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By E-Mail and USPS

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Re: Baltimore Upper Shore Cardiac Surgery Review
Anne Arundel Medical Center (Docket No. 15-02-2360)
University of Maryland Baltimore Washington Medical Center
(Docket No. 15-02-2361)

Dear Counsel:

As you know, on August 24, 2016, Health Service Cost Review Commission ("HSCRC") staff responded to my request for comments on the above-referenced Certificate of Need applications. I am writing to seek commitments from each applicant regarding matters raised by HSCRC staff in its comments. I am also requesting commitments by the two respective institutions that are partnering/coordinating with each of the applicants: The Johns Hopkins Hospital ("JHH") with Anne Arundel Medical Center; and the University of Maryland Medical Center ("UMMC"), with University of Maryland Baltimore Washington Medical Center ("BWMC"). I have a specific request for information from AAMC that results from comments made by HSCRC staff. In addition, I give notice to all parties about my use of data in the review.

I request that the responses to my questions or request for updated information be submitted via e-mail in Portable Document Format ("PDF") format to all of the parties in this review, to Ms. Ruby Potter, and to others copied on this letter ruling or on the e-mail by which this ruling is also sent.

Issues raised by HSCRC that are common to the applicants.

Background and Question 1.

In its comments, HSCRC staff noted that each applicant hospital:

> 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, an 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. ... If the hospital represents that it will not need an increase [in approved revenue] 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.

Therefore, my first question, for each applicant hospital is:

1: Is an authorized representative of the applicant hospital willing to make a binding commitment that, if the applicant hospital is issued a CON to establish a new cardiac surgery program, it will not approach HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the objective of obtaining additional revenue from the provision of cardiac surgery services?

Background and Question 2.

In its comments, HSCRC staff also stated,

> 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 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 the 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 those 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.

AAMC projects in its application that a portion of the cardiac surgery cases originating in its service area would, in the absence of a cardiac surgery program at AAMC, otherwise be performed at JHH, and states that JHH and its medical staff will actively collaborate with AAMC in causing this "market shift" of cardiac surgery cases to AAMC. Similarly, BWMC projects that a portion of the cases originating in the BWMC service area would, in the absence of a program at BWMC, otherwise be performed at UMMC, with UMMC and its medical staff actively collaborating with BWMC in causing this market shift to BWMC.

In light of HSCRC's comments, my question to The Johns Hopkins Hospital and to University of Maryland Medical Center (each, the "collaborating hospital") follows:

2: Is an authorized representative of the collaborating hospital willing to make a binding commitment that, if its partner applicant hospital is issued a CON to establish a new cardiac surgery program, the collaborating hospital will not approach HSCRC in the future to request an increase in global budgeted revenue that has, as any part of its basis, the lost revenue generated by cardiac surgery services that have shifted to its partner applicant hospital?

My goal, in seeking responses to these two questions, is to obtain confirmation and a greater level of confidence that the system savings projected by the applicants through a shift in cardiac surgery case volume from higher charge to lower charge hospitals will be sustained if one or both of these CON applications are approved. Thus, in accordance with HSCRC staff's comments, I ask each applicant and its key collaborating hospital to impose limitations on their own future actions through binding written commitments made in the CON review process. I view this as an important way in which the Commission can assist HSCRC staff in ensuring that a hospital lives up to representations made in its CON application with respect to any future requests for increases in budgeted revenue based on the revenue impact associated with redistribution of cardiac surgery case volume.

HSCRC issue limited to AAMC.

Finally, HSCRC staff stated that "AAMC's assumption that it would be able to retain 85% of the cardiac surgery revenue" related to the 33% of its projected volume for transfers from other Maryland hospitals … is contrary to HSCRC policy on market shifts." I note that in its August 25, 2015 response to interested party comments regarding this inconsistency, AAMC

stated that it "can reasonably expect to retain 85% of the revenue generated by the AAMC's proposed program [based on indications by HSCRC] that, for new services, it [HSCRC] has the flexibility to provide targeted funding through the annual update process for individual hospital budgets." (DI #45GF, p. 19).

Given HSCRC staff's comment regarding this issue, I request that AAMC provide revised versions of all the financial schedules previously submitted that fully conform with standard HSCRC policy with respect to retention of revenue generated from projected shifts in cardiac surgery case volume from hospitals with existing cardiac surgery programs to AAMC.

Notice of use of HSCRC Discharge Database and District of Columbia Discharge Database in this review.

I intend to use information beginning with Calendar Year 2009 to the most recent quarter of information available from the HSCRC Discharge Database and from the District of Columbia Database in this review. **If either applicant or any party in this review does not have access to the HSCRC database, I recommend that you gain access to patient-level de-identified data by making the required application(s) found on HSCRC's website at:** http://www.hscrc.maryland.gov/hsp-data-request.cfm. **If you do not have access to the District of Columbia Discharge Database for this time period, you should obtain access by following the application procedure at:**
http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_data_release/apcd_data_release_dcdischarge.aspx.

I want to remind all parties that this is a contested case and that the *ex parte* prohibitions in the Administrative Procedure Act, Maryland Code Ann., State Gov't §10-219, apply to this proceeding until the Commission issues a final decision.

Sincerely,

Craig Tanio, M.D.
Commissioner/Reviewer

cc: M. Natalie McSherry, Esquire
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