LIFEBRIDGE
HEALTH

Sinai Hospital
Northwest Hospital
Carroll Hospital
Levindale Hebrew Geriatric Center and Hospital

Neil M. Meltzer
President and Chief Executive Officer

July 23, 2015

Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Anne Arundel Medical Center Proposal to Change the Type and Scope of Health Care Services Offered to Include Cardiac Surgery - Matter No.15-02-2360; and University of Maryland Baltimore Washington Medical Center Proposal to Change the Type and Scope of Health Care Services Offered to Include Cardiac Surgery - Matter No.15-02-2361

Dear Mr. McDonald:

LifeBridge Health, Inc. ("LifeBridge") submits the following comments pursuant to COMAR 10.24.01.08 regarding the applications for certificates of need to provide cardiac surgery of Anne Arundel Medical Center (the "AAMC Application") and University of Maryland Baltimore Washington Medical Center (the "BWMC Application"), jointly referred to as the "Applications".

LifeBridge requests that it be recognized as an interested party in the reviews of the Applications. LifeBridge's subsidiary, Sinai Hospital of Baltimore, Inc. ("Sinai"), is authorized to provide cardiac surgery services in the same planning area as proposed in the Applications, the Baltimore Upper Shore Health Planning Region ("Baltimore Region"). LifeBridge would be adversely affected by the approval of either of the Applications. Both Applications project that they would divert a number of cardiac surgery cases from other programs in the Baltimore Region, including Sinai's program.

The Applications do not present persuasive evidence that there is a need for an additional cardiac surgery program in the Baltimore Region. Neither Application questions the Commission's latest projection (Maryland Register, 6 Feb. 2015, p. 402) that the number of adult cardiac surgery cases in the Baltimore Region will decline over the next several years, from 3,007 cases in 2014 to 2,635 cases in 2019. They provide no evidence that the existing cardiac surgery programs are not adequately serving the current need for these services, or are

not fully capable of meeting the diminishing need projected by the Commission. Instead, the Applications seek to justify the proposed new programs on the ground of convenience for residents of their service areas and the hospitals' own institutional goals and priorities.

Convenient access for patients is a legitimate consideration, but if carried to its logical conclusion it would dictate having a cardiac surgery program at every hospital in Maryland, or at least in every jurisdiction. The Commission has long taken the position that for tertiary services such as cardiac surgery, convenient access must be balanced against the benefits of regionalization. This position is based on the fact that there exists much evidence that cardiac surgery programs which fall below certain volume thresholds are more likely to provide lower-quality care. As stated in the State Health Plan for Facilities and Services: Specialized Health Services - Cardiac Surgery and Percutaneous Coronary Intervention Services, COMAR 10.24.17 ("Cardiac Surgery Chapter"), p. 6, "for specialized services, the public is best served if a limited number of hospitals provide specialized services to a substantial regional population base. This pattern promotes both high quality care and an efficient scale of operation." Similarly, p. 8 of the Cardiac Surgery Chapter states: "Numerous research studies show that a strong inverse relationship exists between the volume of cardiac surgery performed and patient mortality and surgical complications."

To cite just one recent study, the risk-adjusted mortality for coronary artery bypass graft surgery ("CABG") has been found to be 23% higher for hospitals in the lowest quintile of CABG volume than for hospitals in the highest quintile. Gonzalez, Dimick, Birkmeyer, Ghaferi, "Understanding the Volume-Outcome Effect in Cardiovascular Surgery: The Role of Failure to Rescue", JAMA Surgery, 2014; 149(2): 119-123. The authors of the study concluded that this effect was more closely related to failure-to-rescue ("FTR") rates (defined as the proportion of deaths among patients who developed at least one postoperative complication) rather than complication rates, and estimated that if low-volume hospitals were to have the same FTR rate as high-volume hospitals, 487 deaths would have been prevented during the two-year study period.

Approval of either of the Applications would present two significant risks:

(1) that the new program, despite its best efforts and optimistic projections, would not achieve sufficiently high volumes to ensure high-quality outcomes; and

(2) that, if the new program were to succeed in diverting a substantial number of cases from existing programs, the ability of the existing programs to achieve high-quality outcomes would be adversely affected.

As an illustration of the risk of overly optimistic projections, Suburban Hospital ("Suburban"), the most recent successful applicant for a new program, projected in its application that it would achieve volumes in excess of 350 cases per year. However, during

2011 - 2014, Suburban's volumes were consistently below 250 cases per year. It is worth noting that Suburban's application, like AAMC's, was based on programmatic support from the cardiac surgery program at The Johns Hopkins Hospital.

These risks are compounded because of the pending application of Prince George's Regional Medical Center ("PGRMC") to replace its current facility with a new hospital to be located in Largo, Maryland. An integral part of the PGRMC proposal is the revitalization of its languishing cardiac surgery program; PGRMC projects that its cardiac surgery volume will increase from 13 cases in 2014 to 220 cases in FY 2022. In its March 13, 2015 Responses to Additional Information Questions, Table 79 at page 26, PGRMC projected the following utilization of cardiac surgery cases:

2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
8	22	13	75	100	120	140	160	180	200	220

While PGRMC is located in the Metropolitan Washington Health Planning Region rather than the Baltimore Region, it is actually closer to AAMC and BWMC than most of the cardiac surgery programs in the Baltimore Region. According to Google Maps, the proposed PGRMC site (Boulevard at the Capital Centre) is 21.8 miles by road from AAMC and 29.3 miles by road from BWMC. The service area of PGRMC overlaps with that of AAMC, as AAMC itself noted in its written comments on the PGRMC application. Moreover, both PGRMC and BWMC look to the University of Maryland Medical System ("UMMS") for programmatic support and cooperation in diverting cardiac surgery patients from UMMS, so that approval of both the PGRMC relocation proposal and the BWMC proposal would require UMMS to support the development and growth of two nearby cardiac surgery programs at the same time. This would be difficult, if not impossible, to accomplish simultaneously.

If the PGRMC proposal is approved and if PGRMC manages to achieve cardiac surgery volumes of more than100 cases per year over the next few years, it seems likely that the approval of a successful program at either AAMC or BWMC would have an adverse impact on the PGRMC program such that it would slip back below 100 cases per year. This would violate the Impact standard in the Cardiac Surgery Chapter, COMAR 10.24.17.05.A(2).

Another program which could be adversely affected is Suburban Hospital's. While there is relatively little overlap between Suburban's service area and that of AAMC or BWMC, the Suburban program is operating quite close to the standard of 200 cases per year, making it vulnerable to even a minor reduction in volume. According to LifeBridge's analysis of cardiac surgery cases in the HSCRC database, Suburban had 242 cases in FY 2014, and 161 cases for the first three quarters of FY 2015, which equates to an annualized figure of 215 cases. During the

same three quarters of FY 2015, 12 of Suburban's cases originated in the proposed AAMC service area, which equates to an annualized figure of 16. If 16 cases were to be diverted to a program at AAMC, it would have the effect of reducing Suburban's cardiac surgery volume below 200 cases per year, in violation of the Impact standard. The figures cited above are based on current (FY 2015) volumes and do not take into account the decline in cardiac surgery utilization projected by the Commission during 2014 - 2019. When the projected overall decline of 10.7% (CY 2014 - CY 2019, All Regions) is also considered, Suburban's program is clearly at risk of dropping below 200 cases, especially if it is simultaneously facing a new program at AAMC or BWMC and a revitalized program at PGRMC. This, too, would violate the Impact standard in the Cardiac Surgery Chapter, COMAR 10.24.17.05.A(2).

For all these reasons, LifeBridge respectfully submits that the Applications are not consistent with the State Health Plan and should be denied.

Sincerely yours,

Neil M. Meltzer
President & Chief Executive Officer