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VIA EMAIL: paul.parker@maryland.gov
VIA HAND DELIVERY

Mr. Paul E. Parker
Director, Center for Health Care Facilities Planning and Development
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Prince George's Regional Medical Center, Docket No. 13-16-2351 --- Written Comments of AAMC

Dear Mr. Parker:

Pursuant to COMAR 10.24.01.08(F)(1) and the notice published at 42 Md. Reg. 592-593 (Apr. 3, 2015), Anne Arundel Medical Center, Inc. ("AAMC"), by counsel, hereby seeks from the Maryland Health Care Commission (the "MHCC") interested party status in regard to Docket No. 13-16-2351, the application by Dimensions Health Corporation and Mt. Washington Pediatric Hospital, Inc. (the "**Applicants**") for a certificate of need to replace Prince George's Hospital Center ("**PGHC**") with a new hospital located in Largo, Maryland ("**PGRMC**") as referenced in the April 3, 2015 edition of the Maryland Register (the "**Application**").

AAMC recognizes that the Applicants wish to modernize their facilities. AAMC does not oppose this laudable goal. Prince George's County residents deserve a modern and vibrant health care delivery system in their community. However, AAMC urges the MHCC to evaluate fully the viability of all components of the project.

I. AAMC – Background

AAMC includes a 384-bed, not-for-profit, acute care hospital nationally recognized in quality for joint replacement, emergency heart attack response and cancer care. It is the third busiest hospital in Maryland (measured by patient volume). AAMC was founded in 1902 and remains part of an independent health system located in Annapolis, Maryland. This health system includes a multi-specialty medical group of 300 clinicians in 40+ locations throughout the region, an accountable care organization participating in the Medicare Shared Savings Program, mental health and substance use treatment facilities, unregulated imaging centers, lab services, a clinical research institute, and a simulation and innovation center.

A shared strategic vision – “living healthier together” – was defined in 2010, reorienting what was a successful hospital into a regional health system. This vision of a regional health system dedicated to healthy lives of Marylanders – including its patients in Prince George’s County and throughout the region – has prompted AAMC to comment on this Application.

II. AAMC Qualifies as an Interested Party to the Application

AAMC qualifies as an interested party to the Application. An “interested party” includes, among others, “[a] person who can demonstrate to the reviewer that the person would be adversely affected, in an issue area over which the Commission has jurisdiction, by the approval of a proposed project.”¹ An “adversely affected” person includes a person who:

¹ COMAR 10.24.01.01(B)(20)(e).

- A. “Is authorized to provide the same service as the applicant...in a contiguous planning region if the proposed new facility or service could reasonably provide services to residents in the contiguous area...,”² or
- B. “Can demonstrate to the reviewer that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction...”³

AAMC is adversely affected within the meaning of (A) above. AAMC provides acute care hospital services, and the Application concerns acute care hospital services.⁴ Further, AAMC is in the Baltimore/Upper Shore health planning region, which is contiguous with the proposed project’s proposed location in the Southern Maryland health planning region. Finally, the Application itself states that the proposed project would service residents of the Baltimore/Upper Shore health planning region: the Application states that the PGHC draws patients from Anne Arundel County; the Application includes Severn, Maryland in its secondary service area⁵; and the proposed site is closer geographically to Anne Arundel County.

AAMC is adversely affected within the meaning of (B) above. The Application itself estimates that the proposed project would result in 420 fewer FY 2022 discharges by AAMC.⁶ This is a direct detrimental impact on inpatient hospital volume, an issue area over which the Commission has jurisdiction.

² COMAR 10.24.01.01(B)(2)(a).

³ COMAR 10.24.01.01(B)(2)(d).

⁴ Page 24 of the Application asks that PGRMC “be licensed for 216 inpatient beds comprised [in part] of 133 MSGA beds...”

⁵ See Exhibit 26 to Application at p. 4 (including zip code 21144 in secondary service area).

⁶ See Application at p. 224 (Table 74).

For the above-stated reasons, AAMC qualifies as an interested party to this Application.

III. Comment - Cardiac Surgery at PGRMC

The Application raises multiple questions about whether a cardiac program relocated to PGRMC can satisfy the State Health Plan for Facilities and Services (the “SHP”): Cardiac Surgery and Percutaneous Coronary Intervention Services, codified at COMAR 10.24.17.

First, the Application does not systematically address the SHP cardiac standards. Although the Application states that “[t]he relocation of PGHC to PGRMC does not involve creating a new cardiac surgery service,”⁷ nevertheless “a hospital with cardiac surgery [that] seeks to relocate” must meet “all applicable CON standards” in the SHP.⁸ Perhaps the Application is asking the MHCC to carve out an exception for PGRMC, but the Application does not offer any reasons for such an exception.

Second, the Application does not claim, let alone demonstrate, that PGRMC will meet the SHP’s minimum volume standard for cardiac surgery programs. A cardiac surgery program seeking to relocate must “attain a minimum annual volume of 200 cardiac surgery cases by the end of the second year of operation.”⁹ Yet the Application only claims that PGRMC will attain 179 discharges for cardiac surgery by FY 2022.¹⁰

Prince George’s County can generate the necessary cases if outmigration is sufficiently mitigated, but the Application does not show (or even claim) that PGRMC will capture sufficient market share to reach 200 cases annually in the relevant time period.

⁷ Application at p. 185.

⁸ COMAR 10.24.17.04(C)(1).

⁹ COMAR 10.24.17.05(A)(1)(a).

¹⁰ Application at p. 79 (Table 23).

Third, the Application does not clearly support the conclusion that PGRMC will achieve its own volume projection. The Application calculates that PGRMC must climb from a **2.7%** service area market share in FY 2013 to a **33%** service area market share in FY 2022 to achieve the 179 cardiac surgery cases projected. This represents more than a twelve-fold increase in market share, when the cardiac surgery volume of PGHC **declined** from a 14% market share in FY 2010 to 24 cases in FY 2011 to 5 cases in FY2012.¹¹

In that regard, it is significant that the Application has not demonstrated a referral base to support a cardiac surgery program. The Application asserts that “PGHC has approximately 10-12 loyal cardiologists who have stated that a cardiac surgery program is needed in the community. They believe there is adequate volume potential, and support to revitalize the cardiac surgery program with University of Maryland cardiac surgeons.”¹² What substantiates this belief? What volume can these cardiologists bring to the program? If these cardiologists are loyal and generate a number of cardiac surgery cases, why did PGHC perform only 5 cases in FY 2012? Can PGRMC grow its base of loyal cardiologists when other regional hospitals are investing in cardiology practices, outreach, and education in Prince George’s County?¹³ The Application does not answer these questions.

Similarly, the Application has not specified the source of the cardiac surgery volume it expects to gain from its trauma center. The Application states that PGRMC should retain a

¹¹ See Exhibit 26 to Application at p. 6 (including zip code 21144 in secondary service area).

¹² Application at p. 188.

¹³ That said, AAMC does not view its own proposed cardiac surgery program as competitive with PGRMC. AAMC does not anticipate that AAMC would draw a large number of cardiac surgery cases from Prince George’s County.

cardiac surgery complement in connection with its Level II center.¹⁴ But how many cardiac surgery cases (from the proposed service area and otherwise) currently originate in the trauma center? Would this volume be sufficient in the absence of the (speculative) increase in referred, non-emergent cardiac surgery cases by local cardiologists? What percentage of total cardiac surgery program volume would this represent? Should the trauma center justify retention of the cardiac surgery program, when cardiac surgery is not essential for a Level II trauma center?¹⁵

Rather than address these natural questions directly, the Application relies on an unpersuasive 2012 business plan to demonstrate that PGRMC is capable of this market share breakthrough. The business plan is heavily redacted.¹⁶ For example, the business plan asserts that the Applicants will recruit and expand access to cardiologists, but specific steps to achieve this goal are absent or at least redacted.¹⁷

The business plan – now over two years old – is also outdated. For instance, the plan assumes a funding stream in line with a pre-waiver reform expectation that an “HSCRC 85% variable cost factor [will be] applied to service line volume growth for both Inpatient and Outpatient charges” for the program.¹⁸ The business plan also calls for PGHC to achieve 300 cardiac surgery cases by FY 2017¹⁹ when the Application does not anticipate that the Applicants can achieve even 200 cases by FY 2022. Similarly, the business plan calls for collaboration with

¹⁴ See Application at p. 185.

¹⁵ See COMAR 30.08.05.09 (cardiac surgery is a desirable but not essential service for a Level II trauma center).

¹⁶ See Exhibit 26 to Application.

¹⁷ *Id* at pp. 15-16.

¹⁸ *Id* at p. 28.

¹⁹ *Id* at p. 6.

UMMS on a new “Heart & Vascular Institute,”²⁰ but the recent application of Baltimore-Washington Medical Center to perform cardiac surgery suggests that UMMS’ attention may be elsewhere and that UMMS’ vision for UMMS cardiac surgery (one program, three locations) does not include a fourth location (namely, PGRMC).²¹

Finally, the business plan may already be faltering. For instance, the business plan appears to call for significant physician recruitment to begin in FY 2013 (allocating increased capital to physician recruitment and salaries for FY 2014), but the Application states only that the head of cardiac surgery has been replaced (effective July 2014) as Dimensions remains “**in the process** of recruiting one or more cardio-thoracic surgeons” for the program.²²

For the above reasons, the MHCC should carefully scrutinize whether PGRMC’s proposed cardiac surgery relocation satisfies the volume and other requirements of the SHP.

IV. Comment - Viability of PGRMC

The Application does not demonstrate that Marylanders would be better served by the establishment of the new PGRMC, rather than by substantial investments in the health care delivery system in Prince George’s County. Given the health care practitioner shortage facing the County, it is doubtful that PGRMC can become viable as a \$650,000,000, 215-bed hospital without first investing in ambulatory care, especially primary care, in the County.

²⁰ *Id* at p. 17.

²¹ See “Certificate of Need Application: Cardiac Surgery, Research, and Training Program at the University of Maryland Baltimore Washington Medical Center as Part of the University of Maryland Division of Cardiac Surgery – ‘One Program, Three Locations’” (Feb. 20, 2015) at p. 5 (“The proposed program at UM BWMC will be part of the existing University of Maryland Cardiac Surgery Program currently located at the University of Maryland Medical Center [] and University of Maryland St. Joseph Medical Center [].”)

²² Application at p. 77 (emphasis added).

Prince George's County has had tremendous difficulty attracting and retaining a strong medical community of physicians. The Application itself candidly acknowledges that Prince George's County "lack[s]...a well-functioning ambulatory care safety net. Prince George's County has a substantially lower ratio of primary care providers to the population compared to surroundings [sic] counties and the state."²³ Three recent studies concur: (1) a 2012 study by the University of Maryland School of Public Health entitled "Transforming Health in Prince George's County, Maryland: A Public Health Impact Study" (the "UM Study"),²⁴ (2) Dimension's own 2013 community needs assessment for PGHC (the "Dimensions CHNA")²⁵ and an associated implementation strategy plan for fiscal 2014-2016 (the "Dimensions ISP"),²⁶ and (3) a 2009 study by the RAND Corporation of health and health care access in Prince George's County (the "RAND Study").²⁷

For example, the RAND Study assesses the health care access challenge facing Prince George's County as access to ambulatory care, not lack of hospital capacity. "Prince George's appears to have adequate hospital capacity" but "[p]rimary care physicians are in short supply" and "Prince George's lacks a primary care safety net."²⁸ The UM Study similarly identifies "a substantially lower ratio of primary care providers to the population compared to surrounding counties and the state" with particularly dire need in certain sub-county geographic areas

²³ Application at p. 9.

²⁴ University of Maryland School of Public Health, *Transforming Health In Prince George's County, Maryland: A Public Health Impact Study* (July 2012), <https://sph.umd.edu/sites/default/files/files/TransformingHealth.pdf>

²⁵ Dr. Lori Simon-Rusinowitz *et al.*, *Community Health Needs Assessment Prince George's County Hospital Center* (June 7, 2013), <http://www.dimensionshealth.org/wp-content/uploads/2013/07/FINAL-PGHC-CHNA-REPORT.2013.pdf> The Dimensions CHNA is Exhibit 45 to the Application.

²⁶ The Dimensions ISP is Exhibit 46 to the Application.

²⁷ Nicole Lurie *et al.*, *Assessing Health and Health Care in Prince George's County* (2009), http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR655.pdf

²⁸ RAND Study at p. v.

containing “16 percent of County residents”²⁹ in its assessment of the distribution of the primary care workforce.³⁰

This shortfall in medical community support translates into a shortfall of patient support for PGHC. In accounting for the high level of Prince George’s County residents seeking care outside of the county, the RAND Study identifies factors including “resident preferences, convenience, and provider referral patterns.”³¹ Dimensions CHNA itself cites survey evidence showing that among County residents viewing PGHC unfavorably, over half (51.7%) said that adding quality health care practitioners would be the most important change PGHC could make to change that unfavorable view, an additional 20.7% said adding practitioners was as important as facility modernization or a new facility, and only 17.1% said that a new facility or facility modernization is a more important than adding quality physicians or adding quality non-physicians to PGHC staff.³² Similarly, community leaders and health experts cited by the Dimensions CHNA proposed strategies for addressing the County’s needs focusing largely on improving access to **community-based** providers.³³ Examples include establishing “medical daycare centers and mobile clinics,” placing “services into the community to promote health and intervene early” in “partnership with community-based organizations,” a focus on “reach[ing] residents where they are,” deploying “PGHC specialists in the community to increase access to

²⁹ UM Study at p. 6.

³⁰ For example, table 4 on page 7 of the UM Study compares Prince George’s to Anne Arundel, Baltimore County, Howard County, Montgomery County, and Maryland as a whole, and places Prince George’s County last in primary care physicians per 100,000 residents, nurse practitioners per 100,000 residents, and physician assistants per 100,000 residents.

³¹ RAND Study at pp. v-vi.

³² Dimensions CHNA at p. 41 (Table 12).

³³ Dimensions CHNA at p. 41 (Table 13).

care” and partnering with other hospitals and health systems “to link patients to specialty care.”³⁴

No mention is made here of renovation or replacement of the physical plant.

Indeed, the Dimensions ISP recognizes the need for “physician recruitment and establishing access points such as primary care offices within the community”³⁵ but does not supply benchmarks or other concrete targets for these strategies. That is, neither the Dimensions ISP nor the Dimensions CHNA establishes any metric to evaluate success in meeting the goals of improving health access and health care practitioner availability. Instead, the Dimensions ISP merely delegates the “proper execution of the plan” to “internal and external advisors” and “engag[ed] partners.”³⁶

It is therefore not clear how the Applicants will overcome the serious shortage of local area specialists and a shortage of primary care physicians in particular subregions of the County. Yet a hospital of this size - a **\$650,000,000, 215-bed** hospital - cannot be viable without a local physician base and a physician base with adequate volume. Clearly, the Applicants are committed to supporting **some** number of additional physician practices. However, the investment that would be required to “fill beds” and to make a 215-bed hospital financially viable is substantial.³⁷ That investment may be delayed or denied if available resources for the health care delivery system are diverted to building, staffing, and then filling a 215 bed hospital.

³⁴ Dimensions CHNA at p. 41 (Table 13).

³⁵ Dimensions ISP at p. 6.

³⁶ Dimensions ISP at p. 12.

³⁷ Note that Table G1 of Exhibit 1 of the Application calls for the project to be supported by, among other funds, (a) tens of millions of dollars in grants by the State of Maryland, (b) tens of millions of dollars in grants by Prince George’s County, and (c) a 7.6% capital-related rate increase. The rate increase especially represents a long-term draw on the resources of the health care delivery system, impacting the Health Services Cost Review Commission’s ability to fund properly other Maryland hospitals while still preserving the Medicare demonstration project. In that regard, although CMS may adjust Medicare waiver targets to accommodate this rate increase, the waiver agreement

AAMC hopes that the MHCC will take medical community infrastructure and support into account in evaluating the Application. The SHP states that “[a]cute care hospital services will be provided in the most cost-effective manner possible.”³⁸ The MHCC must “compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities” and “consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.”³⁹

Unfortunately, the Application does not lay out a plan to generate the medical community infrastructure and support necessary to make PGRMC viable. If such a plan exists, it should be shared with the MHCC so that the viability of the project may be assured.

V. Conclusion

With substantial investments in Prince George’s County’s medical community (especially in cardiology and primary care), an appropriately-sized, appropriately-supported hospital project can thrive in Prince George’s County. The Application does not yet contain a plan to achieve this.

does not require CMS to make an adjustment, and the waiver agreement is set to expire in 2017 (before the project is completed) in any event.

³⁸ COMAR 10.24.10.03.

³⁹ COMAR 10.24.01.08(G)(3)(c), (d).

Therefore, as an interested party to the Application, AAMC asks the MHCC to evaluate the viability and cost-effectiveness of all components of the project. In particular, the MHCC should (1) require PGRMC to demonstrate that it will meet the minimum volume threshold for cardiac surgery cases called for by the SHP, and condition PGRMC's retention of that authority upon meeting such threshold, or explain why an exception is being crafted for PGRMC in that regard, and (2) require PGRMC to demonstrate sufficient medical community infrastructure and support to sustain the entire project, or set forth PGRMC's plan for achieving the same, including clear and objective periodic benchmarks that must be met for the project (and associated construction) to proceed.

Thank you for your attention to these comments. Please send copies of relevant notices concerning this matter - Docket No. 13-16-2351 - to me for receipt on behalf of AAMC. Please feel free to contact me with any questions or requests for additional information.

Respectfully Submitted,



Jonathan Montgomery

cc: Anne Arundel Medical Center (Internal Distribution)
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