

IN THE MATTER OF HOLY CROSS  
HOSPITAL—NEW HOSPITAL IN  
GERMANTOWN

Docket No. 08-15-2286

\* BEFORE THE  
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\* MARYLAND HEALTH CARE  
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\* COMMISSION  
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**HOLY CROSS HOSPITAL’S RESPONSE  
TO EXCEPTIONS FILED BY  
CLARKSBURG COMMUNITY HOSPITAL, INC.  
AND ADVENTIST HEALTHCARE, INC.**

Holy Cross Hospital of Silver Spring, Inc. (“Holy Cross”), by its undersigned counsel, files this Response To Exceptions Filed By Clarksburg Community Hospital, Inc. And Adventist HealthCare, Inc. (collectively “AHC”). For the reasons related below, all of the Exceptions should be rejected and the Commission should reissue a Certificate of Need (“CON”), authorizing Holy Cross to continue developing a new hospital in Germantown (“HCH-G”).

**INTRODUCTION**

After spending more than two years seeking approval to build a new hospital in Clarksburg, including seeking legislative intervention in the CON review process, AHC now maintains there is no need for a new hospital in upper Montgomery County. During this review, AHC presented evidence and consistently argued that there was need for a new hospital in Clarksburg (an area projected to have a population in 2018 that will be less than half the population projected for the HCH-G service area). Indeed, AHC did not assert that there was no need for a new hospital in upper Montgomery County until after the Commission rejected its application proposing to build a new hospital in Clarksburg.

In January 2011 the Commission issued a 179-page Decision approving the Holy Cross proposal to build a new 93-bed hospital in Germantown and rejecting AHC's competing proposal to build a new hospital in Clarksburg (the "2011 Decision"). The Commission found that Holy Cross met all 48 applicable State Health Plan Standards and CON Review Criteria and that the AHC application did not meet eight of the applicable standards and criteria.

AHC appealed the Commission's decision in favor of Holy Cross and raised three issues, two substantive and one procedural. Judge Pierson rejected both substantive claims, but reversed and remanded this matter to the Commission because AHC did not have a "meaningful opportunity" to review three databases that were not part of the administrative record.

Judge Pierson described the procedural error as the "only defect" in the Commission's 2011 Decision. He did not say that the CON authorizing Holy Cross to build a new hospital in Germantown had been "improvidently" granted as AHC twice claims. *See* Exceptions at 1 and 6. Nor was the reversal and remand of the decision an "extraordinary step" as AHC again twice claims. *See* Exceptions 2 and 6. This is simply what the law requires.<sup>1</sup>

AHC spends much of its filing complaining about the Commission and distorting the procedural context of the case. *See* Exceptions at 1-12. The actual Exceptions do not even begin until the bottom of page 12. Even then, Section II, "Adventist's Exceptions," revisits ground previously plowed in a futile effort to refute the analysis and findings in Dr. Moon's Recommended Supplemental Decision ("RSD").

There is no dispute among the parties and Dr. Moon that AHC identified two mistakes in the need methodology used in the 2011 Decision. The 2011 Decision is not "rife with errors,

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<sup>1</sup> *See* Md. Ann. Code State Government Article § 10-222(h)(3)(iii), providing that a court reverse or modify an agency decision "if any substantial right of the petitioner may have been prejudiced because a finding, conclusion, or decision . . . results from unlawful procedure."

mistakes, miscalculations and overstatements of need.” *See* Exceptions at 2. Dr. Moon acknowledged and corrected these mistakes in the RSD.

In the RSD, Dr. Moon recalculated the service area bed need analysis for HCH-G’s expected service area (“ESA”) under Section 10.24.10.04B(2) (c)(iv) of the Acute Care Chapter of the State Health Plan. After completing that analysis, Dr. Moon assessed whether HCH-G could achieve the requisite MSGA market share penetration in its ESA that would be necessary to operate a hospital with 75 MSGA beds in 2018. Dr. Moon properly found that HCH-G would achieve the requisite market share.

In her cover memorandum to the RSD, Dr. Moon stated that “Holy Cross Hospital of Silver Spring has a strong record in providing quality care, access to care for the indigent, broad community benefits, and efficient and effective management of its hospital operations. I recommend that the Commission re-issue a Certificate of Need for the proposed Holy Cross Hospital in Germantown.” *See* Memo at 2. As explained in more detail in the responses to AHC’s eight Exceptions below, there is nothing in the Exceptions that would warrant rejecting Dr. Moon’s recommendation.

### **ARGUMENT**

#### **I. AHC’S CLAIM IN EXCEPTION 1 THAT THE RSD DOES NOT ACKNOWLEDGE THE ERRORS OF THE 2011 DECISION IS SIMPLY WRONG.**

The RSD acknowledged two errors in the bed need analysis in the 2011 Decision, i.e., use of the wrong MSGA use rate for adults aged 15-64 and use of incorrect average length of stay (“ALOS”) projections. *See* RSD at 2 and 4. In the RSD, Dr. Moon corrected these two errors and thoroughly analyzed whether the corrected projections generate sufficient bed need to support a new hospital in Germantown.

Dr. Moon correctly concluded that the original finding of need for a new hospital is still appropriate because 75 MSGA beds will be highly utilized at a realistic market share penetration. Specifically, she stated, “an important conclusion from the Decision with respect to HCH-G was simply that the proposed hospital would have ‘a service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed over the coming decade.’ (Decision at 42). This conclusion remains true for HCH-G.” *See* RSD at 7-8.

**II. CONTRARY TO AHC’S CLAIM IN EXCEPTION 2, THERE IS AMPLE SUPPORT FOR A FINDING THAT A NEW HOSPITAL IN GERMANTOWN CAN ACHIEVE THE REQUISITE MARKET SHARE TO FILL 75 MSGA BEDS IN 2018.**

AHC claims that the 2011 Decision set 10% as the maximum market share HCH-G could achieve in its ESA. This claim, which permeates the Exceptions, is simply not true. As Dr. Moon stated in her cover memorandum to the RSD at 2, “a market share of 10% was not put forward as a ceiling in the 2011 Decision.”

Similarly, the RSD does not conclude that 15% is the maximum market share that HCH-G can achieve, as AHC claims. Dr. Moon noted “the 2011 Decision’s use of a 10-20% market share range as constituting the critical range for market share in an analysis of this proposed hospital’s expected service area demand levels as they relate to proposed bed capacity.” *See* Memo at 2. The RSD cited ample hospital market share experience in 2008 supporting the finding that HCH-G would achieve the requisite market share to fill 75 MSGA beds in 2018 in its ESA, including:

- The average MSGA market share in the five existing Montgomery County hospitals’ 85% service areas was 15.5%. *See* RSD at 9.

- Three out of the five Montgomery County hospitals had market shares of at least 15%. *See* RSD at 9.
- The hospital “closest in size and range of services to HCH-G,” MedStar Montgomery Medical Center, had a market share of 15.9%. *See* RSD at 9.
- Limited competition in HCH-G’s service area “should make it easier for HCH-G to achieve the volume needed to support its proposed 75 MSGA beds.” *See* RSD at 9.
- “Statewide, the 47 general acute care hospitals in Maryland operating in 2008, on average, had a market share of 28.8% in their 85% service areas.” *See* RSD at 5.
- The 31 general acute care hospitals in multi-hospital jurisdictions had an average market share of 17.8%. *See* RSD at 6.
- The 23 of these hospitals (excluding hospitals with cardiac surgery) operating in multi- hospital jurisdictions had an average market share of 21.1%. *See* RSD at 6.<sup>2</sup>

In addition, the RSD recognized that Holy Cross Hospital in Silver Spring already has nearly a 7% MSGA market share in HCH-G’s ESA. *See* RSD at 5. As Dr. Moon found, it is likely these patients will not travel to Silver Spring for care and, instead, will seek care at the more convenient Holy Cross hospital located in Germantown.

In sum, the information related above supports Dr. Moon’s finding that the new hospital that Holy Cross proposes to continue developing in Germantown will be highly utilized at a market share penetration rate that is realistic and reasonable, given the experience of other hospitals in Maryland and the new hospital’s unique relationship with Holy Cross Hospital in Silver Spring. AHC’s claim that Holy Cross cannot achieve this market share is particularly surprising in light of AHC’s claim that the new hospital it proposed to build in Clarksburg would achieve a 34.5% MSGA market share in its service area. *See* 2011 Decision at 37. Indeed, as noted above, AHC did not claim that there was no need for a new hospital in upper Montgomery

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<sup>2</sup> AHC criticizes Dr. Moon’s RSD for using examples other than Montgomery County hospitals. In fact, these additional examples merely reinforce the finding that a 15% market share is realistic for the Germantown hospital to achieve.

County in 2018 until *after* the Commission rejected its proposal to develop a new hospital in Clarksburg.

**III. AHC’S CRITICISM, IN EXCEPTION 3, OF THE CORRECTED BED NEED ANALYSIS MISREPRESENTS THE ROLE OF THE MARKET SHARE TARGET IN THE RSD’S FINDING OF NEED.**

In Exception 3, AHC criticizes the RSD for not applying the 15% market share target to all aspects of the bed need analysis. This criticism represents a fundamental misunderstanding of how bed need is determined. Bed need does not begin with a target market share. Rather, it looks objectively at the size and age mix of an area’s population as well as historical and current utilization patterns to determine future demand. The analysis assesses whether a hospital has a “service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed over the coming decade.” *See* RSD at 7 and 8. HCH-G has such a service area.

As noted in the 2011 Decision, HCH-G will serve a large population that is projected to grow rapidly over the coming years. In particular, the growth of the population in HCH-G’s ESA will be concentrated among people over age 65. The 65+ population in Montgomery County is projected to grow 37.4% between 2008 and 2018. In HCH-G’s ESA, the growth will be 50% higher at 56.4%. *See* 2011 Decision at 39. This extraordinary growth of the 65+ population is critical to bed need because the 65+ population’s hospital use rate is approximately five times higher than that of the population under age 65. This growth and aging of the population will drive a sizable growth in gross bed need in the Germantown area.

Market share is not relevant to all aspects of the need analysis. It is only relevant in assessing whether it is likely that a new hospital’s MSGA beds will be highly utilized at a realistic market penetration. Nevertheless, AHC claims that market share should be applied “to

all aspects of the 2011 CON Decision's bed need analysis." *See* Exceptions at 19. Specifically, it cited two tables (Table 28 and Table 30) from the 2011 Decision that have nothing to do with market share. AHC even criticizes the RSD for not applying a market share test to the determination of bed need in the new hospital's service area (Table 31 of the 2011 Decision), even though the first table on page 5 of the RSD does precisely that.

#### **IV. THE "MISTAKE" AHC IDENTIFIES IN EXCEPTION 4 INCREASES RATHER THAN DECREASES NEED FOR MSGA BEDS.**

In the RSD, Dr. Moon noted that in the 2011 Decision "a conservative target occupancy rate of 80% was used rather than the 70 to 75% targets actually applicable to the projected ADC." *See* RSD at 5. A higher occupancy rate target results in a lower bed need (i.e., fewer beds are needed if they operate at 80% occupancy rather than at 70% occupancy). Dr. Moon updated a table from the 2011 Decision with the occupancy rates mandated in the State Health Plan (rather than the more conservative 80%) to show that using these occupancy rates would have resulted in a higher bed need in the 2011 Decision. *See* RSD at 5.

AHC turns this correction on its head, arguing that this "mistake" in the 2011 Decision "further supports denial of the Holy Cross CON Application." This makes no sense because the correction results in a finding of a higher not lower MSGA bed need.

AHC also performs an analysis in this section that clings to the erroneous notion that the 2011 Decision established 10% as the maximum market share HCH-G could capture. As Dr. Moon stated, "the Adventist Entities incorrectly elevated the Decision's finding with respect to the level of use that HCH-G could achieve at a quite conservative market share level of 10 percent to the status of a threshold standard for approval. The Decision does not support their position." *See* RSD at 9. As Dr. Moon stated, "a market share capture assumption of ten percent

is a very conservative benchmark.” See RSD at 5. Moreover, Dr. Moon explicitly found that “10 to 20 percent constitutes a critical range of market share for consideration in an analysis of expected service area demand levels of this type and their relevance to proposed bed capacity.” See RSD at 7. AHC’s insistence that the 2011 Decision found that 10% is the maximum market share that HCH-G could achieve is simply wrong.

**V. AHC’S CALCULATIONS IN EXCEPTION 5 ARE UNRELIABLE BECAUSE THEY ARE BASED ON AN UNADJUSTED USE RATE RANGE.**

AHC used an incorrect use rate to support its claim that the maximum bed need in the Germantown service area at a 15% market share is 69 MSGA beds. In making this calculation AHC used an MSGA use rate range for the entire adult population aged 15 and older of 77.4 to 90.5 discharges per thousand that was identified in the first full paragraph on page 3 of the RSD. However, this is an *unadjusted* use rate range and should have not been used because the State Health Plan need methodology mandates use of an *adjusted* use rate range. See COMAR 10.24.10.05. While the numbers can be plugged into a formula as AHC has done in Exception 5, the results are meaningless and should be rejected.

Even using AHC’s incorrect use rate, AHC’s calculation in Exception 5 requires a market share of just 16%, rather than 15%, for 75 MSGA beds at HCH-G to meet the State Health Plan’s 75% occupancy rate target in 2018. Projecting the market share of a new hospital six years in the future is not an exact science, with one specific number right and another precise number wrong. That is why Dr. Moon identified a MSGA market share range of between ten and twenty percent as reasonable and realistic for HCH-G in 2018.

HCH-G will serve the growing and aging population of upper Montgomery County for decades to come. Even if one accepts the calculation offered by AHC, a claim that the Holy

Cross application should be denied as a result of a 1% difference in projected MSGA market share makes no sense and should be rejected.

**VI. HCH-G IS FINANCIALLY VIABLE, DESPITE AHC'S CLAIMS TO THE CONTRARY IN EXCEPTION 6.**

As Dr. Moon notes in the RSD, AHC tries to "piggyback" a new claim that HCH-G is not financially feasible on AHC's criticism of the Commission's bed need analysis. *See* RSD at 10. AHC did not challenge HCH-G's ability to achieve the volume projections it presented previously in the comparative CON review; nor does it show now that HCH-G cannot achieve these volume projections.

AHC's contention that HCH-G is not financially feasible relies entirely on its mistaken claim that the 2011 Decision set a 10% market share as an inflexible, maximum level of market share penetration achievable by HCH-G. As related in the RSD, AHC does "not undertake any analysis of the financial feasibility of the HCH-G project that is based on HCH-G capturing more than ten percent of the total MSGA demand in its expected service area." *See* RSD at 10.

Dr. Moon concludes that

there 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. *See* RSD at 10.

AHC offers no valid basis for the Commission to reject this finding.

**VII. CONTRARY TO AHC'S CLAIM IN EXCEPTION 7, THE RSD DID NOT ADDRESS IMPACT BECAUSE AHC DID NOT RAISE THE ISSUE IN ITS COMMENTS AND THE BASES FOR THE COMMISSION'S FINDING HAVE NOT CHANGED.**

As a matter of law, AHC waived its right to address impact on existing providers because it did not raise or discuss this issue in its Comments. AHC cannot raise an issue in its Exceptions

if it had not been previously raised in the Comments. Moreover, since AHC did not discuss impact in its Comments, Dr. Moon did not address impact in the RSD. If a matter is not addressed in the RSD, there is nothing for AHC to critique in its Exceptions.

Substantively, there was no reason for Dr. Moon to modify the Commission's finding regarding impact on existing providers. In the 2011 Decision, the Commission evaluated a number of factors related to impact. For example, "with respect to the issue of travel time accessibility in general, the Commission found that the HCH-G site, because of its nearness to more densely populated areas of Montgomery County, has a greater potential than the CCH site to reduce the overall travel time to a hospital experienced by Montgomery County residents." *See* 2011 Decision at 168. The 2011 Decision also found that HCH-G has greater potential for positive impact on "demographic access to services." *See* 2011 Decision at 168.

In the Exceptions, AHC reiterated its claims regarding negative impact on its facilities but failed to acknowledge the 2011 Decision's finding that "AHC raises concerns about the threatening impact of HCH-G on the GEC and SGAH's obstetric, MSGA and emergency department services. However, AHC does not explain how it arrived at its projected ED volume impacts and does not quantify the impact of losses in volume in any of these services on occupancy, costs, or charges (revenue) at SGAH or GEC." *See* 2011 Decision at 169.

Even with a higher market share requirement than anticipated in the 2011 Decision, there is no basis for changing the Commission's determination that HCH-G "can achieve full occupancy within a reasonable amount of time without reducing volume at existing hospitals, other than Holy Cross Hospital of Silver Spring" because patients in the HCH-G ESA who had been traveling to HCH-SS (1,385 cases in 2008) would shift to HCH-G and the general population in the ESA will be aging and growing. *See* 2011 Decision at 169. In fact, MSGA discharges in the

HCH-G ESA will increase by thousands of cases between 2008 and 2018. This growth, coupled with the shift of existing cases is sufficient for the new hospital in Germantown to be highly utilized without having a negative impact on existing providers.

**VIII. AHC’S CLAIM IN EXCEPTION 8 THAT DR. MOON’S DECISION TO ISSUE THE RSD WITHOUT CONDUCTING AN EVIDENTIARY HEARING VIOLATES DUE PROCESS OF LAW HAS NO MERIT AND SHOULD BE REJECTED.**

In Exception 8, AHC claims that issuance of the RSD without conducting an evidentiary hearing “denied Adventist due process of law.” *See* Exceptions at 31. AHC, however, offers no support for this due process claim.

The bulk of the narrative under Exception 8 on pages 31-34 simply summarizes (with significant editorializing) what happened in this case. On page 31, AHC first reminds the reader that an evidentiary hearing had been held in this case and describes some of what occurred during that hearing. *See* Exceptions at 31-32. AHC next restates what it has said in its Exceptions many times before, i.e., that Judge Pierson remanded the case to the Commission to give AHC a “meaningful opportunity” to review material that had not been made part of the administrative record. *See* Exceptions at 32.

AHC next criticizes the “speed” of the remanded proceeding, but does not relate how “pace” violates AHC’s due process rights.<sup>3</sup> AHC then states again what neither Holy Cross nor Dr. Moon disputes, i.e., that AHC identified mistakes that impacted the need analysis in the 2011 Decision. *See* Exceptions at 32-33.

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<sup>3</sup> Given that AHC filed its Comments 72 days after Judge Pierson’s decision and 15 months after receiving the extra-record data, it is hard to imagine what an acceptable pace might have been.

However, in the narrative addressing Exception 8, AHC offers no statutory or case law support for its remarkable claim that Dr. Moon's decision not to conduct an evidentiary hearing "denied Adventist due process of law." *See* Exceptions at 31. This is not surprising, as AHC well knows that the Commission is not required by Maryland law to conduct an evidentiary hearing in contested case proceedings. Instead, the Commission has the discretion to hold an evidentiary hearing if it determines that the matter at issue warrants proceeding in that manner (as occurred in this case in 2010 with respect to the comparative review). *See* Md. Ann. Code Health-General Article § 19-126(f).

The only commentary on pages 31-34 that even arguably addresses AHC's claim that due process requires an evidentiary hearing as part of this remand begins in the middle of page 33 and ends at the middle of the next page. On page 33, AHC asserts, "[o]ne would think that a further evidentiary hearing was warranted in this important health policy case . . . ." AHC then states how it believes such a hearing would have been conducted. None of this, of course, supports AHC's claim that Dr. Moon was legally required to conduct another evidentiary hearing. While AHC clearly believes that an evidentiary hearing "was warranted" in this case, this does not mean that failing to proceed in that manner "denied Adventist due process of law."

Put simply, AHC offers no argument supporting its claim that Dr. Moon denied AHC due process of law by not conducting an evidentiary hearing before issuing the RSD. This is not surprising because there is no case or statutory law mandating that an evidentiary hearing be held under the circumstances present here. In fact, as noted above and as AHC well knows, under Maryland law, the Commission has the discretion whether or not to hold an evidentiary in a contested proceeding. Dr. Moon exercised her discretion not to do so and AHC has offered nothing whatsoever to support its claim that

Dr. Moon's decision to proceed in that manner "denied [AHC] due process of law."

**CONCLUSION**

For the reasons related above, all of AHC's Exceptions should be rejected and the Commission should re-issue a Certificate of Need authorizing Holy Cross to continue developing a new hospital in Germantown.

Respectfully submitted,



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Date: May 28, 2012

**CERTIFICATE OF SERVICE**

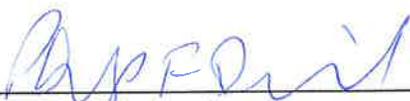
I hereby certify that on the 28th day of May, 2012, a copy of the foregoing Response to Exceptions was sent via email to the following:

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I also certify that on Tuesday, May 29, 2012, 30 copies will be delivered by courier to the Commission and copies will be sent by first class mail to Ms. Shapero and AHC counsel.

  
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Philip F. Diamond