GORDON·FEINBLATT LLC
ATTORNEYS AT LAW

JONATHAN MONTGOMERY
410.576.4088
FAX 410.576.4032
jmontgomery@gfrlaw.com

233 EAST REDWOOD STREET
BALTIMORE, MARYLAND 21202-3332
410.576.4000
www.gfrlaw.com

August 25, 2015

VIA E-MAIL AND HAND DELIVERY

Mr. Paul E. Parker
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Anne Arundel Medical Center
Comment on University of Maryland Baltimore-Washington Medical Center Modified Certificate of Need Application
Docket # 15-02-2361

Dear Mr. Parker:

Pursuant to COMAR 10.24.01.08(E)(3)(a), Anne Arundel Medical Center ("**AAMC**") hereby submits to the Maryland Health Care Commission (the "**Commission**") the following written comments to the modified Certificate of Need ("**CON**") application (the "**Modified Application**") of UM Baltimore Washington Medical Center ("**BWMC**") for the establishment of a cardiac surgery program.

I. Summary

The centerpiece of the Modified Application is the decision of the University of Maryland Medical System (**"UMMS**") to accept a 50% reduction in UMMS' system-wide Global Budget Revenue ("**GBR**") for cases shifted to BWMC's proposed program from the University of Maryland Medical Center ("**UMMC**").

Notwithstanding this change, the Modified Application does not overcome AAMC's superiority on cost savings, both for "cardiac surgery patients…and for the health care system" as a whole.[1] For cardiac surgery patients, AAMC will charge less than BWMC, on BWMC's own calculations.[2] And, as explained below, BWMC's calculations overestimate AAMC's charges, relying on a flawed analogy between charges at UMMC's cardiac surgery program and AAMC's proposed program. For the health care system as a whole, AAMC will generate superior costs savings by drawing more cases to its low-cost program, and more cases from D.C. hospitals in particular.

The Modified Application also fails to overcome a key problem in BWMC's original application: BMWC admits it would fail the financial feasibility criteria of the State Health Plan. The Modified Application attempts a fix by conflating the feasibility of cardiac surgery at BWMC with the profitability of cardiac surgery within UMMS as a whole. But, as explained below, BWMC (a) cannot rewrite the State Health Plan in this way, (b) does not appear to include UM St. Joseph's Medical Center (much less Prince George's Hospital Center) in its purported UMMS whole-system analysis, and (c) inflates UMMS' profitability to levels clearly unsupported by HSCRC mandates and methodologies.

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[1] COMAR 10.24.17.05(A)(4)(b); *see also* COMAR 10.24.17.05(A)(8)(a) (The applicant whose proposal is most cost effective for the health care system" will have preference in a comparative review).

[2] *Compare* BWMC Exhibit 49 at Line 1 (BWMC rate center charge per case of $51,952) with BWMC Exhibit 50 at Line 1 (AAMC rate center charge per case of $50,749).

II. Financial Feasibility

The Modified Application does not satisfy the State Health Plan's financial feasibility standard. An applicant must show that "[w]ithin three years or less of initiating a new or relocated cardiac surgery program, it will generate excess revenues over total expenses for cardiac surgery, if utilization forecasts are achieved for cardiac surgery services."[3] BWMC admits it cannot meet this standard. "As a stand-alone cardiac surgery program, the proposed project would not achieve excess revenue over total expenses within three years."[4] BWMC instead attempts to show that "the larger cardiac surgery program managed by the UM Division of Cardiac Surgery" – of which BWMC would become part – would remain financially feasible as a whole, notwithstanding the losses BWMC will incur. The Commission should reject this attempt for the following reasons.

First, the State Health Plan criteria cannot be waived or ignored during this comparative review. The State Health Plan is a *bona fide* Maryland regulation with the force of law.[5] And the revision to the State Health Plan implied by BWMC would work a revolution in the CON process: merged asset systems could leverage a profitable service in one part of the system to subsidize the creation of uneconomic facilities or services in another part of the system. This

[3] COMAR 10.24.17.05(A)(7)(iv).

[4] BWMC Modified Application at p. 7.

[5] A regulation adopted by an administrative agency pursuant to properly delegated authority has the force of law, and the agency must "honor and follow the regulation as it is written." *Sec'y, Dept. of Public Safety and Corr. Serv. v. Demby*, 390 Md. 580, 597, 606 (2006).

would overturn the Commission's careful facility-by-facility approach to ensuring the financial viability of health care facilities in Maryland.

Second, even if the State Health Plan measured financial feasibility at a health system level, BWMC appears to ignore the cardiac surgery program at UM St. Joseph Medical Center (much less Prince George's Hospital Center) when assessing the projected financial performance of the UM Division of Cardiac Surgery as a whole. In other words, BWMC presents a selectively consolidated analysis without explanation.

Third, this assessment does not present profit and loss statements in accordance with the standard schedules provided by the CON application. In fact, BWMC does not present profit and loss statements in accordance with standard cost accounting principles whatsoever, instead relying on an undocumented approach not transparent to the Commission or to interested parties such as AAMC. That is, BWMC does not provide the required "statement containing each assumption used to develop the projections" used in the Modified Application. [6]

Finally, BWMC's feasibility analysis is not only unorthodox and opaque, it entails implausible results. The Modified Application projects a FY 2016 profit margin for the combined cardiac surgery programs at BWMC and UMMC at **33%** (or $39.8 million). If UMMC's program were so profitable, why would the HSCRC, with its cost-based rate setting system, not simply force a reduction in UMMC rates to generate savings to the health care system? Why should the Commission permit BWMC to create an uneconomic cardiac surgery

[6] COMAR 10.24.17.05(A)(7)(a).

program at BWMC just so that UMMC will stop overcharging UMMC patients? Similarly, the Modified Application does not attribute any incremental operating costs to the establishment of BWMC's cardiac surgery program. BWMC has asked the Commission to believe that operating expenses will simply shift on a one-to-one basis between UMMC and BWMC.

Even if the Commission were inclined to consider financial feasibility on a system-wide level rather than a facility level, the Commission cannot credit a financial feasibility analysis so misaligned with standard accounting principles.

III. Comparative Cost Effectiveness

A. Impact on Health Care System

Adding a cardiac surgery program in Maryland will have two impacts on overall costs to the health system: (1) an increase in payments to the hospital adding the new program, and (2) a decrease in payments to hospitals losing cases to the new program. The difference between (1) and (2) is the net impact of the new program on the system as a whole.

In that regard, a program at BWMC would save the health care system as a whole less money than a program at AAMC because BWMC's program would not decrease payments to other hospitals to the same extent that a program at AAMC would.[7] BWMC would take almost all of its cardiac surgery cases from Maryland hospitals. Under the HSCRC's market shift adjustment policy, those Maryland hospitals would retain half the revenue associated with the lost revenue. AAMC, on the other hand, would take the bulk of its cardiac surgery cases from

[7] The enclosed Exhibits 8 and 9 restate the impact of the AAMC and BWMC programs in light of the Modified Application.

District of Columbia hospitals. These non-Maryland hospitals would not retain any revenue associated with lost cases. (This lost revenue is also quite substantial due to D.C. hospital's high charge per case). As shown in the enclosed Exhibit 11, AAMC achieves a total annual savings to the system of $7.7 primarily through the relocation of services from Washington D.C. hospitals, while BWMC achieves a total annual savings to the system of $3.5 million.

Moreover, the Modified Application presents an analysis that misleadingly purports to demonstrate BWMC's "System Savings". That analysis compares charges to open heart surgery patients and their payers using a rate center methodology to the amount that will be allowed to be earned by a hospital under the GBR system. The resulting difference is identified as a "Projected Healthcare System Charge Savings." However, by this analysis, BWMC would have the Commission ironically believe that higher charges to patients/payers for open heart services at the top of the analysis actually results in more "System Savings". Factually, however, that is not true. The "Savings" are actually either retained by the hospital if volumes of the hospital's other (non-OHS) services are lower than historic levels, or are disproportionately shared with some of the payers, depending upon the payer mix and volumes of such other services.

Accordingly, while Exhibit 11 correctly compares AAMC's and BWMC's total savings, BWMC's analysis does not. Although the Modified Application improves BWMC's case on cost effectiveness, AAMC's proposed program remains superior in achieving savings for the health care system.

B. Cost for Cardiac Surgery Services

The Modified Application also fails to overcome AAMC's lower cost to cardiac surgery patients, even on BWMC's own calculations.

BWMC misapplies the rate center methodology in overestimating AAMC's projected cardiac surgery charge per case. In general, the rate center methodology derives a hospital service line's charge per case by, for each rate center of the hospital (such as laboratory or imaging services): (a) identifying the **utilization** (measured in units) of that rate center for the average case in that service line, and (b) multiplying the utilization (measured in units) of that rate center by the hospital's **unit rate** for such rate center. BWMC does account for the **unit rate** differences between AAMC and BWMC. But BWMC gets the utilization wrong. BWMC assumed a "common spread of cardiac surgery ***units***" at AAMC and BWMC based on "UMMC experience in FY 2014, excluding extreme cases."[8] On the contrary, using UMMC experience by itself is not representative of the patient volume that may be shifted from other existing cardiac surgery programs, and does not account for volume from Washington, D.C. hospitals. A non-academic medical center such as AAMC will not have the same utilization pattern as a quaternary academic medical center such as UMMC. That is why AAMC's Application uses a composite profile of all FY 2014 adult cardiac surgery cases at non-academic medical centers in Maryland to create its anticipated utilization profile.[9]

[8] BWMC Modified Application at pp. 3-4 (emphasis added).

[9] AAMC Application at pp 61-62.

The flaw in BWMC's analysis is borne out by a comparison of the relative efficiency of BWMC and AAMC in other inpatient product lines tracked by the HSCRC. A comparison of the adjusted charges per case in each service line will account both for the difference in the unit rates and the difference in the units per case of the two hospitals in each product line. For example, if one hospital has a substantially lower length of stay per case in a product line, it would be expected to have lower charges per case in the product line than its competitor.

In that regard, the charges per adjusted case at BWMC are, on average, 14.8% above those of AAMC, according to FY 2015 data. This latest data shows that the BWMC charge per case is $11,453, 14.8% higher than that of AAMC ($9,975), as set forth on Exhibit 10 (enclosed).[10] Therefore, we can project the AAMC charges per case as the ratio of the BWMC projected charges per case ($51,952) divided by 1.148, or $45,254:

$$\$45,254 = \$51,952 / 1.148$$

This estimate of AAMC's charges per case corroborates the independently derived estimate of approximately $44,000 derived by AAMC included in AAMC's CON application.

[10] This FY 2015 data updates the cost per case at a CMI of 1.00 for each of BWMC and AAMC from the figures used at the time BWMC and AAMC prepared their initial original applications. The traditional charge per case methodology reflects AAMC's further lowering of its charges per case mix adjusted case.

IV. Conclusion

The Modified Application confirms that BWMC will neither meet the financial feasibility criteria of the State Health Plan nor provide cardiac surgery services more cost-effectively than AAMC.

Thank you for your attention to this matter.

Sincerely,

Jonathan Montgomery

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Enclosures

cc: Mr. Ben Steffen
Mr. Kevin McDonald
Ms. Ruby Potter
Suellen Wideman, Esquire
Tom Dame, Esquire
Anne Arundel Medical Center (internal distribution)
Richard M. McAlee, Esquire (via email)
Joel Suldan, Esquire (via email)
Natalie McSherry, Esquire (via email)
Mr. Steven Schuh (via email)
Ella Aiken, Esquire (via email)
John T. Brennan, Jr., Esquire (via email)
Jinlene Chan, M.D. (via email)