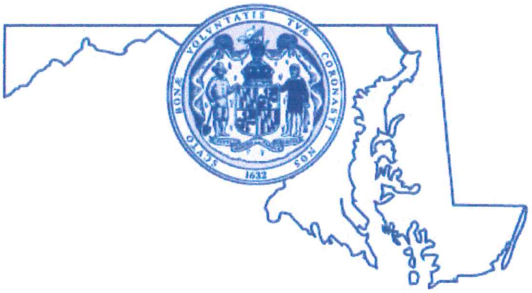

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Date: August 24, 2016

To: Craig P. Tanio
Commissioner/Reviewer, MHCC

From: Donna Kinzer, Executive Director, HSCRC
Gerard J. Schmith, Deputy Director, Hospital Rate Setting, HSCRC

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

On July 15, 2016 you requested that we review and comment on the financial feasibility and underlying assumptions of proposed new Cardiac Surgery programs at Anne Arundel Medical Center (AAMC) and University of Maryland Baltimore Washington Medical Center (BWMC).

Per your request we will address each of the six specific questions outlined in your letter regarding the Certificate of Need (CON) applications for the two new proposed programs.

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?**

AAMC assumed that it would be able to retain 85% of the additional revenue associated with the cardiac surgery program. Under the current HSCRC policy for market shift changes of Maryland residents, hospitals with increased volumes that are taken from other Maryland hospitals are allowed to retain 50% of the revenue associated with the additional volume while hospitals that lose volume to other Maryland hospitals are allowed to retain 50% of the revenue associated with the lost volume. Additionally, under the HSCRC market shift policy, hospitals are not allowed to retain any of the increases in revenue related to volume increases that are not matched by reductions in other Maryland hospitals.

AAMC has projected that Maryland residents will comprise the 67% of its cardiac surgery cases that will come from D.C. and other out-of-state providers. Under the Hospital's GBR agreement, AAMC would be able to retain 50% of the cardiac surgery revenue associated with these Maryland residents. Verifying the AAMC projections requires analysis of Medicare data (which the HSCRC

obtains monthly), commercial data (which is reported to MHCC with a greater lag time), and estimates from Medicaid. Likewise, Systems associated with Maryland-based providers are required to provide the HSCRC with claims data for their DC-based facilities under the GBR agreement. AAMC could also retain 50% of the revenue related to the 33% of its projected volume for transfers from other Maryland hospitals. AAMC's assumption that it would be able to retain 85% of the cardiac surgery revenue is contrary to HSCRC policy on market shifts; however, as discussed below, AAMC has other sources of revenue to apply to the project and, therefore, we do not believe a change in this assumption would impact the feasibility of the program.

BWMC's assumption that it will retain 50% of the new revenue associated with the cardiac surgery program is consistent with HSCRC market shift policy.

2. **Is the revenue impact at each of the applicant hospitals 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?**

Please see answer to Question 1 for the revenue impact at the applicant hospitals.

The applicants correctly modeled the impacts on revenue for those hospitals projected to lose significant cardiac surgery case volume if the new cardiac surgery programs are put into operation. However, as discussed below, those assumptions do not address the possibility that the affected institutions will "backfill" the cases from other areas of Maryland or for other services.

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 payers 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 on:**
    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 if either or both the AAMC and BWMC programs are approved to adjust their variable costs so that net income derived from this service will not be greatly affected?**

AAMC and BWMC could deliver cardiac surgery volumes with the increases in revenue under the new payment model using the resources that are provided in the system, including the population adjustment, capacity from reduced avoidable utilization, and reallocation of overhead already funded in the system as evidenced in each hospital's profits to cover the difference between marginal cost

and fully allocated costs that includes existing overhead. However, this would require a commitment from the hospitals to avoid seeking a rate increase in a separate action.

In certain cases related to replacement facilities, a hospital could secure a CON exemption by taking the "Pledge," which prevents a hospital from requesting an increase to revenue or patient charges related to the capital cost of the project in the future. However, in this case there is no such mechanism, per se, that would preclude a hospital from requesting a rate or revenue increase for an approved CON. If the hospital represents that it will not need an increase to accomplish the project during the CON process, the HSCRC staff would do all that it could to ensure that the hospital lived up to its statements. Under the current GBR methodology, hospitals have the right to approach the HSCRC to request an increase in their allowed GBR revenue if the GBR methodology does not provide sufficient revenue. Additionally, in the future, hospitals will be able to submit full rate applications requesting increases in rates if their approved GBR revenue is not sufficient. If not addressed in the CON process, this could leave the system open to unexpected hospital revenue increases from a new program.

Dimension Health Services (DHS) has provided the HSCRC with a proposed GBR arrangement that DHS believes will allow it to operate at a profit in the future based on a set of assumptions. One of DHS' assumptions is that DHS' cardiac surgery program will grow significantly over the next 5 years. AAMC draws some of its patients from Prince George's County, and this could impact the DHS program. While many of the patients that would be served in DHS' cardiac program may not be likely to travel to AAMC for services based on historic migration patterns, changes in volume levels at Washington Hospital Center resulting from a new program at AAMC may impact available capacity at Washington Hospital Center, making it more difficult for DHS to grow its volumes in the face of this increased capacity. Thus, there is the potential to directly or indirectly impact program volumes at DHS, and, therefore, its financial performance.

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 prospective 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 payers 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 system savings that we have not considered?**

The CON process does not affect the rights of a competing or cooperating hospital to request rate increases to cover lost volumes in the event of a comprehensive rate review. The CON process does not limit this ability, unless specifically agreed to by hospitals during the CON process. Additionally, the savings may be undermined through "backfill," whereby the hospital losing market share secures market shift for patients from another service area of the State or for an alternative

service for patients from the State. Nevertheless, there could be an inherent advantage of moving lower severity patients out of high cost academic medical centers and teaching facilities into lower cost settings, thereby freeing up capacity for new procedures under development, referrals of patients for highly specialized services from outside the service area, and other high value activities without expanding capacity at the academic medical center or teaching facility. Therefore, the desirability of moving services out of these settings should be weighed in considering the ability to assure cost savings over time through reducing the need for capacity in these high cost environments.

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 Maryland waiver?**

The Maryland Medicare waiver targets limit the increase in total annual Medicare spending per Maryland Medicare enrollee. Under the targets, Maryland would benefit if the average Medicare payment for a cardiac surgery patient is lower compared to the current Medicare payment at Washington area hospitals. For those Medicare cardiac surgery patients treated at AAMC, the estimated Medicare payment could be lower depending on how much additional revenue AAMC were allowed to generate under its GBR Agreement.

Of more concern, if a new cardiac surgery program at either AAMC or BWMC would result in new cardiac surgery cases that were not previously performed, the waiver would be negatively impacted.

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

In the current environment, it is not likely that the ability of D.C. hospitals to negotiate charge levels for cardiac surgery with individual commercial payers will make it more difficult to shift volume away from these hospitals to new Maryland providers. This is because patients and doctors make the decisions about where patients receive services and not payers. Further, out-of-pocket costs for a high cost procedure are generally not affected by the choice of facility. However, as physicians and patients become more price sensitive through the use of PCMHs, ACOs, episode payments, value-based insurance design, and other mechanisms, the point of emphasis may change. There is an increasing number of employers, for example, that are determining which facilities employees can use for tertiary procedures, using both cost and outcomes measures. CareFirst encourages its PCMH physicians to consider episode costs when referring patients. If Washington Hospital Center lowers its episode prices in response to competition from AAMC, it could potentially affect facility selection in a more price sensitive environment.

In a situation with no additional variables, Washington Hospital Center's net income could decrease by as much as half of the $12,000,000 in reduced revenue it may experience if AAMC's program were approved. This loss in net income would provide a strong incentive for Washington Hospital Center to negotiate with third parties to retain the cardiac surgery volume

that AAMC would be attempting to recapture, to backfill the same procedure from other areas of the state, or to backfill with some other service. The same analysis would apply to BWMC. The results are difficult to model in the short run. If 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. Conversely, if the outcome is slower growth, or contraction at high cost academic centers, then system costs may be affected positively, so long as the services produced by AAMC or BWMC are high quality efficient services with equal or better outcomes.

Finally, a look at prior CON cases can be instructive. For example, Suburban Hospital previously projected that it would perform more than 400 cardiac surgeries annually by 2008 in its cardiac surgery CON. Suburban is presently performing around 200 cardiac surgery cases annually. In spite of the fact that it is less expensive than Washington Hospital Center, it has been unable to attract a higher market share of these services historically. The recent overall statewide reduction in cardiac surgery also contributed to Suburban's much lower than projected cardiac surgery volumes.

Please advise if you have further questions.