I find that, using the corrected bed need, the proposed HCH-G hospital is financially feasible.” (Exhibit 10 at p. 10). The Recommended Supplemental Decision does not perform any calculations or assessments about how the estimated Holy Cross 15% market share will affect project revenue or whether the project will be financially feasible within five years, nor does it analyze how that new, higher market share will impact other health care providers in the expected service area.

II. ADVENTIST’S EXCEPTIONS

THE RECOMMENDED SUPPLEMENTAL DECISION FAILS TO DEMONSTRATE THERE IS A NEED FOR THE HOLY CROSS HOSPITAL PROJECT.

Exception No. 1: The Recommended Supplemental Decision does not dispute or refute the fact that the need projections on which the 2011 CON Decision was based are wrong.

Of paramount importance, the Recommended Supplemental Decision does not dispute or refute the fact that the need projections on which the 2011 CON Decision was based are wrong.

To the contrary, the Recommended Supplemental Decision admits, time after time, that the 2011 CON Decision's bed need projections "contained miscalculations" (Exhibit 10 cover letter) contained "errors" "that occurred in the analysis of the service area bed need" (Ex. 10 at p. 2), used an "overstated base year use rate [which] affected the range of use rates employed in projecting demand in the target year, ten years after the base year" (*Id.* p. 3), and "resulted in an inappropriately high range of ALOS for both the Medicare and non-Medicare patient population." (*Id.* at p. 4).

Yet, the Recommended Supplemental Decision soldiers on to nonetheless suggest a CON so that Holy Cross can build a new 93-bed acute care hospital in Germantown. The Recommended Supplemental Decision does so by moving past these errors to matter-of-factly declare that "these miscalculations do not warrant any alteration in the Commission's conclusions with respect to the need for or the viability of the new hospital." (*Id.* at p. 2 of cover letter).

How does the Recommended Supplemental Decision come to the conclusion that a decision based on errors can serve as the foundation for a \$200,000,000 hospital that will be the first new hospital constructed in Maryland in 30 years? It does so by simply swapping out the 2011 CON Decision's original finding that Holy Cross would achieve a 10% market share in its expected service area and replacing it with a finding that Holy Cross will now achieve a 15% market share.

The SHP project review standards require that an applicant prove the hospital beds it seeks are needed. See COMAR 10.24.10.04B(2) and (6). An accurate and reliable projection of bed need is a core component of the CON process, and a CON based on inaccurate and unreliable projections cannot legally be approved. See HEALTH-GEN §19-126(c)(1) (mandating that all CONs "shall be consistent with the [SHP] and the standards for review established by the

Commission”); see also Adventist Healthcare Midatlantic, Inc. v. Suburban Hosp. Inc., 350 Md. 104, 121 (1998) (applications that are inconsistent with the governing SHP and CON review criteria are facially “unapprovable”); COMAR 10.24.10.04B(2).

The MHCC needs to look no further than its own conclusions in the 2011 CON Decision to verify that the latest Holy Cross Germantown CON must be denied. Therein the MHCC stated: “The need for beds at HCH-G highly depends on the market share HCH-G is expected to capture.” (Exhibit 1 at p. 84). If bed need “highly depends on the market share,” market share projections should be correct and should be based on sound research and findings.

As explained next, the 15% market share the Recommended Supplemental Decision now claims Holy Cross will achieve is based on neither. Changing express and uncontested findings midstream to move market share up by 50% is a sizable shift that warrants significantly more attention than the Recommended Supplemental Decision seeks to give it. It also warrants that the MHCC reject the Recommended Supplemental Decision.

Exception No. 2: The Recommended Supplemental Decision does not explain or establish how Holy Cross Germantown can possibly obtain a 15% market share in its expected service area.

The Recommended Supplemental Decision also states that “[i]t will be noted that, when a market capture share assumption of fifteen percent is applied to HCH-G’s expected service area, the range of corrected bed need projected for HCH-G, 59 to 75 beds, is almost identical to the overstated bed need projection in the [2011 CON] Decision at the ten percent market capture rate for this 75-MSGA bed hospital (60-71).” (Exhibit 10 at p. 5).

This sentence epitomizes all that is wrong with the Recommended Supplemental Decision. It shows that: (1) the 10% the MHCC used throughout the 2011 CON Decision has now been altered to try to legitimize a new Holy Cross CON; (2) the 2011 CON Decision’s original (but now proven wrong) tables, calculations and projections can be swept aside and

forgotten in order to achieve a desired result; and that (3) this desired result will undergird the construction of a new hospital in Maryland's most populous jurisdiction with a price tag exceeding \$200,000,000.

In effect, a fundamental premise of the 2011 CON Decision – that Holy Cross could “reasonably” expect to capture a 10% market share in its expected service area – has now been replaced with a brand new fundamental premise without any stated reason for that switch. The 2011 CON Decision embeds the 10% market share throughout its calculations, not as a range, but as a hard number, in connection with its analyses of several different State Health Plan components. For example, relative to bed need, the 2011 CON Decision said:

With respect to the new hospitals' proposed ESAs, this analysis reflects the much larger service area population expected for the HCH-G project when compared with the CCH ESA and the ability of the proposed 75 MSGA beds at HCH-G to be highly occupied with a market penetration of MSGA patients originating in the service area of 10% while the CCH project would need to achieve market penetration in excess of 20% in its expected service area to fill its proposed 70 beds at similar levels. (Exhibit 1 at p. 42) (emphasis supplied).

Similarly, as to bed need the 2011 CON Decision said that:

As shown in the preceding table [Table 25], market share observed to be achieved by Montgomery County hospitals in '90%' service areas ranged from 7 to 21 percent, but only one of the five [existing hospitals in Montgomery County], SGAH, achieved a market share above 10% in an service area representing this level of importance for a hospital. This strongly suggests that the proposed HGH-G project would be likely to achieve efficient utilization of its proposed MSGA needs by penetrating its expected service area at a level that existing hospital experience indicates is realistic. (Exhibit 1 at p. 42). (emphasis supplied).

With respect to impact, the 2011 CON Decision also said that:

In terms of market share assuming each of the proposed hospitals' ESAs would account for 85% of discharges, HCH-G would have to achieve a market share in its ESA of about 10%, which is reasonable, given the observed experience of existing hospitals

(see earlier consideration of MSGA bed need in this report).
(Exhibit 1 at p. 169) (emphasis supplied).

These 2011 CON Decision findings – which propped up the determination of need for Holy Cross’s 75 MSGA beds – are traded for a 50% higher market share the Recommended Supplemental Decision now declares that Holy Cross Germantown can attain. The Recommended Supplemental Decision starts by noting that “it is true that my Recommended Supplemental Decision and the [2011 CON] Decision identified utilization projections at the proposed hospital level at a market share rate of ten percent in comparing the two hospitals’ applications. A market share capture assumption of 10% is a very conservative benchmark.” (Exhibit 10 at p. 5).

Adventist’s Comments proved (and the Recommended Supplemental Decision has now acknowledged) that the Holy Cross Germantown 93-bed hospital project is neither needed nor financially feasible based on the 2011 CON Decision’s 10% Montgomery County hospital market share. Thus, approval now requires a change in the 2011 need calculations and determinations. The Recommended Supplemental Decision makes this change by selecting exactly which mix of Maryland hospitals should be included to arrive at a higher market share penetration average.

While the 2011 CON Decision used only Montgomery County hospitals to assess market share for the expected Holy Cross service area (Exhibit 1 at p. 35) the Recommended Supplemental Decision casts a much wider net. Particularly, the Recommended Supplemental Decision chose to “examine the 32 hospitals that operated in the multi-hospital jurisdictions in 2008, to get a better sense of what a reasonable benchmark would be for HCH-G. Excluding the extreme outlier James Kernan Hospital ... which had a market share of only 0.2%.” (Exhibit 10 at pp. 5-6).

This “better sense of a reasonable benchmark” then completely shifted from the 2011 CON Decision’s focus on only existing Montgomery County Hospitals’ to hospitals statewide without explanation of why the benchmark should shift. (Id.). Averaging the market share of these 31 multi-jurisdictional Maryland hospitals achieved a 17.8% average market share. By comparison, the 7 Montgomery County hospitals the 2011 CON Decision originally used to establish market share averaged only an 11.1% market share.

The Recommended Supplemental Decision then calculated further by “eliminating” selected hospitals, such as those with cardiac surgery services, and then averaged market share of “the remaining 23 community hospitals in Maryland without cardiac surgery services that are located in multi-hospital jurisdictions, [which] commanded an average 21.1% market share in their 85% service areas in 2008.” (Id. at p. 6). These calculations achieved what the Recommended Supplemental Decision classified as a “better ‘peer group’ for HCH-G” which “better peer group” had an even higher market share than the 17.8% derived from the 31 hospital average calculations. (Id.).

Thus, the Recommended Supplemental Decision apparently adjusted the hospital components to arrive at a different market share average. It included 32 multi-jurisdictional hospitals, but selectively excluded the lowest market share hospital from that group of 32 hospitals because it would have skewed the average down. Without explanation, it also changed direction from the 2011 CON Decision’s elemental premise that “because of the multi-hospital nature of Montgomery County” a “service-area level analysis should serve as the basis of its consideration of the [bed need] standard.” (Exhibit 1 at p. 35). Additionally, the Recommended Supplemental Decision’s analysis moved from the 2011 CON Decision’s market share assessment using a 90% expected service area of existing Montgomery County hospitals to an 85% service area of selected statewide hospitals.

By these mathematical manipulations, the Recommended Supplemental Decision tries to validate its conclusion that a new Holy Cross Germantown Hospital is “needed” because it can capture 15% market share. In straying from the existing Montgomery County hospital service area to assess the need for Holy Cross Germantown, the Recommended Supplemental Decision arrives at a higher market share percentage, which is quite different than the 2011 CON Decision’s market share calculations. These new calculations should not be allowed to establish the “need” for a new Montgomery County hospital.

Crucially for these purposes, there was no testimony or evidence about “hospitals that operated in multi-hospital jurisdictions,” or about “23 community hospitals in Maryland without cardiac surgery services that are located in multi-hospital jurisdictions” during the 3+ year comparative review process. How then can this group of hospitals now serve as the “benchmark” for the service area of the proposed new small, Montgomery County hospital? Why was it correct for the 2011 CON Decision to use a “service area level analysis [to] serve as the basis of its consideration of the [bed need] standard ” (Exhibit 1 at p. 35), but now for the Recommended Supplemental Decision to shift suddenly to a 31 multi-jurisdictional Maryland hospital “benchmark?” (Exhibit 10 at pp. 5-6). The choice was either wrong in 2011 or wrong now—it can’t be correct both times because the measures are so very different.

Similarly, why was a conservative 10% market share valid in the 2011 CON Decision, but invalid now without any explanation about why market share should be increased by 50%? By the same token, how can 31 or 23 existing hospitals that have been operating in Maryland for more than 30 years possibly be “peers” to a yet unbuilt, small hospital such as the Holy Cross Germantown project?

The answer to this critical question is that 31 or 23 existing hospitals cannot possibly be “benchmarks” or “peers” for the new proposed Germantown project. These existing hospitals

have their own unique, mature markets with well-established medical staffs. It is apples and oranges to compare them to the unbuilt Holy Cross Germantown Hospital in an area already serviced by numerous other hospitals. Calling these hospitals “peers” and benchmarks” does not make it so, and certainly does not establish the need for Holy Cross’s new project that Maryland law requires.

Absent a showing of need, which the Recommended Supplemental Decision lacks, the Holy Cross project CON should be denied, and the Recommended Supplemental Decision must not be approved. See HEALTH-GEN §19-126(c)(1) (mandating that all CONs “shall be consistent with the [SHP] and the standards for review established by the Commission”); see also Adventist Healthcare Midatlantic, Inc. v. Suburban Hosp. Inc., 350 Md. 104, 121 (1998) (applications that are inconsistent with the governing SHP and CON review criteria are facially “unapprovable”); COMAR 10.24.10.04B(2).

Exception No. 3: **The Recommended Supplemental Decision picks and chooses how it will use the newly established 15% market share for Holy Cross’s expected service area and does not apply that new market share to all aspects of the 2011 CON Decision’s bed need analysis.**

Although the Recommended Supplemental Decision seeks to expand Holy Cross’s expected service area market share from 10% to a 50% higher market penetration of 15%, it only makes that substitution selectively. Comparing Adventist’s Comments to the CON Decision bears this out.

Adventist’s Comments revealed why and how the forecasted MSGA bed need for Montgomery County in the seven existing hospital service areas, and the two expected service areas for HCH-G and CCH is incorrect. (See Affidavit of Richard J. Coughlan, attached as Exhibit A to Exhibit 7). Therein, Adventist quantified how the 2011 CON Decision’s discharge rate for the Montgomery County population age 15-64 should have been 47.29, which is 28%

lower than the 66.51 published rate on 2011 CON Decision Table 26. (Exhibit 7 at p. 10). Mr. Coughlan further detailed how the error he identified from the Additional Evidence equally tainted the 2011 CON Decision's forecasted MSGA bed need. (Exhibit 7 at p. 11).

Mr. Coughlan stated a foundation for his conclusion as follows: "This is a logical conclusion since discharge rates are an integral factor and flow through in the computations required to generate the Non-Medicare trend values found on Table 28 – 'Average Annual Changes in Discharge Rates and Average Length, Montgomery County 1998-2008,' Table 30 – 'Gross MSGA Bed Need, MSGA Bed Capacity and Net MSGA Bed Need, Seven Selected Hospitals,' and found on Table 31 – 'Gross MSGA Bed Need and Implied Bed Need at the New Hospitals at Selected Levels of Market Share Capture of Bed Demand, Two New Hospital Expected Service Areas.'" (Exhibit 7 at p. 11).

In fact, the Recommended Supplemental Decision agrees with Mr. Coughlan's analysis, and agrees, over and over again, that the 2011 CON Decision's base line and projections were wrong, just as Mr. Coughlan said. (Exhibit 10 at pp 2, 3, 6).⁵ Rather than fixing these base line and projection errors, the Recommended Supplemental Decision takes a detour and goes down a different road – a road that uses a higher market share to support a "need" for Holy Cross Germantown.

Although the Recommended Supplemental Decision endeavors to replace the previously determined 10% market penetration for Holy Cross with a 50% higher market share, it does not perform the necessary and rigorous analysis to support that change to all aspects of the CON

⁵ In the same vein, Holy Cross does not try to refute Mr. Coughlan either, and meekly says it is up to the MHCC to decide if the 2011 CON Decision's bed need calculations that predicated the Holy Cross CON are wrong. (Exhibit 8 at p. 3). As is evident from the Recommended Supplemental Decision, the Reviewer most certainly did determine that these calculations are wrong.

Decision's bed need discussion. Specifically, the Recommended Supplemental Decision fails to pull this 15% market share change through to each of the relevant charts, tables and discussion in the 2011 CON Decision's extensive need analysis. Nowhere in the Recommended Supplemental Decision is there any effort to correct Table 28, Table 30 or Table 31 – all of which Mr. Coughlan identified as having the “integral factor” of discharge rates which “flow through in the computations required to generate” those Tables. If the Tables and calculations mattered in 2011, they matter just as much now, and they should be corrected to prove that the “need” for the Holy Cross Germantown project exists as the Recommended Supplemental Decision claims.⁶

The MHCC should not permit an incomplete and flawed Recommended Supplemental Decision to rule the day. Instead, the MHCC should insist that the Reviewer perform a full need analysis that takes the newly proposed 15% market share into account on all aspects and calculations of need. The MHCC should insist on such a rigorous and thorough analysis before voting to approve the Recommended Supplemental Decision. Anything less would violate the State Health Plan, and would allow a \$200,000,000 hospital to be built on an unsound regulatory foundation.

Exception No. 4: The Recommended Supplemental Decision concedes an additional mistake in the 2011 CON Decision that further supports denial of the Holy Cross CON Application.

The Recommended Supplemental Decision identifies yet another, distinct mistake in the 2011 CON Decision which shows that its need calculations were incorrect in yet another way

⁶ These Tables are listed by way of example only. Most certainly, there are numerous other tables and discussions in the 2011 CON Decision's extensive need analysis that the Recommended Supplemental Decision did not recalculate. Without this level of computation on baseline figures and projections, it is a guessing game whether the change from 10% market share to 15% supports 75 MSGA beds for Holy Cross Germantown.

and that there was no “need” for the 75 MSGA beds the CON Decision originally approved (and which the Recommended Supplemental Decision now seeks to approve once again).

This new error appears on p. 5 where the Recommended Supplemental Decision acknowledges, in the paragraph prior to the chart entitled “Projected Bed Need at HCH-G at Two Levels of Market Capture and the State Health Plan Target Occupancy Rate” that the 2011 CON Decision used target 80% occupancy rate, when the MHCC should have properly used a 70% occupancy rate for a projected MSGA average daily census (“ADC”) of 1-49, and a 75% occupancy rate for a projected ADC of 50-99.⁷ (See Exhibit 10).

The result of this mistake is set forth in the “Projected Bed at HCH-G” Chart referenced on page 5 of the Recommended Supplemental Decision. That chart shows that when the MHCC voted in January, 2011 to award a CON to Holy Cross based on a 10% market share, the range of bed need was really only between 39 and 53 beds. (Compare chart on p. 5 of the Recommended Supplemental Decision, Ex. 10, listing between 39 and 53 beds as the “corrected projection of minimum beds” to p. 41 of the 2011 CON Decision which contains a range of 53 to 66 beds based on a 10% Holy Cross market share). Furthermore, the Recommended Supplemental Decision Chart identifies a minimum of 60 beds and a maximum of 71 beds as having been projected in the 2011 CON Decision. (Exhibit 10 at p. 5). The 2011 CON Decision, however, does not contain those numbers. Rather, it states that the demand for bed capacity at 10% will be between 53 and 66 beds. (Exhibit 1 at p. 41).

Thus, the Recommended Supplemental Decision shows that even with the 10% market share, the 2011 CON Decision overstated the range of bed need by 13 – a significant number of beds – and that the maximum number that could have possibly been established was 53 beds, not

⁷ Pursuant to COMAR 10.24.10.05D(4), the MSGA Bed Need Occupancy Rate Standard is determined by Hospital ADC: ADC = 0-49, 70% Occupancy; ADC = 50-99, 75% Occupancy.

the 66 listed in the 2011 CON Decision. These errors also are further indicia of spotty calculations and projections that just do not add up in both the 2011 CON Decision and the Recommended Supplemental Decision.

In addition, below is a chart that calculates the minimum and maximum bed need using the ALOS and 10% market share and applicable ADC occupancy rate, using the approach the MHCC claims it applied in the 2011 CON Decision. The chart shows why even the Recommended Supplemental Decision’s corrected bed need (assuming a 10% market share) should have been a minimum of 41 beds and a maximum of 50 beds, not a range of 39 to 53 beds as described in the Recommended Supplemental Decision. Thus, even the so called “corrected” 10% market share bed need continues to be wrong and overstated.

**HCH- Germantown Expected Service Area
MSGA Bed Need Calculations - 2018**

Corrected Calculations: TOTAL

Ranges	Discharge Rate	ESA Adult Population	Discharges	10% Market Share Assumption		Patient Days	10% Market Share Assumption	FOR HXH-G @ 85% Service Area Patient			Beds Needed @ SHP Occupancy
				ALOS	ADC			Discharges	Days	ADC	
Min	77.4	310,694	24,048	2,405	3.63	87,293	8,729	2,829	10,270	28	41
Max	90.5	310,694	28,118	2,812	3.80	106,848	10,685	3,308	12,570	34	50

Despite this additional and fundamental error in projecting need, Holy Cross was awarded a CON in 2011 for 75 of these beds, which is significantly more than any of the minimum and maximum amounts the MHCC itself calculated under its own methodology.

The Recommended Supplemental Decision, which claims to “correct” errors in bed need calculations, really does nothing of the sort. As Adventist has shown, even these corrections remain inaccurate. An inaccurate Recommended Supplemental Decision which seeks to approve the highest possible bed need for Holy Cross cannot form the foundation for a Holy Cross CON.

Exception No. 5: The MHCC is being asked to issue a CON for more than the maximum bed need because even assuming arguendo that a higher 15% market share can now be used, the maximum bed need is 69 beds, not 75 beds.

On page 3, the Recommended Supplemental Decision states: “The [2011 CON] Decision used a range of projected 2018 use rates for the HCH-G expected service area, unadjusted, of 64.3 to 71.2 discharges per thousand population aged 15-64. The correct range of projected 2018 use rates for this age group in the HCH-G expected service area which should have been used in the [2011 CON] Decision, prior to any adjustment, was 46.6 to 52.3 discharges per thousand population.”⁸ (Exhibit 10 at p. 3).

In the Richard J. Coughlan Affidavit attached to Adventist’s Comments, Mr. Coughlan explained why this discharge rate should be even lower, i.e. from 45.8 to 50.8 discharges per thousand. (Exhibit A to Exhibit 7). The Recommended Supplemental Decision simply includes a corrected, recalculated rate but never explains how it reached a different calculation than Adventist did in its Comments. As a result, even the corrected use rate for the population aged 15-64 used in the Recommended Supplemental Decision appears to be overstated.

The same paragraph of the Recommended Supplement Decision then goes on to state that the use rate for the entire population aged 15 and up, i.e. including the population aged 65 and up, should, as corrected, should be 77.4 to 90.5 discharges per thousand. (Exhibit 10 at p. 3). Here too, no calculations were included in the Recommended Supplemental Decision or are a part of the Additional Evidence. Consequently, there is no way to test, based on information in the record, the accuracy of this total, adult discharge rate or to see how the discharge rates for the

⁸ The original calculations referenced in the first part of the sentence do not appear in the 2011 CON Decision, and were not part of the Additional Evidence. Consequently, Adventist cannot now test the calculations the MHCC now claims that it used but which the Recommended Supplemental Decision nevertheless admits was wrong.

two populations, 15-64 and 65 and above, were combined. Since the total, corrected rate relies on the 15-64 discharge rate, however, this combined use rate also appears to be overstated.

Furthermore, the Recommended Supplemental Decision is also wrong in stating that its use of a 15% market share results in a maximum bed need of 75 beds. Below is a chart detailing that bed need will only reach 61 (minimum) and 69 (maximum) even if one accepts the now-admitted mistakes in the 15-64 corrected discharge rate, assumes the Recommended Supplemental Decision’s proposed adult discharge rate per thousand of 77.4 to 90.5, and accepts the Recommended Supplemental Decision’s ALOS of 3.63 to 3.80. Obviously, 61 to 69 beds are significantly fewer than the 75 beds identified in the Recommended Supplemental Decision’s chart on page 5.

**HCH- Germantown Expected
Service Area
MSGA Bed Need Calculations –
2018**

Corrected Calculations: TOTAL

Ranges	Discharge Rate	ESA Adult Population	Discharges	15% Market Share Assumption	ALOS	Patient Days	15% Market Share Assumption	FOR HXH-G @ 85% Service Area			Beds Needed @ SHP Occupancy
								Discharges	Patient Days	ADC	
Min	77.4	310,694	24,048	3,607	3.63	87,293	13,094	4,244	15,405	42	61
Max	90.5	310,694	28,118	4,218	3.80	106,848	16,027	4,962	18,855	52	69

These continued and continuing mathematical errors, missteps and miscalculations further call into question the validity of the Recommended Supplemental Decision. Why does testing the stated “corrections” against the 2011 CON Decision yield lower bed need numbers? Why are the bed need calculations wrong at a conservative 10% and now wrong also at a less conservative 15%? Why are all the bed need projections and calculations incapable of supporting a 75 MSGA bed need regardless of the percentage used? These important but unanswered

questions point up yet more reasons why the MHCC should vote against approving the Recommended Supplemental Decision.

THE RECOMMENDED SUPPLEMENTAL DECISION FAILS TO DEMONSTRATE THAT THE HOLY CROSS GERMANTOWN PROJECT IS FINANCIALLY FEASIBLE

Exception No. 6: The Recommended Supplemental Decision violates Maryland law because it fails to establish that the Holy Cross Germantown project is financially feasible.

In addition to establishing that there was no “need” for the Holy Cross Germantown project under COMAR 10.24.10.04B(2) and (6), Adventist’s Comments equally established that the Holy Cross Germantown project would not be financially feasible within 5 years of initiating operations or less, as required by COMAR 10.24.10.04B(13). Specifically, Adventist’s expert witness David Cohen, CPA, used the corrections Mr. Coughlan made to discharge rates to determine if the Holy Cross project can be financially feasible with fewer projected MSGA admissions to a significantly smaller number of beds. (Exhibit 7 at pp. 16-21).

Using the very financial projections Holy Cross submitted to the MHCC, Mr. Cohen determined that the Holy Cross Germantown project will not be financially feasible by its fifth year of operation. To the contrary, Mr. Cohen found that Holy Cross would suffer a loss of \$1,578,000 by its fifth year of operation (Exhibit 7 at p. 21).

The Recommended Supplemental Decision does not, in any way, address these findings. Instead, it says:

As previously noted in this Recommended Supplemental Decision, the incorrect bed need calculation used in the Decision does not change the Commission’s findings and conclusions with respect to the need for the HCH-G project. There is a sufficient bed need in HCH-G’s expected service area for this new hospital to support a revenue base that will result in the profitable operation of the hospital. I find that, using the corrected bed need, the proposed HCH-G hospital is financially feasible. (Exhibit 10 at p. 10).

Thus, the Recommended Supplemental Decision uses the restated 15% market share to both “prove” bed need and to make the blanket determination that the Holy Cross Germantown project will be financially feasible. Just as this cavalier approach cannot justify “need” it equally cannot justify a conclusion that the project will be financially feasible.⁹

Moreover, there is not a shred of analysis as to whether Holy Cross Germantown can even attain a 15% market share in its first five years of operation. The Recommended Supplemental Decision simply states – without factual support or exploration of any kind—that the hospital will be financially feasible. Such untested and unproven blanket statements should not form the basis for a new hospital CON.

The Recommended Supplemental Decision’s refusal to even assess financial feasibility in light of a 15% new market share contrasts sharply with the 2011 CON Decision in which financial feasibility was analyzed and “served as a basis for vigorous comment and response” between the applicants. (Exhibit 1 at p. 73). The foundation of the 2011 CON Decision’s conclusion that Holy Cross had satisfied these criteria states:

The Commission finds that the HCH-G case for financial feasibility is more plausible because it has made a stronger case with respect to market feasibility and has the resources to implement this project. The Commission finds that the CCH project is not consistent with this standard because it has employed assumptions concerning market share that are not consistent with historic trends.

(Id. at p. 173). Now that Adventist found persistent and endemic flaws in the Holy Cross application and in the 2011 CON Decision, however, the Recommended Supplemental Decision to uses completely different “historic trends.”

⁹ The Recommended Supplemental Decision contains no updated financial feasibility analysis whatsoever, much less one that takes into account the higher project costs Holy Cross now cites in its quarterly progress reports.

The 2011 CON Decision itself shows that a proposed Holy Cross 10% market share was an integral building block in approving the Holy Cross Germantown hospital. Now, however, the Recommended Supplemental Decision changes that market share and increases it by 50% to get Holy Cross Germantown to a 15% market share. If the MHCC wishes to approve the Holy Cross project on such a basis, it must have the Reviewer and Staff perform the necessary leg work and analysis to prove that this new market share is really attainable. A new hospital CON should not be assembled by piecing together untested assumptions that rely on the market share of other hospitals functioning in mature multi-hospital markets. This is particularly the case here where, as Mr. Coughlan demonstrated in a chart attached to his Affidavit, Holy Cross Germantown expected service area is already being served by eight existing hospitals. (See Exhibit 4 to Coughlan Affidavit attached to Exhibit 7 hereto).

Lastly, it bears repeating that the MHCC looked at historic Montgomery County trends to determine market share assumptions, and based the 2011 CON Decision on those historic county-wide trends. Now, when those trends do not suit the desired result quite so well, the Recommended Supplemental Decision has expanded the comparative pool to “32 hospitals that operated in multi-hospital jurisdictions in 2008, [minus one outlier]” (Exhibit 10 at pp. 5-6). If the Montgomery County trends were the proper measure in 2011, there is no reason why they should not be in 2012. This is especially true here where these trends are being used in the Recommended Supplemental Decision to satisfy not only bed need, but also financial feasibility.

According to the MHCC’s regulations, a project that is not financially feasible may not be awarded a revived CON. The MHCC must vote against the Recommended Supplemental Decision because there is no proof that the Holy Cross Germantown Hospital is financially viable. See, COMAR 10.24.10.04B(13).

THE RECOMMENDED SUPPLEMENTAL DECISION FAILS TO DEMONSTRATE THE IMPACT OF THE HOLY CROSS GERMANTOWN PROJECT.

Exception No. 7: The Recommended Supplemental Decision violated Maryland law because it failed to make a determination of the Holy Cross Germantown Hospital Project's impact on existing providers.

Maryland law is crystal clear that certificate of need decisions must "be consistent with the State health plan and standards for review established by the Commission." HEALTH-GEN, § 19-126(c)(1). See also Maryland General Hosp. v. Maryland Health Res. Planning Comm'n, 103 Md. App. 525, 529 (1995). Additionally, pursuant to COMAR 10.24.01.09A(4), "The proposed decision shall state the reviewer's determination as to whether:

- (a) Each relevant State Health Plan standard or review criterion set forth in Regulation .08G of this chapter:
 - (i) Is met by the applicant,
 - (ii) Is not applicable to the project, or
 - (iii) Is applicable to the project and is not met by the applicant."

(emphasis supplied).

One of the relevant .08G regulations that directly applies in this case is found at COMAR 10.24.01.08G(3)(f). That regulation provides that:

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

In violation of Maryland law and the MHCC's own regulations, the Recommended Supplemental Decision ignores the regulatory mandate that proposed decisions "shall state the reviewer's determination" as to whether Holy Cross has "provided information and analysis with respect to the impact of the proposed project on existing health care providers in the same health

planning region ... and on costs to the health care delivery system.” COMAR 10.24.01.09A(4); 10.24.01.08G(3)(f).

When the MHCC issued the 2011 CON Decision, it did conduct such an analysis. At that time, the MHCC expressly determined that:

In terms of market share assuming each of the proposed hospitals’ ESA’s would account for 85% of discharges, HCH-G would have to achieve a market share in its ESA of about 10% which is reasonable, given the observed experience of existing hospitals (see earlier consideration of MSGA bed need in this report). (Exhibit 1 at p. 169).

Thus, the 2011 CON Decision performed an impact analysis on Holy Cross’s proposed project, but, that impact analysis was based on the express finding that Holy Cross would achieve a 10% market share in its Expected Service Area. In May 2012, the Recommended Supplemental Decision has abandoned that 10% market share and substituted a 15% market share. This change from a 10% to a 15% market share amounts to a 50% increase, yet there is no analysis of how such a significant change will affect other providers in the proposed Holy Cross Germantown Expected Service Area.

Because the Recommended Supplemental Decision has made this significant and drastic change in Holy Cross Germantown’s proposed market penetration, the Reviewer must, as mandated by the regulations, provide her determinations on impact analysis – this time based on the dramatic increase in market share the Recommended Supplemental Decision determines Holy Cross can obtain.

This is no small matter. In the comparative review, Adventist commented on the numerous ways how the proposed Holy Cross Germantown Project may “impact” existing providers. Indeed, Adventist explained that the proposed Holy Cross Germantown project “will increase the market share of a competitor in the heart of [Shady Grove Adventist Hospital’s]

primary service area.” (Exhibit 1 at p. 167). Adventist further detailed that “approval of HCH-G will jeopardize the nearby Germantown Emergency Center, and will inevitably reduce the future volume of ED visits at SGAH.” (*Id.*). Moreover, Adventist clarified that “HCH-G will be a much larger hospital threatening the existing health care system because ED observation rooms could be converted to ED treatment rooms.” (*Id.*).

The Recommended Supplemental Decision is silent on how increasing Holy Cross’s expected service area market share by 50% will impact existing providers. This failure violates Maryland Law, violates the MHCC’s governing regulations, and is a valid reason, in and of itself, why the MHCC should not approve the Recommended Supplemental Decision. Even though the regulations say any proposed MHCC Decision “shall” conduct this analysis, the Recommended Supplemental Decision does not. See, Johnson v. State, 282 Md. 314, 319 (1978) (“the use of the word ‘shall’ is presumed to have a mandatory meaning, and thus denotes an imperative obligation inconsistent with the exercise of discretion”).

THE RECOMMENDED SUPPLEMENTAL DECISION DENIES ADVENTIST DUE PROCESS OF LAW.

Exception No 8: The decision to decline additional findings, evidence or oral argument after the case was reversed once and after Adventist found errors and miscalculations throughout the 2011 CON Decision, was wrong and once again denied Adventist due process of law.

In the original proceedings, Dr. Moon ruled on April 9, 2010 that she would hold an evidentiary hearing on three SHP Acute Care Hospital Review Criteria: access, need, and the financial viability of the two hospital projects. (Appx. A to Exhibit 1 at p. 7). Dr. Moon further permitted the parties to submit pre filed testimony of their fact and expert witnesses on those same topics. (*Id.* at p. 11-12). Witnesses were cross examined at a 6 day evidentiary hearing based on their pre filed testimony, exhibits and the parties' CON applications. Some of those

witnesses testified about, and were cross examined about the need and financial viability of the two competing applications.

The 2011 CON Decision then wrongly used information that was not in the record and which related to both need and financial viability. Because this information was not in the record, Adventist had no opportunity to meaningfully respond to it, rebut it, or question it. This failure violated the Maryland Administrative Procedure Act which was designed to "ensure that "certain basic principles of common sense, justice and fairness... are applied in administrative procedures." Dep't of Health & Mental Hygiene v. Chimes, 343 Md. 336, 338 (1996). The Maryland APA also exists to "ensure that the agencies 'observe the basic rules of fairness as to parties appearing before them.'" Bereano v. State Ethics Comm'n, 403 Md. 716, 740 (2008) quoting Fairchild Hiller Corp. v. Supervisor of Assessments for Washington County, 267 Md. 519, 524 (1973). Indeed, Judge Pierson reversed the CON and remanded the entire case back to the MHCC to remedy this blatant error of law. (Exhibit 3 at pp. 5-6).

On remand, however, the importance of the process was minimized as things sped along towards recommending another Holy Cross CON award. Within days of the remand, Dr. Moon proposed that Adventist file its comments by April 2, 2012 – at a time when the Additional Evidence had not yet even been compiled and entered into the record. (Exhibit 4).

Finally, on March 29, 2012 the Additional Evidence was entered into the record and given to Adventist. As explained herein, that evidence established that the need projection – and ensuing revenue projections for the Holy Cross Germantown Hospital which flow from that need projection – were wrong. Adventist's Comments carefully found and described these errors. Its Comments further explained that these need projection errors disproved the need for and the financial viability of the Holy Cross project, such that no new CON could possibly be awarded. (Exhibit 7 at pp. 8-21).

What happened when Adventist detailed that the CON Decision's finding of "need" for and financial feasibility of the Holy Cross Germantown project were utterly wrong and based on errors, miscalculations and mistakes? A Decision was made which declined to accept more filings, evidence, oral argument, or even schedule a hearing. (Exhibit 9). Instead, a Recommended Supplemental Decision was filed which admits that the need and financial feasibility findings in the CON Decision are wrong, but which nonetheless proposes a CON for Holy Cross. It does this by altering the 10% CON Decision market share finding to which no exception or appeal had been taken, and which should not therefore have even been considered on remand.

One would think that a further evidentiary hearing was warranted in this important health policy case involving construction of first new hospital in Maryland in 30 years. One would also think that construction of a hospital in Maryland's most populous County would warrant further review, explanation, and discussion about how a CON Decision which is premised on incorrect base line population data, incorrect projections of need, incorrect ALOS calculations, and incorrect financial feasibility and revenue calculations would warrant further and more careful review. No such evidentiary hearing occurred, and Adventist received no further opportunity to question the critical data, which has now been recalibrated to justify a new CON for Holy Cross.

Most certainly, an evidentiary hearing could have allowed the parties to explore the substantial issues, would have allowed further exploration on how the Recommended Supplement Decision simply substituted a 15% market share for the 10% market share used throughout the CON Decision. The Reviewer could and should have allowed cross-examination of the same sort of critical issues on which she permitted cross examination before the remand, such as need and financial feasibility. Adventist was denied that opportunity.

Furthermore, an evidentiary hearing and the process that accompanies it would have been even more justified in this matter precisely because the case has already been reversed once by Judge Pierson for evidentiary and procedural errors. Under these circumstances, it would have been much more prudent and valuable to allow the parties an opportunity to thoroughly engage in, understand and respond to the data that now undergirds the Recommended Supplemental Decision. The MHCC has always benefitted from testimony, and cross-examination of witnesses and experts in CON reviews; this case should have been no different. That is particularly true when the MHCC's ruling will impact the delivery of health care for years to come.

III. CONCLUSION

The Recommended Supplemental Decision, just like the 2011 CON Decision which preceded it, is full of errors, miscalculations and fundamental flaws. For all the reasons described in these Exceptions, Adventist respectfully asserts that the MHCC should not approve the Recommended Supplemental Decision at its May 31, 2012 meeting. A CON should not be based on the faulty foundation the Recommended Supplemental Decision tries to build.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 23rd day of May, 2012, a copy of the foregoing Adventist's Exceptions to the Recommended Supplement Decision was e-mailed, prior to noon to:

Suellen Wideman, Esquire
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Jack C. Tranter, Esquire
Philip F. Diamond, Esquire
Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201

And mailed, first-class, postage prepaid to:

Loretta E. Shapero, Esquire
Associate County Attorney
1301 Piccard Drive, 4th Floor
Rockville, Maryland 20850

I ALSO CERTIFY THAT 30 copies of Adventist's Exceptions to the Recommended Supplemental Decision will be delivered on May 24, 2012 to:

Suellen Wideman
Assistant Attorney General
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299



Diane Festino Schmitt