BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF APPLICATION OF GREEN SPRING STATION SURGERY CENTER FOR CERITIFICATE OF NEED	Matter No. 15-03-2369

APPLICANT'S RESPONSE
TO WRITTEN COMMENTS OF LIFEBRIDGE HEALTH, INC.

Pursuant to COMAR 10.24.01.08F(3), Applicant Johns Hopkins Surgery Centers Series ("Hopkins") submits this response to the written comments on its certificate of need ("CON") application in this matter filed by Lifebridge Health, Inc. ("LBH").

INTRODUCTION AND SUMMARY OF PROJECT

Hopkins seeks a CON to establish the Green Spring Station Surgery Center ("GSSSC") as a state of the art, freestanding ambulatory surgical center with five operating rooms (ORs) and four procedure rooms. GSSSC would be established at the Johns Hopkins at Green Spring Station campus as an integral part of a much-needed expansion of that campus. Johns Hopkins at Green Spring Station has grown since it was established in 1994 into the largest free-standing outpatient medical center in the Baltimore-Washington region. Over 400,000 patients visit the campus each year to receive primary care and a wide array of specialty care, ancillary and other medical services from 65 primary care physicians and over 400 specialists. Patients from a large geographic area travel to Johns Hopkins at Green Spring Station each year to receive medical care; indeed, a third of those patients travel from outside Central Maryland and from outside the state. They are attracted not only by the quality and scope of outpatient care offered there, but also by the

convenience of the suburban location which is easily accessible off the Baltimore Beltway and I-83 and offers free parking. See Application, at 7-9.

With the success of Johns Hopkins at Green Spring Station, however, the demand for clinical space on the campus has exceeded supply for many years. Clinical departments of Johns Hopkins Medicine ("JHM") have needed to take whatever space becomes available as other tenants vacate, hindering new program development and splintering departments into inefficient multiple suites in separate locations on the campus. Lack of space also has created problems with patient access to specialist care on the campus. Even with the large complement of JHM physicians with a presence on the campus, more than a third of overall specialty care must be referred to non-JHM specialists at other locations, and referrals to surgical specialists must be made to other locations at an even higher rate. These patient access issues not only create inconvenience for the patient, but they also disrupt continuity of care and population health management. See Application, at 9-10.

The new Pavilion III to be constructed on the campus will provide medical office space for a variety of new and expanded specialist practices to improve patient access and continuity of care, including a comprehensive Radiology practice and a new Musculoskeletal Center (including orthopedic surgeons). The building would also house various surgical specialties (including otolaryngology, plastic surgery, urology, gastroenterology and medical oncology), as well as the proposed new ambulatory surgery center (GSSSC). Co-locating GSSSC with these services in the same building will also make it easier for patients, who will be able to access all of these services not only on the same campus, but within the same building. See Application, at 10-11.

The case for the expansion at Green Spring Station becomes even more compelling when considered in light of the new challenges of the Affordable Care Act and the new Medicare waiver.

In particular, the Affordable Care Act and the new Medicare waiver incentivizes better outcomes in lower cost settings, encouraging the shift from inpatient to ambulatory settings. Expansion of the campus will enable Johns Hopkins to respond to the increased pressure to provide convenient, efficient and consolidated services to patients. Co-location of primary, specialty and ancillary services at Green Spring Station will allow Hopkins to increase the comprehensive integration of services and promote population health management.

The GSSSC specifically will enable Johns Hopkins to provide a safe, high quality and cost effective alternative to its regulated inpatient and outpatient operating rooms at the Johns Hopkins Hospital in order to respond to the changes in clinical practice and reimbursement. As operating room cases continue to migrate from hospitals to ambulatory surgery centers, Johns Hopkins must be positioned to respond to this shift, and GSSSC is essential for this purpose.

The overwhelming majority of the cases projected to be performed at GSSSC are based on "physician specific volume," or actual outpatient surgical cases currently being generated by identified physicians, nearly all of them employed by JHM, that would be performed at GSSSC if that option was available (83 percent of projected volume in 2018). The remainder of the cases projected to be performed at GSSSC (17 percent of projected volume in 2018) represent growth in the number of cases to be performed by specialists at Green Spring Station resulting from the expansion of the JHM presence at Green Spring Station, the increased capacity of many of the specialties to see patients, and the co-location of the clinics and GSSSC (the category of volume "retained referrals"). See Application at 102-103.

Consistent with the objective of providing a lower cost, safe alternative to performing outpatient surgery in a higher-cost hospital setting, most of the projected volume to be performed at GSSSC represents volume currently being performed in a hospital setting. For example, nearly

two-thirds of the projected volume for FY 2018 (2,720 out of 4,346 cases) represents cases moving from a hospital setting. Nearly all of those cases (2,447 cases) are moving from Johns Hopkins Hospital ("JHH") specifically, with an estimated 42 percent reduction in cost. See Application at 114.

As described in the Application, the five operating rooms at GSSSC will achieve the optimal level of utilization required under the State Health Plan by the third year of operation, and they will do so without adverse impact on any existing hospital or ambulatory surgery center. See Application at 67. Physician-specific volume to be performed at GSSSC (representing the overwhelming majority of projected volume) is almost entirely volume performed at a JHM site currently. While the remainder of the volume projected for GSSSC (the projected growth in volume represented by increased referral retention) represents (by definition) cases that would very likely be performed at a non-JHM facility in the absence of GSSSC, the impact is de minimus (less than 1% impact on all hospitals, and the largest estimated impact on a non-hospital facility is 7%). See Application at 109-113.

While the vast majority of the projected GSSSC cases that would be moved from a hospital setting to GSSSC would come from Johns Hopkins Hospital, the result of that shift represents only 4 percent of JHH's total OR minutes. That loss in minutes is projected to be regained (to pre-GSSSC levels) by FY 2019, based on a continued 2 percent annual growth in OR minutes that JHH has experienced since 2008, representing a minimal impact on JHH. See Application at 106.

Accordingly, the expansion of Johns Hopkins at Green Spring Station, including the establishment of the GSSSC, will achieve important objectives for patients, JHM and the health care system as a whole. Patients will have better access to a wider array of high quality, efficient and consolidated outpatient services, including outpatient surgery, at one, convenient location

without disruption of care The health care system will benefit by moving a large number of outpatient surgery cases from the higher cost hospital setting to the lower cost, freestanding (rate unregulated) setting. The project will enable Johns Hopkins at Green Spring Station to continue its progress towards becoming a model for an integrated, academically based patient-centered outpatient health care delivery system. Finally, the project will achieve these objectives without adverse impact on any existing provider.

ARGUMENT

In its Comments on the Application, LBH argues that Hopkins has not demonstrated need for the Project because it has not demonstrated an unmet need within the service area population (which LBH suggests is a required showing under COMAR 10.24.01.08G(3)(b)), and has not complied with the need methodology in the State Health Plan for Facilities and Services: General Surgical Services (COMAR 10.24.11) (the "Surgical Services Chapter"). LBH suggests that Hopkins demonstrated only that the Project will meet "internal institutional goals" whereas the State Health Plan requires a service area population-based need methodology. While it argues that the Surgical Services Chapter requires a population based need methodology, LBH did not challenge the methodology used by Hopkins, the application of that methodology and/or the conclusions reached by applying that methodology. As set forth below, LBH's arguments regarding need and the need methodology applied by Hopkins are without merit. Hopkins is not required to demonstrate "unmet need" within the service area population, and its need methodology complies with the Surgical Services Chapter and is consistent with Commission precedent over at least the last decade.

LBH makes a similar argument (that a population based need analysis was required) under other standards, arguments that likewise fail. LBH argues that Hopkins has not demonstrated that

more cost effective alternatives are not available because Hopkins did not conduct an analysis of existing providers that could perform the cases projected to be performed at GSSSC. Again, the Surgical Services Chapter does not require the applicant to make such a showing. It argues that Hopkins has not shown financial feasibility because it did not perform population based utilization projections, but no such analysis is required under the Surgical Services Chapter and Commission precedent. Finally, LBH argues that Hopkins has not demonstrated the absence of adverse impact on existing providers, but has failed to provide any evidence of an adverse impact on any existing provider.

As set forth below, Hopkins has met the applicable review and State Health Plan criteria and LBH's Comments are without merit.

1.

Hopkins Has Demonstrated Need for the Project

LBH argues that Hopkins is required to demonstrate that there is an unmet need for outpatient surgery capacity in the service area population. This is incorrect. COMAR 10.24.01.08G(3)(b) provides as follows (emphasis supplied)

> The Commission shall consider the applicable need analysis in the State Health Plan. *If no State Health Plan need analysis is applicable*, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

There is an "applicable need analysis" in the Surgical Services Chapter, so the requirement to demonstrate unmet need within the service area population is inapplicable. Specifically, Standard .05B(2) provides that need is established by demonstrating that "each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility." As recognized in the Staff Report and Recommendation on the

establishment of new ambulatory surgical facility approved by the Commission in Docket No. 14-15-2352 (Rockville Eye Surgery, LLC d/b/a Palisades Eye Surgery) (at p. 17), the minimum utilization standard in Standard .05B(2) "is definitive with respect to the need criterion applicable to a project such as this one." Accordingly, there is no requirement in this context to demonstrate unmet need within the service area population.

LBH's argument that Hopkins did not correctly apply the methodology required by the Surgical Services Chapter is similarly without merit. LBH's attempt to paraphrase what is required by the optimal utilization standard in the bullet points on pages 7 and 9 of its Comments is unsupported by the actual language of Standard .05B(2) or .06B(1), or by Commission precedent applying those standards . Similar to its argument that Hopkins was required to demonstrate "unmet need" for outpatient surgery in the service area, LBH's argument on the need methodology boils down to a claim that the Surgical Services Chapter requires Hopkins to provide a population based analysis to demonstrate that the proposed project will meet the optimal utilization standard, rather than an analysis (such as that performed by Hopkins) that demonstrates optimal utilization by documenting where the cases projected to be performed at the new facility will come from.

The Commission has rejected the very argument made by LBH. In the Rockville Eye Surgery Center CON cited above (Docket No. 14-15-2352) in which the Commission approved a new ambulatory surgical facility, the Staff Report and Recommendation states (at 17, emphasis supplied):

> The State Health Plan includes a "minimum utilization standard (see subparagraph .05B(2) above) that is definitive with respect to the need criterion applicable to a proposal such as this one. *It does not include a population-based projection method for assessing need for surgical facilities or operating rooms.*

There, the application showed that optimal utilization would be achieved based on documented historical and projected utilization by the physicians who would perform cases there. The applicant

did not (and was not required to) project need within the entire population of the service area of the proposed new facility approved by the Commission.

This is consistent with numerous other cases approving new ambulatory surgical facilities and expansions of ambulatory surgical capacity over the last decade. In Docket No. 12-15-2328 (Massachusetts Avenue Surgical Center or "MASC"), the Commission approved the expansion of ambulatory surgical capacity based on growth in the physicians' practices that utilize the facility, as well as population growth and the acceptance of more insurance carriers. Likewise, the Commission approved three new ambulatory surgical facilities for a health maintenance organization based on projected utilization within the HMO's membership and projected growth in membership. See Staff Report and Recommendation in Docket Nos. 10-03-2306 (Kaiser Permanente Baltimore Surgical Center), 09-15-2303 (Kaiser Permanente Gaithersburg Surgical Center), and 09-16-2304 (Kaiser Permanente Largo Surgical Center). The HMO was not required to perform a population based need analysis as LBH suggests is required.[1]

Further, in 2008, Sinai Hospital itself relied only on its institutional need to obtain a CON to expand its ambulatory surgical capacity. Specifically, in Docket No. 07-24-2199, Sinai Hospital was granted a CON to add four mixed use ORs in the hospital. It demonstrated optimal utilization for the four ORs based on volumes within its existing ORs (which exceeded optimal capacity) as well as projected growth based on trended growth in its OR volumes. It did not -- as LBH now suggests Hopkins is required to do -- assess whether there was any unmet need for outpatient

[1] See also Docket No. 01-03-2092 (Anne Arundel Surgical Center), Docket No. 04-02-2149 (Chesapeake Eye Surgery Center), and Docket No. 06-15-2181 (Massachusetts Avenue Surgery Center).

surgery within its service area, or whether the projected growth in its OR volumes could be absorbed within other existing providers in the service area.[2]

LBH also suggests that Hopkins was required to demonstrate need for the 2 percent growth in total OR minutes projected at JHH to backfill the loss of 4 percent of its OR minutes to GSSSC. As explained in the application, the 2 percent projection is firmly based on historical growth in JHH's OR minutes, growth that has continued even under the new Medicare waiver. Hopkins is not required to demonstrate need for JHH's continued growth in OR minutes that it has been experiencing for many years. JHH is not applying for a CON and its backfill plan does not impact GSSSC or its operations.[3]

2.

Hopkins Has Demonstrated The Absence of More Cost Effective Alternatives to Achieve the Project's Goals

Under COMAR 10.24.01.08G(3)(c), the Commission is required to compare the cost-effectiveness of the proposed project with that of providing the service through alternative existing facilities, and the Applicant is required to provide a description of the planning process used to

[2] The 2008 CON was the second time that Sinai Hospital applied to add the four mixed use ORs to its hospital capacity. In 2005, Sinai Hospital applied to add four mixed use ORs using the same need methodology as it did in 2008, and the CON was granted, but Sinai Hospital later relinquished the CON. See Docket No. 05-24-2160.

[3] LBH suggests that the Surgical Services Chapter contains a finding that existing ambulatory capacity in the State exceeds the demand for that capacity. Comments at 10. While a page reference is not provided, it appears that LBH is referring to part of the narrative around the growth in surgery in hospital and non-hospital settings that the "supply of operating rooms at ASFs and POSCs in Maryland exceeds the demand for these rooms, as measured by the operating room capacity assumptions that have been used by MHCC in recent years." See p 4. This general statement is clearly not a finding that there is no need for additional freestanding ambulatory surgical capacity anywhere in the State. To the contrary, that same paragraph explains that any oversupply is explained by the ease with which one-OR POSCs can be established, and further that one-room POSCs raise concerns with respect to the efficient use of resources. See pp. 4-5. The same section also concludes that *"[t]o the extent that surgical cases may be performed safely and appropriately in a non-hospital setting, regulatory policy should seek to make such settings sufficiently available and accessible for appropriate patients."* (See p. 5, emphasis supplied). The Surgical Services Chapter also notes (at 5) that "promoting the efficient use of resources may be a reason to encourage the development of non-hospital surgical facilities with more operating rooms." Accordingly, approving the GSSSC is entirely consistent with the policies set forth in the Surgical Services Chapter.

develop the project, explain the primary goals and objectives of the project, and identify the alternatives considered to meet those goals. The Application satisfies this standard.

As described in the Application, the need to establish freestanding ambulatory surgical capacity at Green Spring Station has long been anticipated in recognition of the large number of JHM physicians practicing there, the range of services offered there, and the convenience and popularity of the campus for patients and providers. Internal surveys show that access issues for Green Spring Station patients are the greatest for Johns Hopkins surgical specialties, with some surgical specialties being referred out at much higher rates than others, therefore reinforcing the need to establish this additional capacity. Likewise, the Affordable Care Act and the State's new Medicare waiver also demonstrates the importance of establishing freestanding ambulatory surgery capacity as a lower cost, safe alternative to more costly hospital-based outpatient surgery where most of the outpatient surgery cases from Green Spring Station are currently being performed.

JHM established a series of goals for the project, including: increasing access to JHM's specialty physicians at Green Spring Station, increasing the retention of patients within the Hopkins system, moving ambulatory surgery into a lower cost setting when appropriate, improving convenience for patients, and providing adequate space for existing volume as well as future growth. App. at 91. Three alternatives to the Project proposed in the Application were identified and evaluated for their ability to achieve the identified goals (doing nothing, finding another location for freestanding ambulatory surgical capacity near Green Spring Station, and building additional capacity at JHM's one-OR White Marsh Surgery Center. As explained in the Application (at 91-92), none of these options was found to be a viable alternative to the Project that meets the Project's goals.

LBH argues that Hopkins did not adequately address this standard, again suggesting that to meet this standard, Hopkins is required to show that existing ambulatory surgical capacity in the proposed service area is inadequate to handle the volume proposed to be served by GSSSC. This standard does not require an applicant to demonstrate that the documented physician volume it proposes to serve cannot be served by other unrelated ambulatory surgical facilities in the service area, and it has never been applied in this manner by the Commission. In none of the cases described above did the Commission require the applicant to demonstrate why it could not send its documented volume proposed to be served at the project to another existing provider. Rather, the applicants described alternatives through which the *applicant* could serve the documented volume proposed to be served by the project. For example, in the Massachusetts Avenue Surgical Center (MASC) application (Docket No. 12-15-2328), the identified alternatives rejected by MASC were (1) doing nothing, (2) purchasing a single OR freestanding ASC and relocating it to the existing MASC site, or (3) purchasing an existing multi-OR ASC and relocating it to the existing MASC site. The Commission approved the project and did not require MASC to demonstrate that existing providers could not serve the volumes MASC proposed to serve.

Further, Hopkins identified and investigated the alternative of expanding JHM's existing White Marsh Surgery Center to serve this volume, but rejected that alternative partly because it did not meet any of the objectives of the project, and was impossible in any event because there is not enough space to sufficiently expand that facility. Also, this alternative would require a CON just as GSSSC requires a CON.

Additionally, the option of "doing nothing" which JHM considered and rejected encompassed having existing providers serve the volume proposed to be served by GSSSC. As described in the Application and above, most of the GSSSC physician specific volume is now being

served by JHH and other JHM providers of ambulatory surgery. JHM considered this option and rejected it because it did not achieve any of the Project's objectives and was not more cost effective than performing those cases at GSSSC.

Finally, on page 13 of the Comments, LBH speculates that approving the CON application "would likely add costs to the system." This statement is unsupported and should be disregarded. Indeed, the Application demonstrates – and LBH has not disputed with contrary evidence – that GSSSC will lower costs to the system by moving appropriate outpatient surgery cases out of the more expensive hospital setting to the freestanding setting. In the case of JHH specifically, the hospital from which most of the volume would shift, the cost savings is estimated conservatively to be at least 42 percent.

Moreover, LBH argues that the Commission should assess the potential revenue impact on JHH of the shift in volume to GSSSC. LBH suggests that Hopkins "counts on" its globally budgeted revenue ("GBR") remaining unchanged, but points to nothing in the Application or elsewhere demonstrating that Hopkins "counts on" its GBR remaining unchanged or that the Application is contingent on such an outcome. To the contrary, JHM expects that there will be some change in the GBR, but the HSCRC has not yet addressed how it will account for shifting volume to a lower cost unregulated setting. Nevertheless, the Application demonstrates that outpatient surgery performed at GSSSC would be significantly less expensive than the same outpatient surgery performed at JHH. LBH has speculated that this is not the case, but has not provided any evidence demonstrating to the contrary. Accordingly, this is not a basis to disapprove the Application.

3.

Hopkins Has Demonstrated That the Project Will Not Adversely Impact Existing Providers or Patients

GSSSC will not have an adverse impact on any of LBH's hospitals. Hopkins projected where cases will be shifted from based on actual referral patterns for patients currently being referred out of Green Spring Station. It showed fewer than ten cases likely coming from either Sinai Hospital or Carroll Hospital and only 74 cases shifting from Northwest Hospital. See Application at p. 112.

LBH has not introduced any evidence of an adverse impact on any of its hospitals. Further, applying the standards in the Surgical Services Chapter conclusively demonstrates the absence of an adverse impact. Sinai Hospital is the closest hospital to GSSSC. Hopkins is not aware of Sinai changing its OR capacity since it received approval for the following capacity in 2008:

Table 1
Existing and Proposed Operating Room/Procedure Room Capacity at Sinai Hospital of Baltimore

Operating/Procedure Room	Before Project		After Project	
	Inside Sterile Area	Outside Sterile Area	Inside Sterile Area	Outside Sterile Area
General Purpose Operating Room				
• Inpatient	1		1	
• Outpatient	4		4	
• Mixed Use	9		13	
Special Purpose Operating Room				
• Inpatient (open heart)	2		2	
• Outpatient	0		0	
• Mixed Use (orthopedic)	5		5	
Total Operating Rooms	21		25	
Total Procedure Rooms	5		5	1
Dedicated C-Section ORs	2		2	

Source: September 12, 2007 Completeness Response (DI #10, Attached Ambulatory Surgery Provider Directory Information form)

Source: Sinai Hospital of Baltimore, Docket No. 07-24-2199, MHCC Staff Report and Recommendation, February 21, 2008 P. 1.

Accordingly, for purposes of this analysis, Hopkins assumes that Sinai Hospital has 25 existing ORs, and will not include the two open heart ORs in Sinai Hospital's OR capacity, reducing Sinai's capacity to 23.

Applying the rules regarding operating room capacity and needs assessment in the Surgical Services Chapter (Standard .06A), Sinai Hospital's ORs demonstrate the following capacity:

	Sinai ORs	Capacity/OR (in Hours)	Minutes/Hour	Capacity/OR (in Minutes)	Total Capacity
Dedicated Inpatient	1	2,375	60	142,500	142,500
Dedicated Outpatient	4	2,040	60	122,400	489,600
Mixed Use	18	2,375	60	142,500	2,565,000
Total	23				3,197,100

Standard .06C(4)(a) of the Surgical Services Chapter provides the following definition of adverse impact on an affected hospital:

> (a) If the needs assessment includes surgical cases performed by one or more physicians who currently perform cases at a hospital within the defined service area of the proposed ambulatory surgical facility that, in the aggregate, account for 18 percent of the operating room capacity at a hospital, then the applicant shall include, as part of the impact assessment, a projection of the levels of use at the affected hospital for at least three years following the anticipated opening of the proposed ambulatory surgical facility;
> and
> (b) The operating room capacity assumptions in .06A of this Chapter and the operating room inventory rules in .06D of this Chapter shall be used in the impact assessment.

Under this definition, the following impact would constitute an adverse impact on Sinai Hospital:

Sinai Capacity (in Minutes)		3,197,100
Definition of Impact	18%	
Definition of Impact for Sinai (in Minutes)		575,478

Therefore, in order to potentially adversely impact Sinai, GSSSC would have to project that it is drawing 575,478 minutes from Sinai.

On page 67 of the GSSSC CON application, Hopkins showed that GSSSC will have a ***total*** of 359,015 case minutes by the third year of operation.

	FY '18	FY '19	FY '20
Cases	4,346	4,731	5,078
Min/Case	70.7	70.7	70.7
Case Minutes	307,262	334,482	359,015
Turnaround Min/Case	25.0	25.0	25.0
Turnaround Minutes	108,650	118,275	126,950
Total Minutes	415,912	452,757	485,965
Capacity/OR	97,920	97,920	97,920
ORs	**4.247**	**4.624**	**4.963**

Source: GSSSC CON Application, p. 67

Therefore, it is simply impossible for GSSSC to adversely impact Sinai. The ***total*** number of case minutes projected for GSSSC is far ***less*** than number of minutes that Sinai Hospital would have to lose in order to be adversely impacted under the SHP's definition of potential adverse impact. Even if every single case projected at GSSSC were drawn from Sinai, it would only account for 11.2% of Sinai's capacity.

Adding the capacity of Northwest Hospital and Carroll Hospital to obtain a complete calculation of LBH's capacity, the percentage would be even smaller. LBH's Comments (p. 4) state that Northwest Hospital has 8 ORs. Hopkins projects that GSSSC will draw 5,232 minutes from Northwest. This calculates to only 0.46% of Northwest's capacity.

	Northwest ORs	Capacity/OR (in Hours)	Minutes/Hour	Capacity/OR (in Minutes)	Total Capacity
Mixed Use	8	2,375	60	142,500	1,140,000
GSSSC Projected Impact					5,232
% Impact					0.46%

Additionally, LBH suggests that Hopkins has not supported how JHH will generate the outpatient minutes required in order to backfill the movement of cases to GSSSC. JHH is not applying for a CON and there is no basis to suggest that the Applicant must demonstrate that JHH's continued growth in outpatient surgical minutes will not adversely impact any existing facility. Further, JHH demonstrated that JHH's outpatient OR minutes have consistently increased by 2 percent annual since at least 2008 and that carrying that rate of growth forward will backfill the shifted minutes by as early as FY 2019. LBH presented no evidence to the contrary. LBH also suggests that Hopkins is required to demonstrate that the projected continued growth in JHH's OR minutes will not adversely impact existing providers. There is no such requirement in the Surgical Services Chapter or COMAR 10.24.01.08G(3)(f). Hopkins has demonstrated that the projected volume to be performed at GSSSC will not adversely impact any existing provider, as required by

these standards. It is not required to demonstrate that the continued growth in JHH's outpatient surgical minutes following the establishment of GSSSC – growth that has been consistently experienced each year since at least 2008 – will not adversely any existing provider. When it was granted a CON to expand its hospital-based outpatient surgery in 2008, Sinai Hospital relied not only on the volumes then being performed in its ORs, but also on continuation of its "trended growth" in its OR volumes and was not required to demonstrate that this growth would not adversely impact existing providers. See Docket No. 07-24-2199, Staff Report and Recommendation at 19-24.

Finally, LBH suggests that GSSSC would adversely impact patients by rerouting them from a "convenient downtown location" in East Baltimore to Green Spring Station, and would adversely impact patients who rely on public transportation. This argument is without merit. Nearly all of the patients who will receive outpatient surgery at GSSSC are patients who elected to seek primary or specialty care at Green Spring Station and are already receiving health care services there. For the hundreds of thousands of patients who travel long distances today to receive care at Green Spring Station, it cannot seriously be suggested that travelling to East Baltimore, located several miles from an interstate highway, for outpatient surgery in a hospital setting is somehow more convenient or appealing than travelling to Green Spring Station, an easily accessible suburban location right at the intersection of two major interstate highways with free parking, where the patient is already receiving care. Indeed, patient demand for care in a more convenient suburban location, such as Green Spring Station, is one of the drivers of this project.

4.

Hopkins Has Demonstrated Financial Feasibility

Similar to its argument regarding Need, LBH argues that Hopkins has not established financial feasibility as required by the Surgical Services Chapter Standard .05B(8) because Hopkins did not provide service area population based utilization projections. As discussed above, the Commission has rejected the argument that such a projection is required under the Surgical Services Chapter. In the Application, Hopkins relied on its internal physician specific referral data to demonstrate where all cases projected to be performed at GSSSC will come from, just as other CON applicants have done, and the Commission has consistently approved over many years.

LBH suggests that the volume projections upon which the claim of financial feasibility is based are unrealistic because Hopkins has not provided support for its assumption that patients would travel to GSSSC from longer distances. As described in the Application, however, even with the pre-expansion level of services provided at Green Spring Station, patients already travel from long distances to receive services on the campus. See Application at p. 9. Only 14 percent are from the 4 local zip codes near the campus, 44 percent come from within a ten mile radius, 23 percent come from outside Central Maryland, and 13 percent come from outside the State. Clearly patients are already willing to travel to Green Spring Station to receive high quality primary and specialty care at this convenient location. Moreover, Hopkins presented detailed information in the Application from each surgical specialty and physician demonstrating not only their historical case volumes, but also for those specialties not already at an 85 percent retention rate, how that rate will be achieved. See Application at pp 46-66. Hopkins has demonstrated that its volume projections are reasonable and LBH has introduced no evidence to show that those projections are unreasonable.

CONCLUSION

WHEREFORE, for the reasons stated above and in its CON Application, Hopkins requests that the Commission grant it a CON to establish GSSSC.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on this 27th day of January, 2016 a copy of the foregoing Applicant's Response to Written Comments of Lifebridge Health, Inc. was sent by electronic and first class mail to John T. Brennan, Jr., Esquire, Crowell Moring, 1001 Pennsylvania Ave NW, Washington DC, 20004-2595, jbrennan@crowell.com.

Marta D. Harting

Marta D. Harting

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Applicant's Response to Written Comments of Lifebridge Health, Inc.are true and correct to the best of my knowledge, information and belief.

Andrew Solberg
A.L.S. Healthcare Consulting Services

1/26/16
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Applicant's Response to Written Comments of Lifebridge Health, Inc.are true and correct to the best of my knowledge, information and belief.

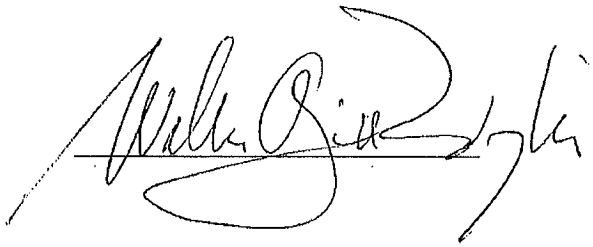
Lynn Widdoss

01/27/2016

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Applicant's Response to Written Comments of Lifebridge Health, Inc.are true and correct to the best of my knowledge, information and belief.

WALKER GILL WYLIE



AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Applicant's Response to Written Comments of Lifebridge Health, Inc.are true and correct to the best of my knowledge, information and belief.

ANNE LANGLEY

January 27, 2016

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Applicant's Response to Written Comments of Lifebridge Health, Inc.are true and correct to the best of my knowledge, information and belief. .

Bill Plans _____ 1/26/16 _____