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MEMORANDUM

TO: Donna Kinzer, Executive Director, HSCRC
Jerry Schmith, Deputy Director, Hospital Rate Setting, HSCRC

FROM: Craig P. Tanio, M.D.
Commissioner/Reviewer CT | eP

DATE: July 15, 2016

RE: Applications for Certificates of Need
To Establish Cardiac Surgery Services
Anne Arundel Medical Center (Docket No. 15-02-2360)
University of Maryland Baltimore Washington Medical Center
(Docket No. 15-02-2361)

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As you know, Anne Arundel Medical Center ("AAMC") and the University of Maryland Baltimore Washington Medical Center ("BWMC") have filed Certificate of Need ("CON") applications proposing to establish adult cardiac surgery services. Both applications propose development of new adult cardiac surgery programs supported by existing Baltimore-based cardiac surgery providers: in the case of AAMC, with the support of Johns Hopkins Medicine; and, in the case of BWMC, with the support of its parent system, the University of Maryland Medical System. AAMC has estimated the cost of developing an adult cardiac surgery program as $2,500,381 for building renovations and equipment. BWMC's project cost estimate is $1,259,117 for equipment and consulting fees. In both cases, the hospitals anticipate funding these project expenditures with cash reserves. Each hospital currently provides both emergency and elective percutaneous coronary intervention ("PCI") services.

I am requesting that HSCRC staff generally review the financial projections provided by these two applicants and the assumptions (revenue, expenses, staffing, and utilization) upon which these projections are based, as provided in the CON application and subsequent filings, and comment on the financial feasibility of the projects and the reasonableness of the assumptions. More specifically, I have a set of questions, provided below, that I would like the HSCRC staff to address, based on MHCC's review and analysis of the applications and interested party filings.

I want to provide you with some brief background on cardiac surgery utilization as you consider the applicants' underlying use assumptions. As you may know, the volume of adult cardiac surgery cases performed at Maryland hospitals began a steady decline in 2002 that continued through 2012. Case volume declined approximately 35% over this time period. Since that time, statewide case volume for Maryland hospitals has begun to increase, fast enough to suggest some increase in the population use rate. COMAR 10.24.17, the Cardiac Surgery and PCI Services Chapter of the State Health Plan for Facilities and Services contains a methodology for projecting adult cardiac surgery case volume, at a regional level, that relies on the most recent six-year trend in the use rate of adult cardiac surgery, adjusted for cross-regional migration, as a basis for projecting the volume of adult cardiac surgery cases six years from the base year. The most recent MHCC forecast, published in 2015 for a base year of 2013, projected a decline in total adult cardiac surgery cases statewide of 10.7% between 2014 and 2019 based on the use rate trend observed for the period 2008 through 2013.

Both of the proposed adult cardiac surgery programs are located in Anne Arundel County, which is located in the Baltimore Upper Shore Region. Adult cardiac surgery case volume was projected to decline 12.4% in this region, in which Baltimore area programs have the highest market share, between 2014 and 2019. The adjacent Metropolitan Washington Region, in which Washington, D.C. area programs have the highest market share, is relevant in this review, because a substantial proportion of cases originating in Anne Arundel County use D.C. hospitals for cardiac surgery. Adult cardiac surgery case volume was projected to decline 7.8% in this region between 2014 and 2019. This forecast can be viewed at http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_cardiaccare/documents/con_projected_cardiac_cases_14_19_20150206.pdf

The applicants, as required by the State Health Plan, addressed this demand projection in their applications. Both applicants assume that, in addition to capturing cardiac surgery market share in their existing service areas for medical and surgical care, which is a shrinking pool of cases based on MHCC projections, they will also be aided in reaching and maintaining an appropriate volume of cardiac surgery cases through the collaborative efforts of their respective hospital system affiliates. Both The Johns Hopkins Hospital and the University of Maryland Medical Center have relatively high cardiac surgery case volumes, the highest in Maryland.

My specific questions are as follows:

1. Does either or both applications accurately reflect the shifts in revenue that will occur under the new payment model if the applicant hospitals succeed in building the cardiac surgery case volume they project?

2. Is the revenue impact at each applicant hospital correctly modeled and is the revenue impact correctly modeled for the hospitals that are projected to lose cardiac surgery case volume if the new cardiac surgery programs are put into operation?

3. Does each application provide a plausible scenario for an overall reduction in the cost of producing cardiac surgery services in Maryland and a reduction in the charges that will be incurred by payors for cardiac surgery services in Maryland, if the hospital is authorized to establish cardiac surgery services and is successful in shifting the projected volumes of service to their lower cost hospitals? More specifically, does each application provide

sufficient information for HSCRC staff to assess the following capabilities and, if so, what is HSCRC staff's assessment:

a. The capability of AAMC and the capability of BWMC to deliver cardiac surgery at the costs each hospital projects;

b. The capability of AAMC and the capability of BWMC to deliver cardiac surgery with the increases in revenue that each hospital will realize under the payment model; and

c. The capability of Maryland hospitals projected to lose cardiac surgery volume if either or both the AAMC and BWMC programs are approved to adjust their variable costs so that the net income derived from this service will not be greatly affected?

4. If a hospital currently providing cardiac surgery services experiences a net reduction in revenue because of the loss of cardiac surgery volume resulting from the creation of a new cardiac surgery program at AAMC or BWMC, or at both hospitals and that hospital is unable to reduce its cost sufficiently to offset this lost revenue, will that hospital be able to approach HSCRC and seek rate relief, negating the projected savings in charges that the applicants project to result from their respective proposals? Does the payment model or HSCRC policy prevent such an outcome? Are there mechanisms by which hospitals, within the context of this project review, can waive any "right" to seek such rate relief, thus assuring that systemic savings for Maryland payors achievable by shifting cardiac surgery case volume to lower charge hospitals will actually occur and be sustained? Are there other mechanisms that would help insure systems savings that we have not considered?

5. Does the shift of cardiac surgery case volume from Washington, D.C. hospitals to Maryland hospitals paid for by Medicare, which is more pronounced in the case presented by AAMC, have a concerning negative impact on the spending and savings targets HSCRC must meet under the Medicare waiver?

6. Is it likely that the ability of D.C. hospitals to negotiate charge levels for cardiac surgery with individual payors will make it more difficult to shift volume away from these hospitals to new Maryland providers?

Please review and comment on any other aspects of this application pertinent to this request. It would be most helpful to have your response no later than August 5, 2016.

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