

BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF

ADVENTIST HEALTHCARE, INC. D/B/A
WASHINGTON ADVENTIST HOSPITAL

Docket No. 13-15-2349

**RESPONSES OF ADVENTIST HEALTHCARE, INC.
TO EXCEPTIONS OF THE INTERESTED PARTIES AND PARTICIPATING ENTITY**

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I. INTRODUCTION AND SUMMARY

Applicant Adventist HealthCare, Inc. (“AHC”) operates Washington Adventist Hospital (“WAH” or the “Hospital”) on a small 13-acre campus in residential Takoma Park. That campus is challenging from both an access standpoint and for the delivery of care. From access to the campus through narrow, traffic-clogged streets, to traffic flow and parking on campus, to limited space, to an aging infrastructure, to small room sizes and to a limited number of private rooms, the challenges to WAH -- which prides itself on the excellent care that it provides -- are considerable. The proposed project -- to relocate WAH to a much larger, more accessible campus 6.5 miles north in White Oak -- is designed to remove barriers to receiving care and to enhance access to modern facilities and services.

As noted by the Reviewer, Commissioner Frances B. Phillips, RN, MHA, AHC first sought a Certificate of Need (“CON”) in 2009, but later withdrew that application and “returned with an alternative plan and more solid financial position from which to launch its plans” for relocation of the Hospital (November 18, 2015 Memorandum of Commissioner Phillips at 2). Although it currently is licensed for 230-beds, AHC proposes a smaller replacement hospital of 170-beds and would leave its acute psychiatric inpatient facilities in Takoma Park, to be relicensed as a special hospital that would be operated by Adventist Behavioral Health. Also remaining on the Takoma Park campus would be a currently-operating Federally Qualified Health Clinic (“FHQC”), a women’s’ care clinic and a 24/7 urgent care center.

The record before the Commission consists of 132 separate items, consisting primarily of submissions by AHC, Interested Parties Holy Cross Hospital (“HCH”), MedStar Montgomery Medical Center (“MMMC”) and Laurel Regional Hospital (“LRH”), along with Participating Entity the City of Takoma Park (the “City”). Also part of the record is a November 6, 2015

Memorandum from the Health Services Cost Review Commission (the “HSCRC”), concluding that AHC’s overall assumptions regarding financial feasibility of the new facility are reasonable and achievable.

Based upon the voluminous record -- and after having conducted site visits at the existing Hospital and the proposed new site -- Commissioner Phillips issued a December 17, 2015 181-page Recommended Decision (the “Recommended Decision”) that thoroughly and thoughtfully assessed the record and recommended approval of AHC’s modified CON application.¹

Exceptions to that Recommended Decision have now been filed by the City, HCH and MMMC.

Both the City and HCH ask that the Commission require AHC to develop a Freestanding Medical Facility (an “FMF”) on the Takoma Park campus. AHC, which will operate a 24/7 urgent care center on the campus, respectfully asserts that conditioning approval of WAH’s relocation on the development of a facility for which regulations have not yet been promulgated or rates set would be premature and unprecedented. The City’s and HCH’s exceptions in that regard are unfounded.

MMMC’s exceptions are equally unfounded. It argues that AHC’s proposed project is neither financially feasible nor viable -- in direct contradiction of the voluminous data and HSCRC analysis that establish otherwise. It contends that relocation of the Hospital would deny access to the indigent and medically vulnerable -- notwithstanding the fact that the services that will remain on the Takoma Park campus will meet the needs of that population and that access in WAH’s existing and likely service areas will remain well within the applicable Standard. It

¹ The Recommended Decision, although dated December 17, 2015 (when the Commission next meets), was released on November 18, 2015.

contends that there is no need for a new hospital in White Oak and that the Commission should hire a university professor to conduct an academic study to assess unwarranted adverse impact -- notwithstanding the fact that the Commission itself has long been charged with ensuring that facilities that wish to relocate meet the applicable State Standards and clearly has sufficient expertise to apply those Standards in this instance. And finally, it contends that AHC has failed to explore a cost-effective alternative (remaining in Takoma Park) because it has not asked the State and County to take land through their power of eminent domain -- notwithstanding the fact that no such site has been identified, that an eminent domain taking would involve an expensive, lengthy and likely acrimonious process, and that relocation within Takoma Park itself would neither address nor ameliorate the challenges presented by WAH's current site.

The exceptions of the Interested Parties and Participating Entity do not establish that AHC has failed to meet any of the Standards governing its CON application, nor do they provide any basis for the Commission to disregard Commissioner Phillips' very comprehensive Recommended Decision.

Accordingly, AHC respectfully requests that its application be approved.

II. THE HISTORY OF THE PROJECT

A. AHC's Prior Application

1. The challenges facing WAH on its Takoma Park site.

In 2009, AHC submitted an application for a Certificate of Need by which it proposed to relocate WAH from the Takoma Park campus, where it had been for more than a century, to a 48.8-acre property in White Oak, Maryland, in order to modernize and expand the facility. The proposed new campus was approximately 6.5 miles from the Takoma Park campus, in the heart of WAH's primary service area, and located next to a new facility being developed by the U.S.

Food and Drug Administration (“FDA”).

Relocation was sought due to constraints with the Hospital’s current site that simply could not be overcome. Specifically, the Takoma Park campus was challenging from both an access standpoint and for the delivery of care. It was (and is) surrounded by narrow, two-lane residential streets on which traffic backups occur regularly. Emergency vehicles compete with normal vehicular and bus traffic for access to the hospital campus. Public transportation options are limited. MetroBus, the region-wide bus system in the Washington metropolitan area, does not travel to the Hospital campus. The only bus access is from the local Montgomery County Ride-On system, creating an additional hurdle for residents who seek and receive care at the hospital. Access challenges continue once on campus where ambulances, automobiles, pedestrians and buses compete for right-of-way.

2. The prolonged application process.

In 2012, Commissioner Barbara Gill McLean issued a Recommended Decision stating that she “regretfully recommend[s] that the Commission deny [the] CON application even though a replacement and relocation of Washington Adventist Hospital . . . may very well offer the best solution for revitalizing the Hospital’s performance and prospects for the future.” The basis for her decision, she advised, lay in her “strong doubts with respect to the financial feasibility and viability of the specific proposal that [had] been presented to the Commission” and she offered the “hope that AHC and WAH promptly move to develop a new plan to achieve the important objectives addressed in [the] application so that the future of both WAH and AHC can be assured.”

3. AHC's withdrawal of the application

AHC voluntarily withdrew its application, advising the Commission that it had “determined that the best course for achieving the important objectives addressed in [the] application [would] be through the development of a new plan that [would] meet with unequivocal Commission approval.”

B. Development Of The New Plan

Following withdrawal of the application, the AHC Board of Trustees held a special meeting and developed 19 objectives to consider in selecting the best option for the Hospital's future. Those objectives, which Board members identified as critical to making an informed decision, were divided into the 7 categories listed below:

Financial Consideration:

1. Financial feasibility
2. Financial viability

Facility: Size, Scope and Description

3. Improves access
4. Sufficient parking
5. Improves campus and building aesthetics
6. Improves effectiveness and efficiency of building utility systems

Regulatory Implications

7. Improves patient flow, staff efficiency
8. Improves private bed capacity
9. Ability to achieve regulatory approval

Clinical Experience

10. Opportunity for future inpatient capacity
11. Increases outpatient capacity/accessibility
12. Increases physician recruitment opportunities

Community Implications

13. Impact on community

Adventist HealthCare impacts

14. Minimizes impact on current operations
15. Ability to achieve project completion
16. Impact on AHC and its services
17. Ensures long-term future of Washington Adventist Hospital

Adaptability to Market Changes

18. Potential to expand
19. Provides flexibility for a dynamic market, now and in the future

Utilizing those objectives, the Board directed AHC's executive team to evaluate options for WAH's future that included two options for staying on the Takoma Park campus and two for relocating to White Oak on the earlier-designated site (within the Hospital's existing primary service area).

The four options considered were as follows:

- A. Limited capital project on the existing Takoma Park campus, maintaining the current buildings;
- B. More significant capital project on the existing Takoma Park campus;
- C. Smaller facility in White Oak with non-rate regulated health care services in Takoma Park;
- D. Similar sized facility in White Oak with some rate-regulated, acute-care services in Takoma Park.

After analyzing each of the options, the AHC executive team concluded that Option D provided both the best alternative for insuring the long-term future of WAH and was the most cost-effective, being the only option that earned a positive financial margin by the fifth year and would not require on-going subsidy by AHC.

C. AHC's Submission Of Its New Application

1. AHC submitted its October 2013 application

On October 4, 2013, AHC submitted a new CON application, proposing to relocate WAH to the White Oak campus, with eight stories above grade and one below grade, and 201 private patient rooms (a reduction in beds from the Takoma Park facility). The application proposed relocating all current hospital units at the Takoma Park facility, with the exception of behavioral health services, which were to remain on the Takoma Park campus.

After the filing of that application, the State of Maryland negotiated a new waiver with CMS, resulting in a new Global Budget Revenue model for acute-care hospitals for Maryland, including WAH. That change had a substantial impact both on how Maryland hospitals are reimbursed and incentives for hospitals moving forward, and further impacted the size and scope of future capital projects. Accordingly, AHC believed it prudent to re-evaluate options for the future of WAH based upon that new paradigm.

2. AHC refined its options based on the new Global Budget Revenue model.

Given the new health care (and health care reimbursement) landscape, four new options were developed and considered:

1. Limited capital project on the existing Takoma Park campus, maintaining the current buildings;
2. Replacement hospital on the existing Takoma Park campus;
3. Relocation of all existing acute-care hospital services, including behavioral health, to a new facility and campus in White Oak; and
4. Relocation of all existing acute-care hospital services to the new facility in White Oak -- except for behavioral health, which would stay in Takoma Park as a specialty hospital.

AHC then began working to develop both the scope and viability of the various options and a scoring matrix to aid in the decision-making process. The scoring matrix specifically was to identify the degree to which each option met the 19 objectives established by the Board.

Option 1, the limited capital project in Takoma Park, was removed from consideration because it failed materially to address pressing facility infrastructure challenges or access issues.

Scope, programming, budget and schedule data then were developed for each of the other three options, which were evaluated pursuant to the options scoring matrix. Option 2 would have involved a significant reinvestment in the existing hospital with a multi-phased program of demolition and construction at the Takoma Park campus. The resulting hospital in Takoma Park would have taken seven years to complete, beginning with site preparation and demolition. Because it would involve replacing portions of the buildings on campus -- while operating a functioning hospital -- the hospital modernization was divided into three separate phases of construction and corresponding phases of demolition. The capital expenditure would have been \$351.2 million.

Option 3, a proposal to build a 210-bed hospital in White Oak, was also considered. The proposal was similar to Option 4 except that, in Option 3, the 40 behavioral health beds would move to White Oak and be operated as acute hospital beds instead of staying in Takoma Park. The capital expenditure for Option 3 would have been \$353.2 million.

Option 4 involved the development of a replacement facility with all private rooms on a 48.86-acre campus in White Oak, while retaining the existing Takoma Park campus for various health care services, including the hospital's behavioral health services (which would become part of Adventist Behavioral Health), an FQHC, the services of Adventist Rehabilitation Hospital of Maryland/Takoma Park, the Women's Center clinic, an urgent care clinic, doctors' offices, as

well as lab, radiology and other ancillary services. The new White Oak facility under Option 4 would have 170 inpatient beds, and a total cost of \$330.8 million.

Under the options scoring matrix, Option 4 received the highest score, followed by Option 3 and then Option 2.

AHC thus concluded that Option 4 provided the best alternative for ensuring the long-term future of WAH and was the most cost-effective, requiring the lowest amount of capital of the three possible options and earning the highest scores when factoring both the gain in White Oak and loss in Takoma Park.²

AHC thereafter modified its application to propose a relocated facility on the White Oak campus with 170-beds and robust health care services (as described below) remaining on the Hospital's current Takoma Park campus.

III. THE PROPOSED PROJECT

AHC has proposed building a 170-bed replacement facility on the 48.86-acre site in White Oak. The new campus is located in WAH's existing primary service area and is within a Maryland state priority funding area. The replacement hospital will include all existing acute-care services -- except for behavioral health services, which will stay in Takoma Park and be licensed as part of Adventist Behavioral Health. The Takoma Park campus will also include other non-acute-care services:

- an FQHC operated by Community Clinic, Inc.;
- the Women's Center, providing prenatal and other services for the community, including low-income women;
- a 24/7 urgent care center;

² A chart depicting AHC's overview of those Options is set forth at page 41 of the Reviewer's Recommended Decision.

- the existing rehabilitation unit licensed as part of Adventist Rehabilitation Hospital;
- physician offices;
- Imaging and other ancillary services in support of the clinical care provided on the campus; and
- 55,000 square feet of space to be leased to Washington Adventist University, a college with an adjoining campus.

This plan addresses the need for new facilities in an accessible location, continued health care services for the community around the existing Takoma Park campus, and reflects the changing dynamics of health care.

Specifically, the relocated hospital in White Oak would include the following components:

- 1) An Emergency Department with 32 treatment bays
- 2) 8 Operating Rooms (6 for general surgery, 2 special purpose (primarily cardiac surgery))
- 3) 2 Endoscopy Rooms
- 4) 1 Cystoscopy Room
- 5) 6 Cardiac/Vascular Angiography suites
- 6) 28-bed Critical Care Unit
- 7) Maternity Unit (18 post-partum rooms, 4 Medical-Surgical patient rooms dedicated to women's care, 7 Labor and Delivery Rooms, 2 C-Section)
- 8) 8 dedicated Short Stay Observation Beds in the patient tower and 12 Clinical Decision beds adjacent to the Emergency Department.
- 9) Approximately 750 surface parking spaces

The Hospital will be organized to maximize patient safety and efficiency with a patient tower of medical-surgical floors on a "base" with emergency, radiology, surgery, cardiac, and

maternity services. A cellar level will house support spaces such as lab, central sterile processing, dietary, maintenance, information technology and mechanical-electrical. Because the elevators are critical to hospital circulation for patients, visitors, and staff, they form the primary organizing vertical element that also helps differentiate horizontal functions. Elevator functions are segregated with one bank for the public and a separate bank for service/patients.

Evidence-based architectural methods have been employed in the hospital design to improve patient outcomes, safety, and satisfaction. Additionally, these design methods also improve staff efficiency, satisfaction, and staff retention. The design is consistent with national or jurisdictional codes and guidelines established for hospital design and construction.

After the completion of the White Oak hospital, AHC will re-develop the Takoma Park campus for the non-acute health care services more suited to campus conditions.

The total project cost for the development of the new WAH facility in White Oak would be \$330,829,524 million, including interest and an allowance for inflation.

In addition, AHC has a signed Memorandum of Understanding (MOU) with the FDA, located adjacent to the proposed WAH campus in White Oak. That MOU provides: “By sharing resources and talents, the two organizations can open up new areas of discovery, funding and cooperation that are critically important for keeping both organizations on the leading edge and for protecting and promoting our nation’s public health.” WAH and the FDA have already begun collaborating on several smaller initiatives regarding major FDA regulatory program areas and the collaborative relationship will expand when the hospital moves to White Oak, a relationship that will benefit public health and health care research.

This collaboration between WAH and the FDA is further enhanced by the recent approval by Montgomery County of the White Oak Science Gateway Master Plan. This

emerging White Oak bioscience corridor will be anchored by the FDA, the proposed new WAH, and the Life Sciences Village. White Oak is poised to become one of the most important biotech corridors in the nation. WAH already has all the Montgomery County development approvals necessary to build its new facility at White Oak. The new campus would allow transformational development of the surrounding area that will be a tremendous benefit to WAH, the White Oak area, Montgomery County, the State of Maryland, and the nation.

IV. THE RECOMMENDED DECISION IS THOROUGH, THOUGHTFUL & CORRECT

The Interested Party that has submitted the most vociferous exceptions, MMMC, would have the Commission believe that the “current Recommended Decision is based in large measure on the findings of the September 2012 Recommended Decision regarding WAH’s previous application to relocate the hospital to White Oak/Fairland and the health care environment that existed at that time” (MMMC Exceptions at 1). That contention is as outlandish as it is demonstrably false.

Commissioner Phillips, assisted by MHCC staff, conducted a detailed, thorough and thoughtful review of the pending application on its independent merits, and her Recommended Decision has analyzed and assessed the data pertinent to that entirely new plan.

MMMC’s unfounded insinuation that the Recommended Decision somehow simply “recycles” data submitted in the earlier proceeding completely ignores the voluminous data contained in the record of this application -- 132 separate items, nearly half of which were submitted following Commissioner Phillips’ designation as the Reviewer for this matter. That voluminous data painstakingly has been reviewed and analyzed by Commissioner Phillips and MHCC staff, including financial projections, impact calculations, demographic data and other

indicators that are wholly unrelated to the previous, wholly different, project.

This project can -- and must -- be considered on its own merits and in the context of the very comprehensive 181-page Recommended Decision submitted by Commissioner Phillips.

A. Financial Feasibility & Viability

1. The Reviewer is correct that the Project is financially feasible and viable.

MMMC takes exception to the Reviewer's findings regarding financial feasibility and viability on the basis that the Reviewer supposedly "relied heavily on the HSCRC's November 6, 2015 Memorandum reviewing and commenting on the financial feasibility and underlying assumptions of WAH's proposed project," while the Memorandum itself "raised a number of significant concerns with the feasibility and viability of WAH's project and the assumptions made by WAH" (MMMC Exceptions at 4). In that regard, MMMC contends that the "chief concern" expressed by the HSCRC is that WAH's projections are based on an unjustified assumption as to future volume increases.

MMMC is, again, wrong.

As a threshold matter, although the Reviewer rightly cited to and relied on the November 6, 2015 Memorandum from the HSCRC, that hardly was the extent of her review and analysis of pertinent data contained within the record. Commissioner Phillips' review of the parties' and HSCRC's submissions and her independent analysis and findings on financial feasibility alone are comprehensively set forth on 18 pages of single-spaced text; her discussion and analysis of viability consumes another 8 pages of single-spaced text. Clearly, her independent analysis reflects more than just a blind reliance on the HSCRC's assessment.

More significant, however, is the fact that the HSCRC Memorandum concerning financial feasibility -- rather than raising “a number of significant concerns” -- reflected an exceedingly positive assessment throughout its 12-page review, including the following:

- “Staff believes that the assumed increases are reasonable in light of the projected changes in population and approved revenue.” (pg. 2)
- “The HSCRC staff also reviewed WAH’s projections of other operating revenue. The projected other operating revenue is considered reasonable and achievable.” (pg. 2)
- “The average variable cost change averages approximately 90% over the 5 year period. However, since the overall volume change is very small during this period, any change to the variable cost percent would have little impact on the overall projection of expenses. Staff believes that the assumptions used in the projections of ongoing annual expenses are reasonable and achievable.” (pg. 4)
- “Based upon these projected ratios, Staff believes that AHC would be able to obtain financing for the project on terms that are consistent with those assumed in the plan of finance.” (pg. 5)
- “Given AHC’s debt situation, Staff believes that WAH has provided a reasonable amount of equity contribution for the project to be financially feasible.” (pg. 7)
- “Staff believes that the overall assumptions regarding the financial viability of the new facility at White Oak are reasonable and achievable depending on WAH attaining the volumes projected in the CON.” (pg. 12)³

Plainly, the HSCRC Memorandum does not support MMMC’s position that the proposed project is not financially feasible.

The HSCRC rightly advised the MHCC carefully to consider overall bed need in the context of current utilization trends. AHC understands this and thus carefully considered bed need and the appropriate sizing of the proposed facility, and specifically reduced its bed capacity to reflect current utilization trends and future expectations. AHC built no volume increases for

³ A copy of that Memorandum is attached as Attachment A.

MSGA and Observation Visits into its projections until 2019 -- when the new facility opens -- and then it projects growth that is approximately equivalent to population growth estimates. Further, while the HSCRC properly suggested that the MHCC carefully review bed need and apply conservatism, Commissioner Phillips has acknowledged the HSCRC's recommendation in her assessment of the Standard (Table IV-15 of the Recommended Decision) and expressly considered the issue in her analysis:

The proposed replacement hospital will have 152 MSGA beds, 19 fewer MSGA beds than were licensed in FY 2015 and 17 fewer beds than are currently licensed. This number of beds represents a reduction in physical MSGA bed capacity for WAH of 87 beds. All of the 152 MSGA beds will be located in private rooms.

This standard provides that only beds identified as needed and/or currently licensed shall be developed at an acute-care general hospital, and contains tests that apply to proposed additional beds. This application seeks to replace MSGA bed capacity that is currently licensed, and does not propose any additional beds. WAH currently has a physical capacity for 239 MSGA beds and has allocated 169 beds within its overall acute-care license to MSGA services in FY 2016. AHC is proposing to develop a physical bed capacity for only 152 MSGA beds at White Oak.

I find that AHC has satisfied this standard.

(Recommended Decision at 25).

Moreover, MMMC's contentions regarding WAH's supposed "substantial decreases in volume" are fundamentally flawed. Although WAH did experience a volume decline between 2013 and 2014, that volume change already has been accounted for in current rates; the HSCRC made prospective volume adjustment in WAH's initial FY 2014 GBR setting of 2.18%. Additionally, the volume adjustment for CY 2014 versus CY 2013 also has already been fully addressed in the FY 2016 Rate Adjustment. At this time, WAH's market shift adjustment is -1.14% or \$1.4M. So for the total impact for volume changes between CY 2014 and FY 2013, WAH's rates have been reduced by a total of 3.32% (2.18% + 1.14%) -- and yet WAH still

shows increasingly positive margins and the HSCRC has confirmed that Global Budget Revenue increases in its projection are reasonable.

Additionally, MMMC looks at data that only takes into consideration inpatient care, and does not account for the fact that many patients are now being seen in an observation or outpatient status. Thus, MMMC's selective analysis plainly fails to take a comprehensive view of WAH's entire service offerings. When both inpatient and observation cases >23 hours are considered, WAH declined 6.19% in case-mix adjusted discharges between 2013 and 2014, which, as noted, has already been accounted for in its Global Budget Revenue rate structure. Case-mix adjusted discharges from CY 2014 to CY 2015 (January - September Final) annualized have actually increased 2.4%. Further, that increase from CY 2014 to CY 2015 is projected to yield a positive market share adjustment in WAH's FY 2017 GBR rates based on the HSCRC's preliminary 6 month estimate reflected in its September 29, 2015 memorandum.⁴

⁴ Attached as Attachment B is the HSCRC final market share calculation for CY 2014 and an excerpt from the September 29, 2015 HSCRC memorandum that contains preliminary CY 2015 first and second quarter market shift data.

Discharges	IP Discharges	OBV <23 hr Discharges	Total Discharges	Variance from Prior Year
2013	13,262	998	14,260	
2014	13,159	940	14,099	-1.13%
2015*	12,446	1,848	14,294	1.38%

CMI	IP CMI	OBV CMI	Total CMI	Variance from Prior Year
2013	0.9866	0.5000	0.9525	
2014	0.9325	0.5021	0.9038	-5.12%
2015*	0.9689	0.5280	0.9119	0.90%

Case-mix Adjusted Discharges	IP Case-mix Adjusted Discharges	OBV >23 Case-mix Adjusted Discharges	Total Case-mix Adjusted Discharges	Variance from Prior Year
2013	13,084	499	13,583	
2014	12,270	472	12,742	-6.19%
2015*	12,059	976	13,035	2.30%

Source: HSCRC Discharge Abstract Data

*January - September Annualized (using final submission data)

2. MMMC erroneously suggests that AHC will be unable to finance the Project.

MMMC contends that AHC's financial ratios will prove to be a barrier to AHC being able to borrow the necessary amount to finance the Project. However, the facts -- as reflected in the record -- belie that contention.

AHC intends to pursue traditional, tax-exempt bond financing for this project. The financing for the proposed project in the anticipated aggregate principal amount of \$244.8 million will be secured pursuant to an Amended and Restated Master Trust Indenture. The ratios of the Obligated Group, including the proposed project presented as part of its AHC's Modified CON application, indicate that the Obligated Group will continue to meet all bond covenants.

During the course of the review, MMMC made similarly flawed arguments, and AHC responded with factual data from its consultant, Ziegler, that established that AHC reasonably can expect to obtain bond financing. That advice was based on Ziegler's knowledge of and experience with recent "BBB" and non-rated health care financings. AHC submitted, as part of the review, materials from Ziegler, showing examples of 18 recent financings, including relevant case studies, that supported Ziegler's opinion that the Project not only is financeable, but that (given the favorable environment) borrowing costs may be below those assumed in AHC's application (*see* Attachment C).

In an effort to rebut that data, MMMC cites Moody's medians for "All Hospitals". However, the AHC Obligated Group that will be involved in the bond financing will be compared to peers in its own rating category, not "All Hospitals". Moreover, comparison to rating agency medians is not the only measure that determines ability to finance a project. Institutional investors perform their own due diligence when evaluating financing transactions, relying heavily on qualitative measures such as market share, reputation and leadership team. It is by no means a narrow analysis that would just focus on Moody's medians. Additionally, the approval of AHC's rate application by the HSCRC will be viewed very positively by prospective bondholders because AHC will receive in rates a significant portion of its annual debt service cost, which contrasts favorably with facilities in other states, where hospitals have to earn additional revenue by increasing volume to pay for capital expenditures.

The Reviewer and the HSCRC were correct -- the Project is financially feasible and viable.

B. No Adverse Impact

MMMC takes exception to the Reviewer's determination that WAH's relocation would not inappropriately diminish access to care by the underprivileged population that WAH serves. Specifically, after noting AHC's commitment to maintain outpatient services on the Takoma Park campus -- including an expanded FQHC, a women's clinic serving indigent women in need of obstetric and gynecological services and a 24/7 urgent care center -- the Reviewer concluded:

In my view, AHC's stated intentions are credible given its historically strong commitment to serving the disadvantaged and indigent population. It has consistently reported high levels of community benefit and charity care. AHC disputed statements by HCH and MMMC that it was leaving a poorer area for one that was better off, providing economic data for its proposed service area that showed only very marginal improvement in the economic and demographic profile of the WAH patient population post-project. Contrary to the opinions expressed by some commenters, I find that this marginal improvement in the economic well-being of the service area population that can be logically assumed for the replacement WAH at White Oak is incidental to the project rather than a strategic objective of the project. The evidence does not indicate that eliminating the level of disadvantage being created through this proposed hospital relocation is so great that MHCC should force AHC to undertake a modernization of WAH on its existing site or force it to find a site for relocation of WAH that will not change access to its hospital facilities in any material way. I find that the impacts are simply not that great and that AHC has committed to responsible actions that will ameliorate those impacts.

(Recommended Decision at 36).

The facts contained within the record establish that the Reviewer clearly was correct in her conclusion.

- 1. WAH has a long history of serving the community -- particularly its indigent and medically underserved residents -- which will continue both on the Takoma Park campus and in the total community that AHC serves.**

MMMC's insinuation that WAH is "abandoning" the community it serves by moving to a state-of-the-art facility only six miles from Takoma Park reflects an ignorance of AHC's strong commitment and contributions to that community. In many respects, AHC's demonstrated

commitment to provide community benefit exceeds that of others, including MMMC.

WAH has a long history of being a leading provider of care for the under-served, and provides a wide array of health and wellness programs for the community, as documented by the significant portion of its income devoted to community benefit services. That is a commitment that will continue with the new campus in White Oak and continued services in Takoma Park.⁵

For State FY 2013, an HSCRC report shows that WAH had the highest level of Community Benefit as a percent of total operating expense of any hospital in Montgomery County, far higher than MMMC (with WAH subsequently reporting an increase to \$38.6 million in community benefit activity in calendar year 2013, 17% of the Hospital's operating expense):

<u>Total Community Benefit as a Percent of Operating Expense; FY 2013</u>	
Washington Adventist Hospital:	15.30%
MedStar Montgomery:	9.77%

http://www.hscrc.maryland.gov/init_cb.cfm

AHC's CON application detailed how it plans to maintain the Takoma Park campus and invest in health care services for the benefit of the community. The application details the urgent care center, population health programs, and specialty hospital services that will be maintained on the campus. In fact, AHC already has established an FQHC, operated by Community Clinic, Inc., on the Takoma Park campus, and that FQHC will be doubling its clinical space in the coming months.⁶ AHC has committed to other services such as a maternity clinic for low-income women, which is already in operation, and an urgent care center.

⁵ Attached as Attachment D is a document that describes the many community programs offered by AHC that will continue to be offered following the relocation of WAH.

⁶ The FQHC currently has 1,443 square feet of space and includes one provider that can handle 4,370 patient visits per year. By the end of this year, the clinic will be expanded to 3,000 square feet, allowing space for an additional three providers and capacity for an estimated 17,480 patient visits; the expansion is being undertaken, in part, using money secured by WAH from a State grant.

As the Reviewer correctly noted, AHC has a “historically strong commitment to serving the disadvantaged and indigent population,” and remains committed to meeting the needs of its local community.

2. Access for the population in WAH’s existing and likely service areas will remain well within the applicable Standard.

As demonstrated in AHC’s filings, 100% of WAH’s likely service area population will be able to travel to a hospital within the 30-minute time period established by the applicable Standard. Moreover, AHC’s travel time analysis has demonstrated that the likely service area population can travel more quickly to the White Oak location than to the existing location, resulting in a “travel time savings” for the likely population of 1,133,019 minutes traveled. It is inarguable that “access” for the population in WAH’s existing and likely service areas will remain well within the State Standard.

3. Additional studies that MMMC asks the MHCC to undertake are neither necessary nor warranted.

MMMC has taken exception to the Recommended Decision on the basis that the Reviewer rejected its suggestion that a study to examine unwarranted adverse impact should be conducted by a professor at Emory University.

There are two reasons why the Reviewer was correct. First, as reflected above and as expressly acknowledged by the Reviewer, WAH has a long history of serving the community, particularly its indigent and medically underserved residents, which will continue in the community that it serves. Second, the Commission long has been charged with ensuring that facilities that wish to relocate meet the applicable State Standards and the Commission and staff clearly have sufficient expertise to apply those Standards in this particular instance without an academic study.

4. The services that will remain on the Takoma Park campus will meet the needs of Takoma Park's underprivileged population.

Throughout its filings, AHC emphasized WAH's long history of serving the community, particularly its indigent and medically under-served residents. AHC's filings further demonstrate that, following relocation, WAH will continue serving such residents, both on the Takoma Park campus and at its new location.

MMMC contends that the underprivileged community that WAH serves needs access to inpatient and outpatient centers to treat chronic medical conditions such as cancer, heart disease, arthritis and diabetes. AHC agrees, which is why its proposal includes a thoughtful, well-planned combination of outpatient and inpatient services on the Takoma Park and the White Oak campuses, both of which are within the Hospital's existing primary service area. As outlined in detail, the Takoma Park campus will include an expanded FQHC designed to provide access to care for patients with routine and chronic conditions who may not have other means of care. The new hospital in White Oak will include a modern, 21st century facility with private rooms and adequate space for inpatient and outpatient services for routine, chronic and tertiary conditions, along with a separate outpatient cancer center -- all on a campus developed with improved transportation access in mind. MMMC seems to suggest that Takoma Park's underprivileged population is best served by relegating the community to aging and crowded facilities. WAH's White Oak campus, which is located in the hospital's existing primary service area, combined with the services on the Takoma Park campus, will strengthen the region's health care infrastructure and ensure continued access to care for all communities served by the

Hospital.⁷

C. The Need For Replacement And Relocation Of WAH

In addition to conducting a detailed analysis of bed need questions called for under COMAR 10.24.01.08G(3)(B), the Reviewer also briefly summarized her other need-related findings, including the following:

With respect AHC's determination that the relocation of WAH is preferable to alternative approaches to modernization, I found that AHC's conclusions with respect to the inferiority of the on-site replacement alternative are well-founded and that it adequately explained its process for evaluating and selecting the best alternatives. This led me to the conclusion that off-site replacement is the unavoidable preferred choice. The chosen site fits WAH's criteria, which I believe are reasonable.

(Recommended Decision at 131).

MMMC takes exception to the Reviewer's findings concerning need, arguing that WAH should remain in Takoma Park and that a new hospital is not needed in the White Oak area (MMMC Exceptions at 19). In two very well-stated paragraphs, the Reviewer rejected that contention, as the Commission should:

I disagree with MedStar Montgomery Medical Center's comments that the needs of the population currently served by WAH will not continue to be met if the proposed project goes forward. MMMC contends that the area surrounding the White Oak site is already well served by three acute-care hospitals and that there is no need for additional acute-care service in the proposed location. I find that the White Oak area is actually served by more than three general hospitals, one of which is WAH. I also find that the area surrounding Takoma Park overlaps with the area surrounding White Oak and is also served by several hospitals, one of which is WAH. MMMC characterizes this project as one that removes a general hospital from one distinct and discrete area to another distinct and discrete area, eliminating a hospital from an area where that hospital is needed to a different area where that hospital is not needed. I do not consider this to be a realistic characterization. In all likelihood, a general hospital in White Oak replacing the general hospital in Takoma Park will result in some changes to the catchment

⁷ Attached as Attachments E and F are materials submitted as part of the review process that provide an overview of some of AHC's accomplishments and the benefits offered by its Center for Health Equity & Wellness.

areas of the general hospitals in this region; however, it is important to recognize that it is a region with multiple general hospital sites located within reasonable travel times for the vast majority of the region's population.

I also note that Takoma Park will continue to be a hospital campus with acute psychiatric and rehabilitation inpatient services and with outpatient health care services being delivered on both a scheduled and unscheduled basis. Contrary to MMMC's assertion, I find that AHC has addressed, in this application, the basic question of whether the White Oak/Fairland or the Takoma Park location is the more appropriate one to meet the needs of the population that WAH has historically served. While the project will have an impact on availability and accessibility to hospital services that will have both positive and negative ramifications for different subareas of the larger region, I find that the evidence shows that any adverse impacts related to this project cannot be realistically portrayed as dire. CON applications cannot be considered in the absolutist terms suggested by MMMC because, taking this type of logic as a guide, one could rarely if ever permit relocation of a hospital and other health care facilities, because all such moves will invariably reduce physical access to some services for some communities or neighborhoods. The population is not static and health care delivery is not static. I conclude that the Commission cannot approach questions about the supply and distribution of health care facilities from a perspective that the current or historic landscape of facilities must be maintained.

(Recommended Decision at 131-32) (footnote omitted).

In arguing against the Reviewer's analysis, MMMC has acknowledged that her "recommended Decision is consistent with the Commission's traditional bed-need analysis on a County-wide basis," but contends that the Commission should adopt some broader approach that would include the study that it has proposed by the university professor (MMMC Exceptions at 22). However, as discussed above, any such study is wholly unnecessary. Moreover, as also discussed above, WAH is not "shedding volume" in areas with significant indigent and medically underserved populations, as MMMC suggests (MMMC Exceptions at 21); it will continue to have a vital and robust presence in Takoma Park through the medical services that will remain on that campus.

As was established by AHC's filings during the course of the review, the physical challenges that WAH faces on its current site (problems with access, a constraint site, limited

parking, insufficient MOB space on campus and a surrounding residential area) would not and could not be solved under any on-site modernization problem or relocation to a like site within Takoma Park. Modernization and relocation within that residential community simply would not allow the Hospital to achieve its stated objectives for providing the best possible patient care. The Commission necessarily must consider what the effect would be on the region's health care delivery system were AHC's application to be denied.

Conversely, there are numerous examples where the Commission has approved the relocation of an outmoded facility, including Upper Chesapeake, Western Maryland, Meritus and the Anne Arundel Medical Center's relocation out of a residential area in downtown Annapolis. Such relocations prompted performance improvements from rival hospitals, resulting in an increased level of quality and patient care and, ultimately, in a new equilibrium distribution of patients across those facilities -- something that results in an obvious public benefit and a strengthened regional health care delivery system.

D. AHC's Consideration Of Cost-Effective Alternatives

MMMC's final exception concerns the Reviewer's finding that the proposed Hospital in White Oak is the most cost-effective approach to meeting the needs that AHC's project sought to address (MMMC Exceptions at 23). In support of its challenge, MMMC argues that the "City of Takoma Park has repeatedly and adamantly stated that it supports retaining the hospital and would work with WAH to find a solution" (*id.* at 24). The City, however, has said nothing of the sort. Rather, as noted by the Reviewer, the City has stated that it "accepts that to fully realize the goal of a more modern hospital and of higher quality acute-care services, AHC must consider locations outside of Takoma Park" (Recommended Decision at 44).

In its efforts to counter the Reviewer’s well-considered findings, MMMC argues that AHC should have taken a so-called “team work approach” that would have involved asking the State and County to exercise their powers of eminent domain to acquire a new site within Takoma Park (MMMC Exceptions at 24). As the Reviewer aptly noted, the suggestion is far from “persuasive”, given that the use of eminent domain -- even if a suitable site could be identified within the City -- “is likely to be divisive, litigious, and expensive, and could take years to resolve with an uncertain outcome” (Recommended Decision at 44).

MMMC’s exception is wholly unfounded.

E. The Takoma Park Urgent Care Center And the Proposed FMF.

Among the recommended conditions that Commissioner Phillips suggested be attached to approval of AHC’s project was one concerning its operation of the proposed 24/7 urgent care center on the Takoma Park campus:

Adventist HealthCare must open an urgent care center on its Takoma Park campus coinciding with its closure of general hospital operations on that campus. The urgent care center must be open every day of the year, and be open 24 hours a day. Adventist HealthCare may not eliminate this urgent care center or reduce its hours of operation without the approval of the Maryland Health Care Commission.

(Recommended Decision at 38).

In response to that condition, the City asks that the Commission essentially expand upon it by requiring AHC to commit to developing, if appropriate, an FMF on the Takoma Park campus:

1. Adding a condition to the CON requiring that AHC conduct a prompt and thorough exploration of a Freestanding Medical Facility commencing upon the promulgation of the Commission’s FMF regulations.
2. Adding a provision authorizing AHC to establish an FMF in Takoma Park, if appropriate, and make any corresponding changes to the proposed project as a modification to the CON in this proceeding.

(City Comments on the Recommended Decision at 6).

For its part, HCH -- contending that WAH's relocation will result in a dramatic increase of emergency department visits to its facility -- goes one step further, arguing that the Commission should "require AHC to provide meaningful and needed emergency services for the Takoma Park community in the form of a freestanding medical facility . . ." (HCH Exceptions at 1).

The relief requested by the City is wholly unnecessary. AHC already, as part of the review process, has committed to meeting the needs of the local community, including evaluating the feasibility of a FMF. Consistent with its establishment of the FQHC (and planned expansion of that facility), AHC committed to participate in the process for evaluating the need for an FMF in Takoma Park. However, the moratorium regarding the creation and development of FMFs was then in place, and regulations concerning possible future development still have not yet been drafted or promulgated. AHC respectfully submits that it would be premature to require AHC to pursue development of a facility when governing regulations have not yet been fully developed and, with the lack of clarity concerning how rates will be structured, under circumstances where it would not have the ability to assess the financial viability of such a facility. To date, AHC has taken a prudent approach toward consideration of an FMF on the Takoma Park campus. Once the regulations have been finalized and published, it will be in a position to conduct a feasibility analysis to assess the appropriateness and viability of such a facility on that campus. That has been, and continues to be, AHC's position. A condition that required AHC to pursue and conduct such a feasibility analysis would be both superfluous and inappropriate.

HCH's request that approval of a CON for WAH's relocation be conditioned on AHC developing an FMF would be unprecedented. As noted, the regulations that will guide the CON process for consideration of such facilities have not been finalized, and it would be unfair to require AHC to develop a facility when regulations have not been developed and there is no means for assessing financial viability. As the Reviewer properly concluded, it would not be "appropriate to require AHC to commit to a more expensive form of urgent and emergent care delivery, the freestanding medical facility model, at this time" (Recommended Decision at 38).

That is especially true given that HCH's request is predicated on the flawed contention that its ED will be overwhelmed following WAH's relocation. Indeed, the Reviewer concluded -- after conducting an exhaustive analysis -- "that it can be reasonably predicted that HCH's Emergency Department may lose volume as a result of the relocation of WAH, rather than gain considerable visit volume, as it predicts" (*id.* at 161).

The Reviewer is correct in that regard, for the reasons previously noted by AHC:

- HCH did not adequately account for the presence of the urgent care center on the WAH campus and previously had stated that it was proposing a pilot program to divert low level EMS calls to alternative locations, including urgent care centers.
- HCH cited public transportation as a key reason patients will visit the HCH campus. ("HCH is on or near the majority of the Montgomery County Ride-on bus routes networked throughout the County that serve both the Takoma Park area and Silver Spring area.") However, WAH's own analysis of ED visits notes that only 1.7% of patients arrived by public transportation to the WAH ED in 2014.
- HCH understated the market share that WAH will retain by having a new ER in White Oak and an urgent care center in Takoma Park.
- HCH claimed its ED would be overwhelmed by the WAH's relocation, but it did not consider that some of the ED cases that currently go to HCH that will instead go to the new WAH ED in White Oak.
- HCH cited proximity as a major reason why patients will flock to the HCH ED, but then discounted that factor as a reason why patients who currently go to HCH might shift to WAH.

- HCH contended that “the HCH ED patients have established relationships, patterns of travel, and the new WAH location is not much closer, accessible or more convenient than the existing HCH ED.” That is plainly incorrect. The new WAH has better road access and will have plentiful parking, whereas the current WAH is surrounded by narrow residential streets and has severe parking challenges. Further, the new WAH ED will be a new modern facility, an attractive element for many people.
- HCH claimed that people residing in zip code 20904 will continue to go to HCH because HCH currently has 60% ED market share there. HCH previously argued that proximity is a major factor, yet when it comes to the proximity of the WAH ED in White Oak, which will be a new ED, HCH discounted that. If market share is a deciding factor for EDs, then it would be true not just for HCH, but for the new WAH as well.
 - For example, WAH has 60.3% market share in zip code 20783, 66.2% in zip code 20912, and 53.1% in zip code 20782, yet HCH ignored that market presence and decreased the estimated market share for the relocated hospital to only 3% within each of those zip codes.
 - In zip code 20782, the average drive time will be the exact same for both the relocated WAH and HCH.
 - In zip code 20912, WAH will be the second most proximate hospital and will remain connected as a result of the remaining services in Takoma Park.
- HCH applied unwarranted and extremely aggressive decreases in WAH market share without considering offsetting increases that would occur when moving into the redefined service area.
 - A reduction of 38.5% in market share was applied to zip code 20903 (Silver Spring), in which the drive time was estimated to have improved by 1 minute to the White Oak location.
 - HCH assumed a market share reduction of 20% or greater for 10 zip codes, but did not assume WAH would realize an increase in market share of 20% or greater in any zip code, not even its new home zip code 20904.

- HCH claimed that a large shift from zip code 20904 would be implausible, in part, because the drive time to the zip code market leader, HCH, is only on average 4 minutes longer than to the proposed site for WAH. That argument seemed to discount proximity even though proximity was cited by HCH as a major reason patients will go to HCH over the relocated WAH. HCH's own inconsistency undermines its analysis and reflects its flawed premises.

HCH's premise for insisting that AHC must develop an FMF on the Takoma Park campus because HCH's ED will be overwhelmed following the relocation of WAH is both unsupported and insupportable.

There simply is no precedent or proper basis for the relief sought by the City and HCH with respect to requiring AHC to pursue development of an FMF on the Takoma Park campus.

V. CONCLUSION

Applicant AHC respectfully asserts that the Reviewer's comprehensive and thoughtful Recommended Decision should be adopted by the Commission and that AHC's modified Certificate of Need application should be approved.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I HEREBY CERTIFY THAT on this 10th day of December, 2015, a copy of the foregoing Responses of Adventist HealthCare, Inc. to Exceptions of the Interested Parties and Participating Entity was sent via email and first class mail to:

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A handwritten signature in black ink, appearing to read "John F. Morkan III", is written over a horizontal line. The signature is stylized with a large loop at the beginning.

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