IN THE MATTER REGARDING	*	
ANNE ARUNDEL MEDICAL CENTER	*	
Docket No. 15-02-2360	*	

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IN THE MATTER REGARDING	*	BEFORE THE
UNIVERSITY OF MARYLAND BALTIMORE-WASHINGTON MEDICAL CENTER	*	MARYLAND HEALTH CARE COMMISSION
Docket No. 15-02-2361	*	

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MEDSTAR HEALTH'S COMMENTS IN RESPONSE TO ANNE ARUNDEL MEDICAL CENTER'S PROPOSED MODIFICATION TO ITS CERTIFICATE OF NEED APPLICATION MADE PURSUANT TO THE PROJECT STATUS CONFERENCE

I. INTRODUCTION

MedStar Health, Inc. ("MedStar"), by its undersigned counsel and on behalf of its two health care facilities MedStar Union Memorial Hospital ("MUMH") and MedStar Washington Hospital Center ("MWHC"), hereby submits these Comments in Response to Anne Arundel Medical Center's Proposed Modification to Its Certificate of Need Application Made Pursuant to the Project Status Conference ("Comments") in response to the application modifications set forth in the Anne Arundel Medical Center Modification to Certificate of Need Application ("Modification") submitted on November 7, 2016. As previously asserted, the two MedStar facilities will be significantly detrimentally affected by this proposal.

In its Modification, Anne Arundel Medical Center ("AAMC") attempts to address requests concerning the Health Services Cost Review Commission Summary and raised again at the October 28, 2016 Project Status Conference ("PSC") by the Reviewer that the AAMC application was deficient, and that AAMC must modify its application to provide revised versions of all financial schedules regarding revenues, expenses, and income for: (1) its general

hospital operation; and (2) specifically, for its proposed cardiac surgery service." *Id.* at 3. In addition, the Reviewer required that the revised financial schedules be "accompanied by a detailed statement of the assumptions used in development of the modified financial schedules . . . [that] address and detail the way in which AAMC accounts for all of the revenue and expense changes it projects to result from its provision of cardiac surgery services, across all of the hospital's departments . . . . [as well as] how and why these schedules have changed in comparison to the revenue and projections filed by AAMC prior to docketing of its application." *Id*.

The requests recognize that the AAMC application as submitted was deficient and ill-conceived. This could not be avoided because there is no need for additional cardiac surgery services in Maryland. As stated by the Reviewer, this new information will have bearing on three standards in the Cardiac Surgery Chapter of the State Health Plan ("SHP") and four general CON review criteria. MedStar agrees that the initial AAMC application suffered from significant deficiencies; the modifications submitted do not cure these "flaws." As the Reviewer stated, the following review standards and criteria are relevant to this application, and remain at issue:

<u>Project Review Standards</u>

- Cost Effectiveness (COMAR 10.24.17.05A(4));
- Financial Feasibility (COMAR 10.24.17.05A(7)); and
- Preference in Comparative Reviews (COMAR 10.24.17.05A(8));

<u>General Review Criteria</u>:

- the State Health Plan (COMAR 10.24.01.08G(3)(a));
- Availability of More Cost-Effective Alternatives (COMAR 10.24.01.08G(3)(c));

- Viability of the Proposal (COMAR 10.24.01.08G(3)(d)); and
- Impact on Existing Providers & the Health Care Delivery System (COMAR 10.24.01.08G(3)(f)).

MedStar contends that, notwithstanding the opportunity to submit additional financial data and statements to AAMC's application pursuant to the project status conference, the deficiencies in the application with respect to the above project review and general review criteria continue to exist. The fatal flaw with respect to this application remains: it is not needed. Instead the applicant seeks its "piece" of a "shrinking pie" of cardiac surgery services. Therefore, the Reviewer should deny AAMC's request to establish a new cardiac surgery program once and for all.

II. AAMC'S MODIFICATION TO ITS APPLICATION FAIL TO REMEDY THE DEFICIENCIES IDENTIFIED WITH RESPECT TO REQUIRED PROJECT REVIEW CRITERIA IN THE CARDIAC SURGERY CHAPTER OF THE SHP.

A. The New Information Supplied in AAMC's Modification Fails to Demonstrate That The Proposed Cardiac Surgery Program is Cost-Effective in Accordance with COMAR 10.24.17.05A(4).

The basic faulty assumption underlying CON regulation is that excess capacity stemming from overdevelopment of health care resources results in health care price inflation. In fact, price inflation and inefficiencies occur when a hospital cannot fill its beds and fixed costs must still be met but through lower volume. This results in higher charges for the beds that are used. Because of this basic premise, the Cardiac Surgery Chapter of the SHP requires that an applicant "proposing establishment or relocation of cardiac surgery services shall demonstrate that the benefits of its proposed cardiac surgery program to the health care system as a whole exceed the cost to the health care system." COMAR 10.24.17.05A(4). The State Health Plan focuses on system-wide need and system-wide demand: the State Health Plan cautions that no new cardiac

surgery programs are currently needed and additional unneeded supply will negatively impact cost.

AAMC claims, in the updated Exhibit 39 submitted along with its Modification, that its proposed cardiac surgery program will save the Maryland health care system $11.3 million. However, there is no indication of growth in demand for which the AAMC program would be needed. Its services would be duplicative and unnecessary, and no "surge" is possible. What AAMC would do is simply re-shuffle demand among more providers, reducing efficiencies throughout the system. Costs of heart surgery services provided in these affected hospitals would likely increase. Furthermore, as stated by the Maryland Health Services Cost Review Commission ("HSCRC") in its August 24, 2016 letter to the Reviewer (hereafter, "HSCRC Letter") "[i]f the addition of the service at AAMC or BWMC results in increased volumes in the system due to increased supply, then system costs may be affected negatively", which means that costs would rise due to overutilization of cardiac surgery services.

AAMC's assumption that moving "lower severity" patients out of high cost academic medical centers and teaching facilities proliferating into "lower cost" setting providers is desirable – an "a surgery center on every corner" philosophy. If such movement occurs within a single hospital system this may be true, but is not true if AAMC were to siphon off only "lower cost" patients from other systems. In this case, the impact on other hospitals and systems is negative, not positive. Of relevance, this would be particularly problematic for Prince George's Hospital Center ("PGHC") where high costs are already an issue.

An AAMC cardiac surgery program in the county immediately adjacent to Prince George's County would undermine the longstanding public efforts to stabilize and redevelop PGHC. With more than $750 million in public funds dedicated to this effort by Prince George's

County and State, it is incumbent on policy makers not to jeopardize these investments.

For these reasons, AAMC's estimated system-wide savings is not realistic. Its proposal would add unnecessary additional costs to the system. Its proposal does not address any "unmet demand" but merely seeks to siphon patients from existing underutilized providers. Excess supply does not reduce costa, it increases costs. AAMC has not fully accounted for the impact that its program will have on costs at other hospitals, which is necessary to assess the overall cost-effectiveness of the proposal on the entire health care system. Without accurate estimates on the potential cost-savings to the system, the Reviewer should not conclude that AAMC's new cardiac surgery program is more cost-effective than the status quo.

B. AAMC'S Agreement to Not Shift Costs Internally to Account for Underutilization Does Not Address System-Wide Issues

AAMC's willingness to absorb additional coasts created by an underutilized cardiac surgery program in which the establishment of its GBR is not helpful to the impact of its program on costs and rates at other facilities. Further, the HSCRC has never in fact taken action to enforce such a requirement on past CON applicants. The HSCRC in fact acknowledges that hospitals awarded a CON have the right to request rate increases to cover lost volumes, "unless specifically agreed to by hospitals during the CON process," which further limits the impact that these commitments have on AAMC and Johns Hopkins.

C. The Financial Data Supplied in AAMC's Modification Fails to Demonstrate That The Proposed Cardiac Surgery Program is Financially Feasible in Accordance with COMAR 10.24.1705A(7).

As AAMC points out in its Modification, the SHP mandates both that a cardiac surgery program be financially feasible and that it not jeopardize the financial viability of the hospital. *Id*. at 4-5. The SHP mandates that <u>both</u> standards must be met for CON approval. With respect to a

project's overall financial feasibility, the SHP requires that "[w]ithin three years or less of initiating a new or relocated cardiac surgery program, [the applicant] will generate excess revenues over total expenses for cardiac surgery, if utilization forecasts are achieved for cardiac surgery services." COMAR 10.24.17.05A(7)(iv).

AAMC's original application premised its financial feasibility on incorrect, inflated assumptions that did not conform to HSCRC policy. That approach to demonstrating "financial feasibility" followed many months of application preparation and financial planning, proved faulty. As stated in the HSCRC Letter, "hospitals with increased volumes that are taken from other Maryland hospitals are allowed to retain 50% of the revenue associated with additional volume." *Id.* at 1. AAMC was admonished that it was required in its Modification to use a lower 50% revenue shift factor in accordance with HSCRC market share policy rather than the 85% revenue shift factor originally applied, and now AAMC's proposed cardiac surgery service will still operate at a significant losses of over $3 million during each of the first three years of operation. Modification at Table K-2. This anticipated loss is no the mark of a "financially feasible" proposal, and is inconsistent with the SHP, which specifically requires that the program achieve more revenues than expenses on a standalone basis by the third year of operation.

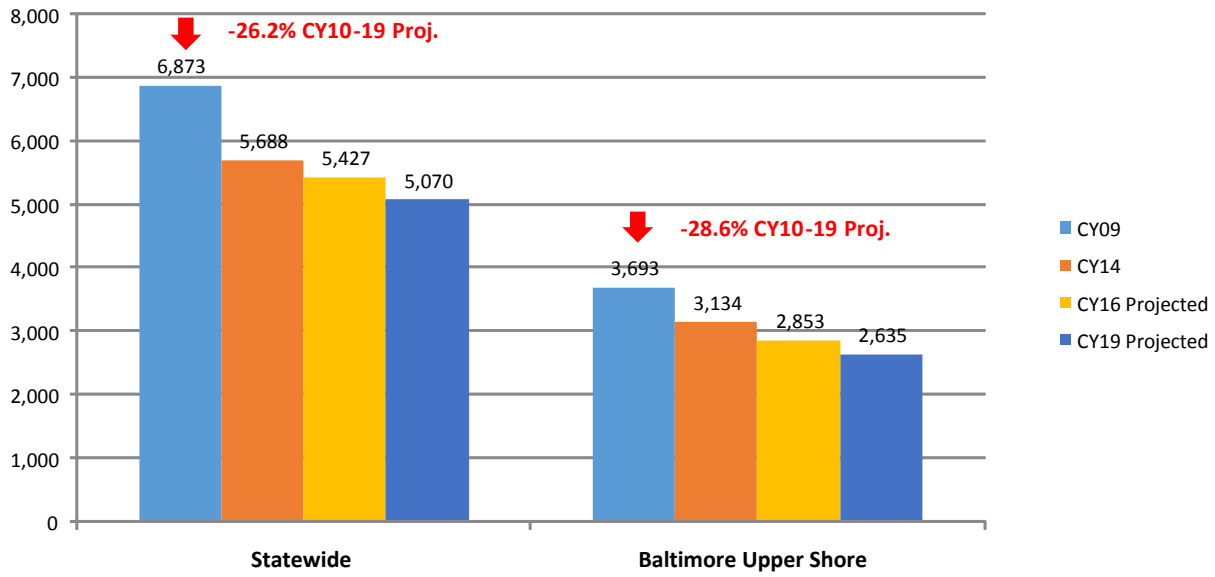
The negative cardiac surgery revenue projections that AAMC disclosed in its Modification are further compounded by the fact that AAMC's financial estimates are premised on underestimates of expenses necessary to operate a high-quality cardiac surgery program, and overestimates of base revenues that AAMC's new cardiac surgery program will earn that are based on infeasible volume projections.

First, with respect to AAMC's estimated expenses for operating the cardiac surgery program, the Modification fails to address the absence of all the necessary salary or contractual

costs for all the staffing necessary to operate a cardiac surgery program 24/7. As described in MedStar's July 2015 comments, AAMC failed to correctly estimate the personnel costs for establishing and running a quality program. Of particular concern is the applicants' failure to address how they would provide adequate staffing by an entire team of specialists, which demonstrates a lack of understanding of, or commitment to, an essential element of a quality program. The Modification also does not reflect realistic projections of growth in drug prices, particularly given the very real possibility that drug pricing controls will loosen due to reduced regulation in the new presidential administration.

AAMC's volume projections also remain illogical and miscalculated. In MedStar's Interested Party Written Comments filed July 27, 2015, MedStar stated that, "[a]t the very core of . . . inability to demonstrate financial viability is the fact that there is no unmet need to justify the addition of a new cardiac surgery service provider." *Id.* at 17. In fact, the Commission's own data shows a significant decline in the number of cardiac surgeries in Maryland and Baltimore Upper Shore planning region from 2009 to 2014. More importantly, the Commission projects a steady decline in utilization continuing through 2019.

Cardiac Surgery Utilization Trends, CY09 MHCC Projected CY19



Source: Maryland Health Care Commission (MHCC) staff analysis of Maryland and District of Columbia discharge data for hospitals with a cardiac surgery programs, CY10-14; MHCC Projected Adult Cardiac Surgery Cases by Health Planning Region, CY14-19, Maryland Register, Volume 42, Issue 3, Friday, February 6, 2015.
Notes: CY10-14 open heart surgery cases were counted based on the definition in COMAR 10.24.17, which includes specific ICD-9 procedure codes. Adult cases are those records with age 15 or older reported.

AAMC's volume projections, which themselves would be siphoned from existing, underutilized providers, fly in the face of this downward trend in cardiac surgery demand. These reduced volume trends are the primary reason why AAMC cannot demonstrate financial viability of the proposed program. Now, the new Prince George's facility has been approved and will provide additional capacity to serve this dwindling cardiac surgery demand. AAMC's revenue projections were overestimated based on unsupported guesses as to the hospital's potential ability to shift surgery volume market share from existing providers like PGHC and WHC. Neither the updated financial tables nor the supporting statements in AAMC's Modification correct these overestimates. When demand for cardiac surgery services is decreasing and there are sufficient numbers of existing providers to meet that decreasing demand, a new service is not needed.

The HSCRC Letter itself supports MedStar's assertions: "it is not likely that the ability of

D.C. hospitals to negotiate charge levels for cardiac surgery will make it more difficult to shift volume away from these hospitals to new Maryland providers." *Id.* at 4. In other words, AAMC's statements that its "lower-cost" setting will drive volume to its cardiac surgery program is a dubious proposition. AAMC's estimate of 2.9% in projected revenue growth from the cardiac surgery program does not reflect realistic surgery volume growth. Because of these unrealistic estimates, it is very unlikely that HSCRC will grant this projected level of revenue growth to AAMC. In fact, AAMC essentially admits that the HSCRC has not granted the potential adjustments to AAMC, and cannot guarantee that HSCRC will do so in the future. Modification at 8.

AAMC seeks to rescue this project from its lack of financial viability by suggesting that the HSCRC could funnel revenue to the proposed cardiac surgery service through other resources. In support of this argument, AAMC suggests that no proposed program would be financially viable without "certain future" paper adjustments allocating revenues from other departments of the hospital to the proposed service. These accounting maneuvers may look good on paper, but they do not make the proposed service itself financially viable.

It is not correct, as AAMC indicates, that under the GBR system any new service would operate at a loss and thus the financial feasibility of the cardiac surgery program is not important. Modification at 8-9. The difficulty this application faces is due not to the GBR system, but to the lack of growth in cardiac surgery cases sufficient to justify a new program. If volumes were increasing enough to warrant a new program, it should be able to be financially viable on its own merits, as required by regulation. Accounting manipulation should not be a basis of a finding of financial viability. In truth, AAMC's proposal to engage in these methods to make an otherwise loss-inducing program into a revenue center is a cover-up of the plain fact that the proposal cannot

generate self-sustaining revenues.

Therefore, for the foregoing reasons, AAMC's proposed project, even as modified, cannot be found consistent with the State Health Plan's criteria related to financial feasibility.

D. AAMC's Modification Fails to Show That Its Proposal Is Cost-Effective, and Therefore Does not Merit Preference in the Present Comparative Review Under COMAR 10.24.1705A(8).

As required in the Cardiac Surgery Chapter of the SHP, "[i]n the case of a comparative review of applications in which all policies and standards have been met by all applicants, the Commission will give preference based on . . . [t]he applicant whose proposal is the most cost effective for the health care system." Thus far, MedStar argues that neither AAMC nor Baltimore-Washington Medical Center have met all of the policies and standards and there is not entitled to additional consideration for approval of its application. But, even if the Reviewer determines that they do indeed met the policy and standards required of applications for new cardiac surgery programs, the financial information and statements submitted in AAMC's Modification clearly establish that its CON application is not the most cost-effective for the health system. These Comments provide detailed arguments regarding the failure of AAMC's application to meet the cost-effectiveness criteria in COMAR 10.24.17.05A, and relies on these same arguments to assert that AAMC should not receive preferential status in this comparative review.

The Reviewer should also consider that the Modification' failure to meet the cost-effective criterion of the SHP is also indicative of AAMC's inability to show that its cardiac surgery program is consistent with cost-reduction and quality improvement goals of Maryland's all-payer system. AAMC's submissions to the Commission, including the Modification being considered here, do not adequately address the impact of the Maryland all-payer model's recent changes on

its surgery program. They also do not show how AAMC will ensure that its program will prevent unnecessary and preventable cardiac admissions in alignment with the all-payer model, such as through directing resources towards prevention, rather than to a high-cost inpatient surgery programs. Thus, because AAMC's Modification does not show that the new cardiac surgery program is cost-effective from a service-line standpoint as well as from a health care policy standpoint, it should not receive the Reviewer's preference in this comparative review.

III. AAMC'S MODIFICATION TO ITS APPLICATION FAIL TO REMEDY THE DEFICIENCIES IDENTIFIED WITH RESPECT TO REQUIRED PROJECT REVIEW CRITERIA

In addition to not meeting the criteria specific to the SHP, AAMC's Modification also does not adequately address the issues that the Reviewer identified in relation to several of the general review criteria. These criteria can be summarily dispensed of:

- Section II of these Comments addresses how AAMC's Modification does not address the. Requirements of the SHP as required by COMAR 10.24.01.08G(3)(a).
- As stated in Section II.A of these Comments, the Modification unsuccessfully addresses the cost-effectiveness criteria of the SHP and therefore, AAMC cannot establish that the proposed cardiac surgery program is more cost effective than "providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review" COMAR 10.24.01.08G(3)(c));
- As stated in Section II.B of these Comments, the Modification unsuccessfully addresses the financial feasibility criteria of the SHP and therefore, AAMC cannot establish that the proposed cardiac surgery program has sufficient "availability of financial and nonfinancial resources . . . necessary to sustain the project." COMAR

10.24.01.08G(3)(d)); and

- Particularly with respect to PGHC, AAMC's Modification does not minimize the negative impact that the application overall would have on existing providers & the health care delivery system. COMAR 10.24.01.08G(3)(f).

To further address the how AAMC's proposal will impact PGHC, it is essential to consider the following facts. On September 30, 2016 the Maryland Health Care Commission approved the certificate of need application to relocate and replace PGHC. The total project cost is $543 million; with 220 beds. The PGHC project relies heavily on a grant of $416 million split evenly between the state and Prince George's County, accounting for approximately 77 percent of the total cost. The balance of the funding needed will be borrowed through the sale of bonds. In addition, the County is donating land valued at $12.3 million.

With regard to revenue projections, the Commission ultimately concluded that while there are financial stability challenges associated with the current high charges, the likelihood of increased charges, and the risk of not achieving projected volumes (emphasis added), failure to make a major investment would make the poor present financial situation even worse. The Commission also stated "[m]oreover, failure to replace and relocate Prince George's Hospital Center will adversely affect access of Prince George's County residents to needed health care services in a safe and modern facility."

The Reviewer in the case has already noted that the project is likely to have a negative impact on the volume of care provided at Doctors Community Hospital (loss of 482 discharges), MedStar Southern Maryland Hospital Center (loss of 361 discharges), Anne Arundel Medical Center (loss of 300 discharges), and MedStar Washington Hospital Center (loss of 294 cases). The Reviewer concluded, however, that the level of impact was not large enough to warrant denial

or reconsideration of the planned approach. In the end, to approve a new cardiac surgery program that would compete with PGHC that is neither financially feasible nor cost-effective, or needed from a geographic or service line standpoint would be completely contrary to sound health planning principles.

Last, from a broader policy perspective, the health care delivery and financing systems in the U.S. are likely to significantly change with the impending administration of President-elect Trump and the Republican leadership of both U.S. House of Representatives and U.S. Senate. The potential impact of the new administration on the future of Maryland's Medicare Waiver is a major unknown, and so at this time, the Commission might want to take a cautious approach to adding new health care services.

CONCLUSION

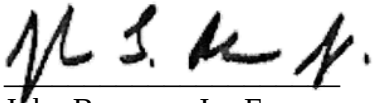
For the reasons set forth above, even with its Modification, AAMC cannot satisfy the CON review criteria in the SHP or the general review criteria applicable to its proposal for a new cardiac surgery program.

Therefore, MedStar respectfully requests that the Reviewer deny AAMC's CON application for the following reasons:

- The project is not needed.
- The project is inconsistent with the SHP.
- The project is not financially feasible.
- The project will have an adverse impact on existing providers.
- The project will increase health care costs to the system.
- There is no access problem that would be addressed by its approval.

This application should be denied.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that on the 14th day of November, 2016, a copy of MedStar Health's Comments in Response to Anne Arundel Medical Center's Proposed Modification To Its Certificate of Need Application Made Pursuant to the Project Status Conference was sent by first-class mail and by email, where available, to:

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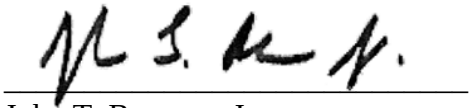

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