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CHS-7783

February 13, 2017



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: *Baltimore Upper Shore Cardiac Surgery Review*
Docket Nos. 15-02-2360 / 2361

Dear Mr. Parker:

Enclosed for filing in the above referenced matter is Interested Party Dimensions Health Corporation d/b/a Prince George's Hospital Center's Response to Anne Arundel Medical Center's Comments on Evidentiary Ruling.

Copies have been emailed and sent via first class mail to the persons named on the attached certificate of service.

Please date stamp and return the enclosed extra copy of this filing to the Courier for our files. Thank you.

Sincerely,

M. Natalie McSherry

M. Natalie McSherry

MNM/mnm
Enclosures:
cc: All Counsel of Record (sent via electronic & first class mail)

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| **IN THE MATTER OF** | * | **BEFORE THE** |
| **ANNE ARUNDEL MEDICAL** | * | **MARYLAND HEALTH** |
| **CENTER, INC.** | * | **CARE COMMISSION** |
| | * | **Docket No.: 15-02-2360** |

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**INTERESTED PARTY DIMENSIONS HEALTH CORPORATION D/B/A PRINCE GEORGE'S HOSPITAL CENTER'S RESPONSE TO ANNE ARUNDEL MEDICAL CENTER'S COMMENTS[1] ON EVIDENTIARY RULING**

Interested Party Dimensions Health Corporation d/b/a Prince George's Hospital Center ("PGHC"), by its undersigned counsel, submits its response to Anne Arundel Medical Center's ("AAMC's") Comments on the Evidentiary Ruling issued January 23, 2017.

## I. INTRODUCTION

AAMC claims, in its comments filed February 3, 2017, that "[t]he Relevant Data confirms that AAMC has the greatest potential to establish a low-cost, high-performance cardiac surgery program, improving access to cardiac surgery services in Anne Arundel County and the broader region without threatening the viability of any existing program (as Prince George's Hospital Center and AAMC can, and should, coexist)." Comments at 1. AAMC's claim is wrong. First, the "Relevant Data" as defined by AAMC was used to prepare an alternative model to estimate the minimum volume standard but, as explained below, that model is flawed and neither it nor the data on which it was based should have

[1] Although AAMC titled its Comments as a "Response", PGHC understands that the appropriate nomenclature for AAMC's submission would be Comments, and PGHC's submission is a Response to those Comments.

been relied upon. Second, PGHC demonstrated, and the Recommended Decision acknowledged, that approval of AAMC's project will have an impact on PGHC.

## II. ARGUMENT

### A. The Flawed Alternative Model

COMAR 10.24.17.05A requires that "an applicant proposing establishment . . . of cardiac surgery services shall document that the proposed cardiac surgery program" will satisfy certain standards relating to, among other things, minimum volume. *Id.* The Reviewer, in his initial recommended decision, determined that: (1) "AAMC's response to this standard was practical, well organized and well documented[;]" (2) "BWMC's approach to evaluating the demand it would likely experience as a cardiac surgery was also practical and sufficiently documented[;]" and (3) "[b]oth applicants forecast the ability to reach a level of cardiac surgery that should allow compliance with the adult open heart surgery part of this standard, given the high proportion of these community hospitals total cardiac surgical case load that would be open heart procedures." Recommended Decision at 26-27. The Reviewer also found that:

> there is a basis for concluding that some assumptions [taken by the applicants] about the market share levels they forecast, especially with respect to market share outside the collaborative framework which is proposed by both applicants to steer case volumes to their new programs, are not assumptions that can be described as conservative.

*Id.* at 27 (internal quotation marks omitted).

The Reviewer then constructed an alternative forecast model to measure minimum volume. *Id.* That alternative model made volume projections based upon the "applicants' observed 85% relevance medical/surgical/gynecological/addictions ("MSGCA") service

areas." *Id.* Based upon that alternative model, the Reviewer concluded that AAMC "presented information and analyses that demonstrate the ability to meet a projected volume of 200 adult open heart surgery cases in the second full year of operation" and that BWMC had not. *Id.* at 32. Implicit in this finding is a rejection of the applicants' analyses in favor of the alternative model.

The alternative model should not have been relied upon. First, the model assumes a correlation between population size of a hospital's MSGA service area and its case volume from all geographic locations. Yet there is nothing in the record establishing *any* correlation between these concepts. Absent a foundation demonstrating that this was the proper point of comparison, the alternative model is irreparably flawed and should not have been relied upon in gauging whether the applicants met the minimum volume standard.

Even if a correlation between population size of a hospital's MSGA service area and its case volume from all geographic locations could be established, the alternative model is still irreparably flawed. First, the alternative model considered volume in CY 2020, but both applicants anticipated implementation such that the second full year of operation would be 2019, not 2020. Data for 2020 is, therefore, not relevant.

Second, the alternative model relied upon the November 9, 2015 version of the State Health Plan, COMAR § 10.24.17.05(A)(1), which requires an applicant to perform 200 *open heart* surgery cases. In contrast, the version of that regulation applicable in this case was published August 18, 2014, and required an applicant to document the ability to perform 200 cardiac surgery cases. The alternative model appears, therefore, to rely upon

the wrong version of the applicable regulation. Consequently, the alternative model unnecessarily reduces the number of cardiac surgery cases. *See* Recommended Decision at 30-31. Similarly, the data provided from Virginia hospitals may be similarly flawed. That data does not indicate how cardiac surgery is defined, and whether that definition is the same as the definition applicable to this review.

Third, the Reviewer admits that he relied upon data without providing the parties the opportunity to comment on that data in advance of its entry into the record and without entering some of it until the filing of the Recommended Decision. This violates Section 10-213(h)(2) of the State Government Article of the Maryland Code, which provides that "[b]efore taking official notice of a fact, the presiding officer . . . shall give each party an opportunity to contest the fact." Md. Code Ann. State Gov't §10-213(h)(2). Thus, a party must be given an opportunity to contest a fact before it can be entered into the record. That did not happen in this case. Exceptions to a recommended decision are not a meaningful opportunity to contest a fact. *See In re Clarksburg Community Hospital*, Case No. 24-C-11-001046 (Pierson, J.) (Balt. City Cir. Ct. Feb. 21, 2012). Just as exceptions to a recommended decision do not provide a meaningful opportunity to contest facts, comments filed after the issuance of a recommended decision are also not a meaningful opportunity to contest a fact.

Because of the lack of a foundation for use of the alternative model, the flaws in the model, and the failure to allow the parties the proper opportunity to respond to the data utilized in the model before that data was entered into the record, the data and the alternative model should be stricken.

## B. The Impact on PGHC

The Recommended Decision found that BWMC did not comply with the Minimum Volume Standard. Recommended Decision at 118. This finding can only be based upon the alternative model because the Reviewer noted that BWMC forecasted "the ability to reach a level of cardiac surgery that should allow compliance with the adult open heart surgery part of this standard[.]" *Id.* at 26-27. This finding that BWMC did not comply with the Minimum Volume Standard obviously contributed to the Reviewer's ultimate finding that the AAMC application was stronger, and his recommendation that the AAMC application be granted and the BWMC application denied. Contrary to AAMC's unsupported assertion in its Comments, approval of AAMC's project will have a dramatic negative impact on PGHC.

As PGHC demonstrated in its Comments and in its Exceptions to the initial Recommended Decision, which are incorporated as if fully restated herein, a proper analysis of the AAMC proposal under both the impact standard and the minimum volume standard, leads inescapably to a showing that approval of a new cardiac surgery program at AAMC would shift cases away from PGHC. This is because AAMC's proposed service area overlaps with PGHC's existing service area and will, as the Reviewer found, subject PGHC to "healthy competition". Recommended Decision, at 118. It cannot be denied that competition will impact the program at PGHC. The only question is the degree of impact. Although AAMC steadfastly refuses to evaluate or quantify the impact that its proposed project will have on PGHC's existing program, PGHC has quantified that impact, and demonstrated that if AAMC's project is approved, there is a substantial

likelihood that this "healthy competition" will cause PGHC's annual volume of cardiac cases to drop below 100. If PGHC is not able to maintain sufficient annual volume to obtain a Certificate of Ongoing Performance within three years of commencing services at its relocated replacement hospital facility, the result could be the closure of its program, which would leave Prince George's County residents without a cardiac surgery center in the county. In other words, PGHC has clearly demonstrated the negative impact that approval of AAMC's project will have on PGHC's existing program and, potentially, the relocated Prince George's County hospital facility. One consideration that must be given under the State Health Plan to any application is the impact that the proposed program will have on existing programs. AAMC has not met this requirement, and to the extent that the newly admitted evidence was used to provide support for approval of the application, it should be stricken.

## III. CONCLUSION

For all of the above reasons, PGHC requests that the data and alternative model be stricken.

Dated: February 10, 2017

Respectfully submitted,

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## CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of February, 2017, a copy of the foregoing Comments on the Evidentiary Ruling was sent via email and first-class mail to:

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