

July 8, 2013

VIA ELECTRONIC MAIL AND
HAND DELIVERY WITH 30 COPIES

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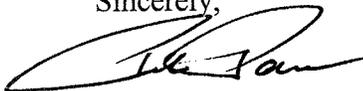
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Re: In the Matter of the Application of Seasons Hospice and Palliative Care of Maryland, Inc. To Establish an Inpatient Hospice Unit on the Campus of MedStar Franklin Square Medical Center (Docket No. 11-03-2318) Before the Maryland Health Care Commission

Dear Suellen:

In accordance with the schedule that Reverend Conway established in the above-referenced matter, enclosed please find a copy of Gilchrist Hospice Care, Inc.'s Exceptions to the Recommended Decision (the "Exceptions"). Thirty (30) copies of the Exceptions will be delivered to the Maryland Health Care Commission as instructed.

Sincerely,



Peter P. Parvis

Enclosures

Cc: Catherine Hamel (*via electronic mail*)
Ben Steffen (*via electronic mail*)
Paul Parker (*via electronic mail*)
Joel Riklin (*via electronic mail*)
Ruby Potter (*via electronic mail*)
Dr. Gregory Wm. Branch (*via electronic mail and first-class mail*)
Howard L. Sollins, Esq. (*via electronic mail and first-class mail*)
John J. Eller, Esq. (*via electronic mail and first-class mail*)
Philip F. Diamond, Esq. (*via electronic mail and first-class mail*)
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Hillary M. Stemple, Esq. (*via electronic mail and first-class mail*)
Molly E. G. Ferraioli, Esq. (*via electronic mail*)
6896774; 102719/26346

IN THE MATTER OF

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**SEASONS HOSPICE AND
PALLIATIVE CARE
OF MARYLAND, INC.**

*

**BEFORE THE MARYLAND
HEALTH CARE COMMISSION**

*

DOCKET NO. 11-03-2318

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**GILCHRIST HOSPICE CARE, INC.'S
EXCEPTIONS TO THE RECOMMENDED DECISION**

Gilchrist Hospice Care, Inc. (“Gilchrist”), through its undersigned counsel, hereby submits its exceptions, pursuant to section 10.24.01.09B of the Code of Maryland Regulations (“COMAR”), to the Recommended Decision rendered by Commissioner Reverend Robert L. Conway (the “Reviewer”), on June 28, 2013 (the “Recommended Decision”) recommending approval of the certificate of need (“CON”) application filed by Seasons Hospice and Palliative Care of Maryland, Inc. (“Seasons”).

The Recommended Decision hinges on one important concept: The Reviewer agrees with Seasons’ argument that its proposed hospital-based inpatient hospice unit (the “Proposed MFSMC Unit”) will serve a large number of patients who would otherwise expire without electing to receive hospice care. The Reviewer believes that this would result in enough “demand,” which he equates with “need,” to fill the 16 bed Proposed MFSMC Unit at MedStar Franklin Square Medical Center (“MFSMC”). This acceptance also led the Reviewer to make statements unsupported by the record regarding the impact of the Proposed MFSMC Unit on the interested parties, including Gilchrist. If the Maryland Health Care Commission (the “MHCC”) agrees with the Recommended Decision and approves the Proposed MFSMC Unit, it will have a profound impact both on Gilchrist and on the nature of hospice programs around the state of Maryland.

EXCEPTIONS

A. THE RECOMMENDED DECISION FAILS TO DEMONSTRATE NEED FOR THE PROPOSED MFSMC UNIT.

Exception No. 1: The Recommended Decision fundamentally changes the need requirement by incorrectly equating “need” with “demand” and by accepting, without proof, that there are enough patients to fill 16 new beds who would only elect hospice if they could go to a hospital-based unit.

As the Recommended Decision points out on page 17, the “current State Health Plan does not provide a need methodology or specific standards for need assessment with respect to inpatient hospice bed capacity.” However, Seasons still had the burden to “demonstrate[] unmet *needs* of the population to be served, and establish[] that the proposed project meets those *needs*.” COMAR 10.24.01.08G(3)(b) (emphasis added).¹ Although Gilchrist has pointed out that “demand” is *not* the same as “need,” *see* Gilchrist Interested Party Comments at 7 (noting that Seasons, at best, demonstrated “that there may be a *demand* for a particular kind of inpatient hospice care in a hospital” but not “a *need* in the community for inpatient hospice care that is not being adequately met by one of the three inpatient hospice providers in Baltimore County” (emphasis in original)), the Recommended Decision incorrectly equates the two terms, which substantially reduced Seasons’ burden of proof on this element.

The Recommended Decision is rife with examples of this change in terminology. As the Recommended Decision aptly states on page 17, “In its CON application (DI#2), Seasons responded to this [need] criterion by focusing on *demand* for inpatient hospice services that could be generated at the proposed unit” (emphasis added). The Reviewer also focuses on demand on page 27 when stating the first reason for why he believes that Seasons proved need:

¹ The MHCC’s application form also asked Seasons to “discuss the *need of the population served or to be served* by the Project.” *See* Gilchrist Interested Party Comments at 4 (citing CON Application at 40).

I am convinced that it [*i.e.*, Seasons] has generated a substantial proportion of its *demand* at the NWH unit from a patient population that it correctly assesses might not have become hospice patients without the existence of the unit. It is logical to assume that this experience may be replicated at the proposed MFSMC campus unit. . . . Much of the Seasons bed capacity proposed at the MFSMC campus is likely to be filled with new *demand* created by the unit, not *demand* that would be using the bed capacity already developed by Gilchrist and Stella Maris. . . . The interested parties did not claim² and I have not found that this new source of inpatient hospice service *demand* should be rejected by MHCC as illegitimate or not indicative of a need perceived by patients, their physicians, and their families. *I consider the application to have demonstrated that an unmet demand for inpatient hospice care does exist that can be met by a project of this type*" (emphasis added).

Although the change in terminology from "need" to "demand" may appear subtle, it is not. Future applicants for inpatient hospice units must only point to a demand for inpatient hospice beds, or a preference for a particular kind of inpatient beds, even if existing inpatient hospice beds are empty or will be harmed significantly (as discussed later in these exceptions). Given this decision's focus on demand from within the walls of a hospital, applicants for hospital-based inpatient hospice units will have an especially simplified road to approval.

In confusing "demand" (which is more appropriately considered as a measure of a project's financial feasibility) with "need,"³ the Recommended Decision embraces, without solid evidence, the concept that hospital-based inpatient hospice units cater to a new source of patients, *i.e.*, those who prefer to obtain inpatient hospice care in a dedicated hospital-based unit, rather than in a nursing home or freestanding hospice facility. Even if this allegation is true (which we debate), Seasons provided no evidence that there were enough patients of this type at

² Contrary to the Recommended Decision's suggestion, Gilchrist has opposed the sufficiency of Seasons' demand-based argument under the need criterion, as pointed out above.

³ For this reason, "demand" is more appropriately considered under the fourth CON review criterion (viability of the proposal) found in COMAR 10.24.01.08G(3)(d). In contrast, the need criterion should focus on whether the population to be served has unmet needs.

MFSMC (or the other MedStar Baltimore hospitals) to need 16 new inpatient hospice beds. Rather, the “evidence” that Seasons provided to justify its ability to fill such a large number of beds came from patients who were 65 years of age or older in medical/surgical/gynecological/addictions (“MSGA”) beds from MFSMC and the other MedStar hospitals in Baltimore City (without any indication of their predisposition for hospice). CON Application at 43. Although Seasons submitted a letter of support for the Proposed MFSMC Unit from the former president of MFSMC, *see* CON Application, Exhibit 6, it did not submit similar letters of support from the MedStar hospitals in Baltimore City or other evidence that those hospitals would transport patients by ambulance to the new unit in Baltimore County.

Seasons also claimed that many of the patients it will admit to the Proposed MFSMC Unit will come from the Intensive Care Unit “(the “ICU”). CON Application at 41–42, 50–51; *see also* Responses to Completeness Questions Received on 7/25/11 (“First Completeness Questions”) at 13, 24; Responses to Second Set of Completeness Questions at 7. It also implied that many of these ICU patients will be on ventilators. *See* First Completeness Questions at 12, 13. However, Seasons never provided evidence on this point. *See* Gilchrist Interested Party Comments at 6. For example, Seasons never submitted data about how many of its patients in the inpatient hospice unit (the “NWH Unit”) that it operates at Northwest Hospital (“NWH”) come from the ICU and/or are on ventilators. We find this lack of evidence troublesome and a further indication that the Proposed MFSMC Unit will shift referrals from Gilchrist and Stella Maris, as opposed to generating a substantial amount of “new” need from patients who otherwise would not elect hospice, contrary to the Recommended Decision’s conclusion.

In fact, Seasons’ data contradicts its theory and the Recommended Decision’s conclusion. Seasons anticipates that the Proposed MFSMC Unit will serve about 725 patients, operating at a

74.5% occupancy rate, and its need methodology calculated 458 referrals from MFSMC. CON Application at 43, 44. If Seasons' theory is correct, we would expect that the majority of these 725 (and, with respect to MFSMC, 458) patients would otherwise die in the ICU, or at least in the hospital. Seasons' statements and the letter of support that MFSMC's former president, Adrienne Kirby, Ph.D., submitted, however, suggest that this number will be significantly less. Specifically, Dr. Kirby stated: "There are approximately four hundred patients per year who pass away as inpatients at Franklin Square, many of whom face the end of their life in the Intensive Care Unit. We anticipate that more than half of these patients and families will choose hospice care as a result of the services being located at the hospital." *Id.*, Exhibit 6. Seasons itself "anticipates" that "the number of deaths in acute beds [at MFSMC] will decline by half." *Id.* at 50. These statements suggest that the Proposed MFSMC Unit can expect only about 200 (well under half of the expected 458) referrals from MFSMC to be patients who would otherwise expire in the hospital without hospice care. We expect that the other approximately 250 plus anticipated patients would have chosen hospice anyway, including from Gilchrist (whose Towson inpatient center admitted 69 patients from MFSMC from October 1, 2010 through September 30, 2011, *see* Gilchrist Interested Party Comments at 14) and Stella Maris (whose inpatient hospice unit served 76 patients from MFSMC in FY 2011, *see* Stella Maris Interested Party Comments at 10) or would not choose hospice at all (with or without the Proposed MFSMC Unit). In either event, Seasons has failed to demonstrate the need of the community for the Proposed MFSMC Unit.

Exception No. 2: By assuming that the NWH Unit may be closed, the Recommended Decision incorrectly relies on Seasons’ “need” to have the Proposed MFSMC Unit to compete with the interested parties.

The Recommended Decision has a two-pronged conclusion on need. In addition to finding an unmet demand, the Reviewer finds it of “equal importance” that it is “reasonable to allow for a general hospice of Seasons size to effectively compete in the Baltimore area with the other two large hospice programs by being allowed to develop similar service offerings when its size makes this feasible.” Recommended Decision at 27–28. This comment relies on the flawed notion that Seasons lacks an inpatient hospice unit and, therefore, should be given the Proposed MFSMC Unit to level the playing field with Gilchrist and Stella Maris, who each have an inpatient hospice facility in Baltimore County. *See id.* at 26 (“Thus, approval of the proposed project would establish the first CON-approved inpatient hospice program operated by Seasons since the termination of its lease at NWH in 2012. *Denial of the project would result in elimination of the ability of Seasons to incorporate an inpatient program that it controls and operates under its own license, until and unless it obtains CON approval for the unit it wants to operate at Sinai. . . . [T]he unit operated at Northwest Hospital by Seasons has the same problems with respect to licensure found to exist with the unit previously operated by Seasons at Sinai*” (emphasis added).); *id.* at 28 (“*The unit it now operates at NWH is not in compliance with a recent determination made by OHCQ and MHCC with respect to operation of dedicated hospital units comprised of licensed general hospital beds. Continued operation of the NWH program by Seasons may be in jeopardy as a result. Authorization of this project will assure that Seasons has the ability to operate an inpatient hospice program under its general hospice license, the same capability enjoyed by the two other major providers of hospice services to Baltimore County*” (emphasis added).)

As far as Gilchrist is aware, neither the Office of Health Care Quality (“OHCQ”) nor the MHCC has indicated that it will force Seasons to close the still-operating NWH Unit until it obtains a CON for it (especially when such unit was established before CONs were needed for inpatient hospice units). Therefore, it is inappropriate for the Recommended Decision to rely on the NWH Unit’s possible closure to justify a need for the Proposed MFSMC Unit.

Exception No. 3: The Recommended Decision incorrectly states the needs methodology upon which Seasons relied in its CON application, which Gilchrist believes is insufficient.

Although Gilchrist opposes Seasons’ needs methodology in this matter, the Recommended Decision should accurately state it. Instead, the Recommended Decision states,

Based on its experience at Northwest Hospital, it [*i.e.*, Seasons] projects that *4.4 percent of the MFSMC patients admitted to medical/surgical/gynecological/addictions (“MSGA”) beds* in a given year will become hospice inpatients at the proposed hospice unit. It further projected that the three other general hospitals operated by MedStar Health in Central Maryland (all in Baltimore City) will be important secondary referral sources. It projects their contribution to be equivalent to *1.5 percent of annual MSGA admissions*, and cites the experience of the NWH unit’s reliance on Sinai Hospital of Baltimore (a sister hospital of NWH operated as part of LifeBridge Health) as a referral source for the NWH unit, as the basis for this assumption. Recommended Decision at 9 (emphasis added); *see also id.* at 18.

This statement is incorrect. In both instances, Seasons pointed to MSGA admissions who were *age 65 and older*. CON Application at 43.

Importantly, the Reviewer did not comment on this methodology in his analysis and findings under the need element. (Instead, as mentioned earlier, he focuses on the general concept of Seasons’ hospital-based hospice units creating an otherwise unmet demand for inpatient hospice care and Seasons’ apparent right to have an inpatient unit to compete with the interested parties.) However, the Recommended Decision could be read to implicitly approve Seasons’ methodology, as it was the only “evidence” Seasons gave to show that it could actually

fill a 16 bed inpatient unit at MFSMC. Given the precedential impact that the Recommended Decision will have on hospice programs in Maryland, the Recommended Decision should correctly state Seasons' methodology.

That said, Seasons' methodology is insufficient. Seasons is part of a national company known as Seasons Hospice & Palliative Care ("National Seasons"), which is the fifth largest hospice provider in the United States.⁴ National Seasons operates twenty Medicare-certified sites across fifteen states and operates nine inpatient centers,⁵ seven of which appear to be hospital-based.⁶ At the time that it filed the application for the Proposed MFSMC Unit, it operated "60 inpatient beds, across 5 hospital locations." CON Application at 6. We would have expected Seasons, being part of a national company with such experience, to have provided a more comprehensive needs methodology than simply one year of data from one hospital-based unit.⁷ Additionally, Seasons did not submit any evidence showing a correlation between its experience with the LifeBridge hospitals and the referrals that it expects to receive from the MedStar hospitals. As previously noted, Seasons also did not produce evidence, such as letters of support, to support a finding that MedStar's Baltimore City hospitals would transfer a significant number of their ICU patients to a hospice unit in a Baltimore County hospital. These patients would have to travel to MFSMC in an ambulance, just as they would to obtain services

⁴ See <http://seasons.org/page/Organization%2BFacts>.

⁵ *Id.* The National Seasons website states that it operates ten inpatient centers, *id.*, listing the Sinai Hospital Inpatient Center as one such center. See <http://seasons.org/page/Inpatient%2BCare>.

⁶ These are Christiana Hospital in Delaware, Holy Cross Hospital, Weiss Memorial Hospital, and Westlake Hospital in Illinois, NWH in Maryland, Sinai-Grace Hospital in Michigan, and Phoenixville Hospital in Pennsylvania. National Seasons also operates what appears to be a freestanding inpatient hospice facility in Illinois and a unit in a long term care facility in Wisconsin. See <http://seasons.org/page/Inpatient%2BCare>.

⁷ It appears that the only specific data that Seasons provided from one of these other inpatient units was to note that the mortality rate at Weiss Memorial Hospital declined by 32% in the year after the hospice unit opened in early 2009. CON Application at 8. Based on the graph provided on page 9 of the CON Application, we assume this was based on the change in mortality rate from year ending ("YE") October 2008 to the YE October 2009 (7.43% vs. 5.02%). Seasons did not highlight that the mortality rate increased the next year (YE October 2010) to 5.72%. When YE October 2008 is compared with YE October 2010, there is only a 23.0% drop in mortality.

at the Gilchrist and Stella Maris inpatient facilities. In fact, they would need to travel further, or at least just as far in the case of MedStar Harbor Hospital, to travel to MFSMC.

B. THE RECOMMENDED DECISION UNDERESTIMATES THE IMPACT THAT THE PROPOSED MFSMC UNIT WILL HAVE ON GILCHRIST.

Exception No. 4: The Recommended Decision incorrectly predicts that the Proposed MFSMC will not harm Gilchrist by inappropriately using data about the impact of the NWH Unit and by accepting Seasons' theory regarding a new market of patients.

Under COMAR section 10.24.01.08G(3)(f), Seasons needed to “provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region.” The Reviewer’s “starting point” for assessing the impact of the Proposed MFSMC Unit on the interested parties is to show that Gilchrist and Stella Maris, along with Seasons, experienced growth in their inpatient units from 2007 (the year before the NWH Unit opened in early 2008) through 2011.⁸ Recommended Decision at 36–37. This data is irrelevant for determining the harm that the Proposed MFSMC Unit will have on Gilchrist. As the Recommended Decision itself recognizes on page 38, “Because of its geographic location, it is probable that a Seasons hospice unit on the MFSMC campus is *more likely to have an impact on demand for hospice services by Gilchrist and Stella Maris, both of which have hospice facility campuses closer to MFSMC than NWH*” (emphasis added).

The prejudicial effect of the NWH Unit comparison can also be felt when tied to the Reviewer’s acceptance that a hospital-based inpatient hospice unit generates an otherwise unmet demand for a certain preference of inpatient hospice care.⁹ Together, the Reviewer uses these

⁸ On page 27, the Recommended Decision also suggests that the NWH Unit did not affect the interested parties under the need criterion, noting that the interested parties’ average daily census “did not decline between 2007 and 2011, when the NWH unit, in its first operational year of 2008, exceeded the demand occurring at Stella Maris and grew 16% over the next two years.” Although we have addressed this point under the impact criterion, we also challenge as inappropriate the use of the topic under the need criterion.

⁹ The Recommended Decision also addresses the new demand issue under the criterion that focuses on the availability of more cost-effective alternatives on pages 29 through 30. Although we have focused our exceptions

concepts to assert on page 37 that “the impact of the proposed Seasons project on the MFSMC campus cannot be viewed as a ‘zero sum game,’ i.e., Seasons’ likely gain in inpatient census will not exactly correspond to losses in inpatient census or overall patient census at Gilchrist or Stella Maris.”¹⁰ Even if the Reviewer is correct that the situation is not a “zero sum game,” the Proposed MFSMC Unit will have a tremendous impact on Gilchrist for reasons previously stated. *See* Gilchrist Interested Party Comments at 7–8, 14–15, 17–19 (noting that admissions from MFSMC to Gilchrist’s Towson facility accounted for 7.5% of the center’s total admissions during a twelve month period from 2010 to 2011, that the percentage jumped to 16% when adding in referrals from Good Samaritan Hospital, Union Memorial Hospital, and MedStar attending physicians, and that based on Seasons’ assumptions, Gilchrist would lose a total of 355 patients and \$2,800,000 per year in lost revenue when lost homecare admissions and lost admissions to Gilchrist’s Towson inpatient facility are considered together). Even if Gilchrist does not lose all of these patients to Seasons, it will lose at least a substantial amount of its current referrals from the MedStar Baltimore hospitals, particularly from MFSMC (and, to the extent that it differs, at least a substantial amount of the patients who live around MFSMC), given that “the proposed project will provide MFSMC with a strong competitive advantage for capturing hospice patients affiliated with the MedStar hospital network, an advantage that it previously established with the LifeBridge hospitals.” Recommended Decision at 38–39.

on this point under the need and impact criteria, we also oppose the Recommended Decision’s statements on the new demand issue under the cost-effective alternatives criterion.

¹⁰ We note that this contradicts Seasons’ own assumptions. In its application, Seasons stated that “[t]he only hospice facility that this project would impact would be” the NWH Unit, which had “42 admissions from MedStar Hospitals.” Seasons “anticipate[d] that referrals from these hospitals will now come to the unit at Franklin Square . . . consistent with the experience of Lifebridge Health, at which Northwest Hospital Center and Sinai Hospital are the predominant referral sources to the Northwest Unit.” *See* CON Application at 54–55.

Exception No. 5: The Recommended Decision's suggestion that Gilchrist must expand its service area to counteract the Proposed MFSMC Unit's impact is irrelevant.

In finding that the Proposed MFSMC Unit will not have a large enough impact on the interested parties to bar approval of the project, the Recommended Decision accepts Seasons' irrelevant comments regarding the activity of Gilchrist and Stella Maris in other jurisdictions. Specifically, the Reviewer notes that Gilchrist had "miniscule penetration in two large markets, Anne Arundel and Prince George's and one medium-sized market, Frederick" and that Stella Maris is not competitive in Anne Arundel and Montgomery Counties. In contrast, the Reviewer emphasizes how Seasons makes "a substantial effort in all eight of its jurisdictions" and "appears to be trying to use all of its potential service area rather than concentrating its efforts to the degree" of Gilchrist and Stella Maris. Recommended Decision at 38. Although the Reviewer notes that his highlighting of this information "is not a criticism of Gilchrist and Stella Maris," he inappropriately uses it against them by deciding in Seasons' favor, commenting that the interested parties "[o]bviously . . . have some ability to offset the negative impact they may experience in the Baltimore City and County region from the expansion of a competitor hospice's service capacity by more effectively competing in other regions where they may face other competitive challenges but may also have new opportunities." *Id.*

In a CON matter regarding an inpatient hospice unit in Baltimore County, considering the degree to which the applicant and interested parties compete in other jurisdictions is irrelevant. Inpatient hospice should be convenient for patients and their families, who often travel to visit their loved ones.¹¹ About 90% of patients who enter an inpatient hospice unit die there. Because patients and their families do not like, and should not need, to travel far for inpatient hospice

¹¹ It is hard to imagine how Seasons would disagree with this point, as its arguments depend on how convenient it is to patients and families to receive hospice care in a hospital setting, including when the loved one can be moved to a hospice unit within the walls of the same hospital. *See* First Completeness Questions 10–13, 22.

services, it would be unreasonable for Gilchrist to expect families to drive about 90 or more miles each day (45 or more miles each way) from Anne Arundel, Prince George's, and Frederick Counties to visit their loved ones during the last six or so days of their lives in Gilchrist's Towson facility.¹² Therefore, expanding into these counties would not impact Gilchrist's Baltimore County facility, and the Recommended Decision's expectation that Gilchrist should mitigate its losses by expanding its business in other counties is prejudicial.

Exception No. 6: The Recommended Decision will set a precedential impact by deciding that up to a 20% negative impact is not enough harm to block a CON application.

On page 38 of the Recommended Decision, the Reviewer states, "I do not believe the likely impact, even if it falls within the 15-20 percent impact range cited by the interested parties, will be existential because of the likelihood of the continued growth in demand for hospice services and the potential for growth that has not been fully exploited by Gilchrist and Stella Maris outside of Baltimore County and City." As noted in Exception 5, we have challenged as irrelevant the notion that competitors must expand in other jurisdictions to offset the losses that a new project will create in Baltimore County. This decision will set a precedent that harm of up to 20% will be within the MHCC's acceptable limits, a proposition that we find unacceptable, especially when it will cause competitors to lose millions of dollars and layoff staff.

Exception No. 7: Again, the Recommended Decision inappropriately relies on the NWH Unit being closed even though there has been no indication that such an event will occur.

The Reviewer bases his finding that "the likely level of impact of the proposed project" on the interested parties "should not bar approval and implementation of the project" on his "expectation that Seasons will not operate the previously established unit at Sinai unless it obtains CON" and licensure approval "and the jeopardy under which the NWH unit exists

¹² As Seasons calculated, the average length of stay for inpatient beds is about six days. See CON Application at 46.

because of its close similarity to the Sinai unit.” Recommended Decision at 39. For reasons stated above under Exception 2, any reliance on this faulty premise (i.e., that the NWH Unit may be shut down, despite no indication that such event will occur) is a fatal flaw.

C. THE RECOMMENDED DECISION WILL LEAD TO AN INFLUX OF INPATIENT HOSPICE UNITS IN MARYLAND AND WILL FURTHER SATURATE THE BALTIMORE COUNTY AND CITY INPATIENT MARKET.

Exception No. 8: By accepting the argument that hospital-based inpatient hospice units care for patients who would otherwise forgo hospice, the Recommended Decision, if approved, will increase the number of inpatient units in Maryland, especially in hospitals.

For reasons stated in other exceptions, this Recommended Decision will set a precedent that will make it very easy for future applicants seeking to establish new hospital-based inpatient hospice units to receive CON approval. If the MHCC accepts the analysis set forth by the Recommended Decision—that need exists because many people would only chose hospice if they could go to a hospital-based unit and that the impact on existing providers is slight as a result—every Maryland hospital could have a large dedicated inpatient hospice unit. Therefore, this decision will likely increase the amount of inpatient hospice units (especially hospital-based units) in Maryland. There are more proper avenues, including through the state health plan and accompanying regulatory process, for such precedents to be set.

Exception No. 9: The Recommend Decision acknowledges, but (if accepted) will only worsen, the saturation of inpatient hospice beds in Baltimore County and City.

The Recommended Decision notes on page 10:

Three of the ten hospices authorized to serve Baltimore City and/or Baltimore County operate inpatient hospice facilities (four if one includes the unit operated by Seasons at NWH). Only eight of the State’s 30 hospices operate inpatient hospice facilities (again, nine if one includes Seasons). Thus, Baltimore County and City have a concentration of inpatient hospice facilities and bed capacity in excess of their importance demographically. With only 25 percent of the State’s population, these two jurisdictions contain 57% of the State’s total existing and approved hospice inpatient bed

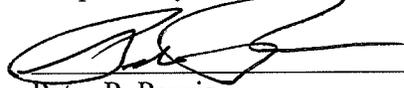
capacity. If one includes the Seasons facilities at NWH, this concentration rises to 64%.

Although we are unsure about the source or accuracy of these percentages (since the underlying data is not provided), approving the 16 bed Proposed MFSMC Unit will only further saturate the amount of inpatient hospice beds in Baltimore County and Baltimore City, which have lower than expected aging growth rates compared to Maryland as a whole. Recommended Decision at 9-10 ("The projected rate of growth of the 65 and older population for the combined two-jurisdiction region, at 26.0% from 2010 to 2020, is lower than that projected for all of Maryland, 41.4%.")¹³ As noted previously, the NWHC Unit cannot be disregarded given that it remains open and, to our knowledge, neither the MHCC nor the OHCQ has taken steps to close it.

CONCLUSION

For the reasons set forth above, the Recommended Decision is flawed. Therefore, Gilchrist respectfully requests that the MHCC not approve the Recommended Decision at its July 18, 2013 meeting.

Respectfully submitted,



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¹³ The MHCC's 2011 Annual Hospice Survey ("2011 Survey") reports 70 dedicated general inpatient beds and 74 beds that were used for mix purposes (general inpatient, residential, and routine care). Although the 2011 Survey only mentions 20 beds for Joseph Richey Hospice, this hospice also has 10 inpatient hospice pediatric beds (known as Dr. Bob's Place) in Baltimore City. In 2012, the MHCC approved two new inpatient hospice projects, adding a total of 20 beds. Based on these numbers, we believe that the beds in Baltimore City and County (comprised of Seasons' 14 beds at the NWH Unit, Gilchrist's 34 beds in Towson, Stella Maris' 22 beds, and Joseph Richey Hospice's 30 beds in Baltimore City) currently account for 57.5% (100 out of 174 beds) of approved and/or existing inpatient hospice beds in Maryland. If the 20 beds approved in 2012 are not counted, they account for 64.9% (100 out of 154 beds). If the Proposed MFSMC Unit is approved, the percentage would increase to 61.1% (116 out of 190 beds), and 68.2% (116 out of 170 beds) if the 20 beds approved in 2012 are disregarded.

CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of July 2013, a copy of the foregoing Gilchrist Hospice Care, Inc.'s Exceptions to the Recommended Decision (the "Exceptions") was sent via email prior to noon to:

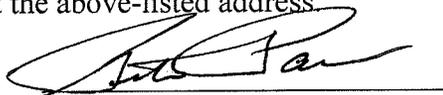
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I also certify that copies of the Exceptions will be mailed via first class mail on the 8th day of July 2013 to John J. Eller, Esq., Howard L. Sollins, Esq., Philip F. Diamond, Esq., Thomas C. Dame, Esq. Hillary M. Stemple, Esq., and Dr. Gregory Wm. Branch at their respective above-listed addresses. I also certify that 30 copies of the Exceptions will be delivered on the 8th day of July 2013 via hand delivery to Suellen Wideman, Esq. at the above-listed address.


Peter P. Parvis