IN THE MATTER REGARDING	*	
ANNE ARUNDEL MEDICAL CENTER	*	
	*	BEFORE THE
Docket No. 15-02-2360	*	
*******************************	*	MARYLAND HEALTH
IN THE MATTER REGARDING	*	
UNIVERSITY OF MARYLAND	*	CARE COMMISSION
BALTIMORE-WASHINGTON MEDICAL	*	
CENTER	*	
Docket No. 15-02-2361	*	

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MEDSTAR HEALTH, INC.'S EXCEPTIONS TO THE REVIEWER'S REVISED RECOMMENDED DECISION

On behalf of MedStar Health, Inc., ("MedStar"), an interested party in this matter, we respectfully submit to the Maryland Health Care Commission (the "Commission") these exceptions ("Exceptions") to the Reviewer's Revised Recommended Decision ("Recommended Decision") dated March 3, 2017 to approve the proposed cardiac surgery program of Anne Arundel Medical Center ("AAMC" or "Applicant").[1] MedStar submits that the Commission cannot adopt the Recommended Decision because it is inconsistent with the requirements of Maryland's Certificate of Need ("CON") laws and the specific State Health Plan ("SHP") chapter, statutes, and regulations established for the review of cardiac surgery applications in this review cycle. The Recommended Decision also violates due process by engaging in improper rule-making beyond the authority of the Reviewer and the Commission.

I. SUMMARY OF ARGUMENT

First and foremost, the Recommended Decision fails to fulfill the most essential statutory objective of this Commission: to determine whether or not there is an "unmet need" for the proposal as required by COMAR 10.24.01.08G(3)(b). Establishing that there exists an "unmet need" is an absolute prerequisite to approving a new health care service. By failing to apply this

[1] Hereafter, the term "Applicants" shall refer to both AAMC and Baltimore Washington Medical Center ("BWMC").

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most essential general review criterion in this case, the Recommended Decision reaches the wrong conclusion on the AAMC application.

Next, the Recommended Decision fails to conform to the requirements of the SHP. First, the Recommended Decision confuses the general need requirement with an assessment of whether the Applicant can achieve the SHP's "minimum volume" standard of 200 cardiac surgeries per year. Whether in fact existing providers currently or could fulfill unmet need is not considered in this Recommended Decision. Absent such an analysis, one cannot reasonably conclude that there is unmet need, that approving AAMC's proposal constitutes "the least costly alternative," or that it will have a benign "impact on existing providers." The Recommended Decision also ignores the SHP's explicit statement that there are no "geographic access" barriers to cardiac surgery services in Maryland. It also erroneously discounts any potential negative impact the AAMC project would have on the nascent Prince George's Hospital Center ("PGHC") cardiac surgery program and makes unsupported determinations sans public comment that "the entirety of [the financial feasibility standard] . . . permit[s] flexibility in its assessment of financial feasibility at the hospital level" rather than at the program level. *Id*. at 123.

Finally, the Recommended Decision also improperly relies on unpublished utilization projections and establishes a planning horizon and new review framework for assessing need beyond that authorized in the Maryland Register on February 6, 2015 or by the SHP in COMAR 10.24.17.08. Unless previously published in the Register, the planning horizon cannot be changed. By *sua sponte* extending the planning horizon beyond 2019, the Recommended Decision engages in improper rule-making and violates due process.

Overall, the Recommended Decision adopts an inconsistent and confused view as to the proper role of the Commission in this regulatory process. On the one hand, the Recommended

Decision virtually ignores the question of "need," particularly in light of PGHC's reemerging cardiac surgery service. On the other, the Recommended Decision focuses like a laser on "costs and charges" – as if this were a Health Services Cost Review Commission ("HSCRC") matter. The result of the Recommended Decision is to carve up an ever-shrinking pie constituting current demand for cardiac surgery into even more slices for providers. Unfortunately, the Recommended Decision fails to fulfill the Commission's regulatory purpose of finding "unmet need" and wrongly recommends approval of AAMC's proposal.

II. FAILURE TO CONCLUDE THERE IS AN UNMET NEED.

The Recommended Decision fails to conclude that there is actual unmet need in the Baltimore/Upper Shore planning region population for a new program, as required by COMAR 10.24.01.08G(3)(b). Rather, the Recommended Decision focuses on the notion that AAMC has the "highest potential" for generating a lower charge cardiac surgery program. Lower perceived charges is simply not an appropriate justification for adding a new cardiac surgery program without first proving need. Moreover, an Applicant's mere "potential" ability to re-direct existing volumes of cardiac surgery services to achieve the SHP's minimum volume requirements cannot alone establish that a population has an unmet need for that service. Therefore, the Recommended Decision fails to fulfill the Commission's primary purpose: to determine whether an unmet need exists for a new service or facility.

A. SHP and Both Applicants Fail to Identify an "Unmet Need" as Required by COMAR 10.24.01.08G(3)(b).

There can be no question that this Commission's primary regulatory purpose is to assess whether or not new facilities or services are "needed."[2] A Recommended Decision that ignores the issue of unmet need is fatally flawed. The general review criteria on "Need" in COMAR 10.24.01.08G(3)(b) apply in all CON reviews of proposed health care projects. Where no SHP need analysis is applicable, the COMAR requirement states:

> "[t]he 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." *Id*. (emphasis added).

The Recommended Decision admits that "[t]he Cardiac Surgery Chapter does not provide any clear indication that Maryland needs additional cardiac surgery programs." *Id.* at 121. MedStar agrees and further contends that the SHP at COMAR 10.24.17.05A does not establish an applicable need analysis that defines how the Applicants can demonstrate unmet need. Rather, the SHP at COMAR 10.24.17.05A(1) and A(6) sets forth two review standards that only address "minimum volume." While COMAR 10.24.17.05A(6) carries the title "Need" , it actually only describes the analysis for Applicants to use to demonstrate that they will be able to generate 200 cardiac surgery cases procedures by the second year of operation to satisfy COMAR 10.24.17.05A. Standard .05A(6) clearly has nothing to do with the needs of the population to be served, it simply describes how the Applicant must justify how it proposes to reach the 200 case minimum. This is not a substitute or clarification of the general need requirement.

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[2] In contrast, the HSCRC is charged with reviewing and approving reasonable hospital rates and publicly disclosing information on the costs and financial performance of Maryland hospitals.

The Recommended Decision incorrectly uses the minimum volume analysis as a substitute for the unmet need demonstration required in the second sentence of COMAR 10.24.01.08G(3)(b). The Recommended Decision completely disregards essential need-related factors such as actual utilization, capacity at existing providers, access barriers, and referral trends that would otherwise require the rejection of a proposed new health care service. As a result, the Recommended Decision fails its first and most crucial objective – to determine whether Maryland, and specifically the Baltimore/Upper Shore planning region, actually needs additional cardiac surgery services.

B. Current Cardiac Surgery Capacity is Adequate to Meet Volumes.

The Recommended Decision notes that "cardiac surgery case volume at Maryland hospitals increased strongly in the 1990s, a 74% increase between 1990 and the peak case volume year of 2000," and thereafter, "[c]ase volumes declined approximately [30% between 2000 and 2011.]" *Id*. at 10 (emphasis added). As shown below in Table 1, current cardiac surgery volume in the Baltimore/Upper Shore planning region is still lower than 2009 levels.

TABLE 1: Cardiac Surgery Cases by Health Planning Region and Hospital, CY 2009–2015

Hospitals	Year						
	2009	2010	2011	2012	2013	2014	2015
Baltimore/Upper Shore Planning Region							
Johns Hopkins Hospital	969	946	969	1,026	1,142	1,182	1,262
St. Joseph Medical Center	717	534	339	285	296	448	454
Sinai Hospital	465	408	296	317	345	382	409
MedStar Union Memorial Hospital	953	677	688	575	588	636	626
University of Maryland Med. Center	733	714	817	851	923	984	1,000
Region Totals	3,837	3,279	3,109	3,054	3,291	3,632	3,751
Washington Metropolitan Planning Region							
Prince George's Hospital Center	27	44	15	18	8	29	105
Suburban Hospital	231	240	205	279	205	244	212
Washington Adventist Hospital	463	370	398	463	374	301	285
MedStar Washington Hospital Center	1,562	1,414	1,399	1,216	1,447	1,694	*
George Washington University Hospital	182	116	122	108	96	193	*
Howard University Hospital	7	10	18	20	16	19	*
Region Totals	2,465	2,184	2,139	2,084	2,130	2,461	*

Eastern Shore Planning Region							
Peninsula Regional Medical Center	437	442	426	378	431	431	433
Western Maryland Planning Region							
Western Maryland Regional Medical Center	250	250	224	215	169	170	174
State Totals							
(excludes D.C. located hospitals)	**5,245**	**4,625**	**4,377**	**4,407**	**4,481**	**4,807**	**4,960**

Source: Maryland Register, Vol. 42, Issue 3, (Feb. 6, 2015) (the "2015 Notice") and Recommended Decision at 12.

In the interim, the Commission approved: (1) the establishment of Suburban Hospital's low-volume cardiac surgery program in 2004, which has been unable to increase its volume above 250 cases per year since inception and (2) the transfer of a reemerging cardiac surgery program to the new Prince George's Regional Medical Center ("PGRMC") facility that will replace the aging PGHC. The approval of yet another low-volume cardiac surgery program cannot be justified based on a small recent uptick in volume that merely backfills previously lost surgery counts in 2010-2011. Given the previous downward trend in adult cardiac surgery cases between 2008 and 2013, the current uptick through 2015 merely demonstrates that volumes are normalizing; since 2009, cardiac surgery trends show no growth, overall.

In conclusion, the Recommended Decision states, "the Cardiac Surgery Chapter does not provide support for the idea that improving access to cardiac surgery is an important need if increasing access will create poorly utilized programs." *Id.* at 121. As noted above, there is no need for additional providers where existing service providers have capacity to take on additional volume and there are no significant access problems. Therefore, the Recommended Decision fails to adequately evaluate how AAMC fulfills the SHP's other need criterion in COMAR 10.24.01.08G(3)(b) to establish unmet needs of the population and justify the approval of its program.

III. CONTRAVENES THE STANDARDS ON IMPACT ON EXISTING PROVIDERS (COMAR 10.24.17.05A(2)) AND ACCESS (COMAR 10.24.17.05A(5)).

The Recommended Decision makes erroneous determinations regarding: (1) the potential impact that a new program would have on existing facilities, specifically PGRMC; and (2) the Applicant's ability to improve geographic access to cardiac surgery services in Maryland, which results in the arbitrary and capricious recommendation that AAMC's proposal be approved.

A. Improperly Ignores the Impact a New Cardiac Program Will Have on PGRMC.

COMAR 10.24.17.05A(2) requires that applicants for new cardiac surgery programs "demonstrate that other providers of cardiac surgery in the . . . adjacent health planning region will not be negatively affected to a degree that will (i) compromise the financial viability of cardiac surgery services at an affected hospital." *Id*. This standard is not conditioned upon the volume existing at the affected hospital, which contradicts the Recommended Decision's statement that "the [impact] standard does not speak to the potential impact that a new program might have on the potential for a low volume program to reach acceptable case volume levels." *Id.* at 44. Indeed, MedStar submits that the financial viability of an existing cardiac program covers these low-volume circumstances, at minimum.

The Recommended Decision ignores the Commission's recent approval of a CON to relocate PGHC, including its revived cardiac surgery program, on October 20, 2016. A new competitor cardiac surgery program only half an hour away at AAMC would threaten PGRMC's continued improvement of its cardiac surgery volume levels, likely crippling the program. This in turn jeopardizes the $400 million-plus state- and county-funded investment in that project.

Despite the Applicant's statements to the contrary, the success of the PGRMC project, once complete, will rely on cardiac surgery patients from much of the same service area as AAMC. Yet the existence of PGRMC was ignored in the Recommended Decision's failure to

apply a full assessment of "need" and in assessing AAMC's market share and minimum utilization projections. *Id.* at 45-46. The Recommended Decision states instead that "AAMC cannot be faulted for not quantifying a case shift from PGHC to AAMC in its CON application, given that PGHC's case volume was so negligible during the time frame in which AAMC was preparing its application." *Id.* at 44. This discounts the negative impact the AAMC proposal will have on an important CON project recently approved by the full Commission and discredits the Commission's explicit decision to approve the PGRMC proposal based on its own merits.

The Recommended Decision quite erroneously states that "the public policy issue presented is one of weighing the benefits of having a viable program at PGHC <u>and</u> additional programs in Maryland." *Id.* at 45. Rather, the Commission must weigh whether a viable cardiac surgery program at PGHC/PGRMC is even possible with the addition of a new program in such close proximity. Therefore, MedStar disagrees with the Recommended Decision's assessment that "a finding of non-compliance with this standard based on the potential impact of either proposed program on PGHC is not warranted" against the Applicant. *Id.* at 44.

B. *Improperly Sacrifices the PGRMC Program's Viability Under COMAR 10.24.17.05A(2)(b)(i).*

By dismissing the concerns related to PGRMC as merely "shelter[ing] existing providers from healthy competition," the Recommended Decision reflects a significant error in the assessment of "need" and the "impact on existing facilities" in this case. *Id.* at 123. Moreover, this statement directly contradicts the recommendation in the decision that the Commission should withhold approval of additional cardiac surgery programs in order to "monitor the impact of any approval in this review on the movement of cardiac surgery volume from a high cost center to a lower cost center" for four years. *Id.* at 124. The recently approved PGRMC proposal presents this same concern.

Like the Applicant's proposal, PGRMC's cardiac surgery program is in fact supported by a major hospital system – it is a partnership of Dimensions Healthcare System with the University of Maryland Medical System and the University of Maryland School of Medicine.[3] It is only logical that the Commission should delay approval of the Applicant's proposal until the PGRMC relocation project is complete and the cardiac surgery program is operational at the new location for a four-year period like that proposed in the Recommended Decision, in order to: (1) avoid reversing its own endorsement of the PGRMC proposal; (2) ensure that the state's and county's investment is fully supported; (3) avoid putting taxpayer funds at unnecessary risk; and (4) to maintain consistent health planning approval policies.

C. Disregards the SHP's Conclusions on Geographic Access to Cardiac Surgery Services Under COMAR 10.24.01.08G(3)(f) or COMAR 10.24.17.05A(5)(a)(i).

Under COMAR 10.24.01.08G(3)(f), an applicant must "provide information and analysis with respect to the . . . impact on geographic and demographic access to services. . . ." *Id.* "An applicant that seeks to justify establishment of cardiac surgery services, in <u>whole or in part, based on inadequate access to cardiac surgery services in a health planning region shall</u> [. . . d]emonstrate that access barriers exist." *Id.* The Applicant has done neither.

As stated in the SHP, there is <u>no</u> "geographic access" problem in the state: "[g]eographic access to cardiac surgery services . . . <u>is not a problem in Maryland</u>, with respect to patient travel time or survival." *Id.* at 11 (emphasis added); Docket No. 34GF at 2, 10-11, 21. The SHP states "the public is best served if a limited number of hospitals provide specialized services to a

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[3] Arelis R. Hernandez, "Hospital fight: Prince George's lawmakers oppose Anne Arundel cardiac center," *The Washington Post*, (Jan. 23, 2017) *available at* https://www.washingtonpost.com/local/md-politics/hospital-fight-prince-georges-lawmakers-oppose-anne-arundel-cardiac-center/2017/01/23/f718063c-e198-11e6-ba11-63c4b4fb5a63_story.html?utm_term=.ef2875a810e8; Dimensions Healthcare System, "Rejuvenated Cardiac Surgery Program Nears Significant Milestone at Prince George's Hospital Center," (Feb. 3, 2016) *available at* https://www.google.com/search?q=prince+george's+cardiac+university+of+maryland&sourceid=ie7&rls=com.microsoft:en-US:IE-Address&ie=&oe=&gws_rd=ssl.

substantial regional population base." *Id.* at 67; Docket No. #34GF at 14-15. The Recommended Decision, however, finds that issues related to "travel distance and travel time or delays" can serve as a "secondary justification for [Applicant's] proposed cardiac surgery program." Recommended Decision at 73.

The Recommended Decision acknowledges that "[w]hile many residents of Anne Arundel and the Eastern Shore counties in the Baltimore/Upper Shore region are required to travel longer to a hospital with cardiac surgery services than most residents of the health planning region, the consequences and costs for most of these cases are not sufficiently burdensome that they require preeminent consideration in a decision to approve this project." *Id.* (emphasis added). Yet, while both the SHP and the Recommended Decision properly conclude that there is no geographic access problem in Maryland, the Recommended Decision then disregards those conclusions when it relies on purported geographic access improvements as a secondary justification for the project. *Id*. Therefore, this conclusion should be rejected, and the Commission should determine that AAMC's proposal is inconsistent with the general CON review criterion at 10.24.01.08G(3)(f) and the SHP standards at COMAR 10.24.17.05A(5) regarding access.

IV. UNSUPPORTED CONCLUSIONS ON COST-EFFECTIVENESS STANDARDS (COMAR 10.24.01.08(3)(c) AND COMAR 10.24.17.05A(5)) AND THE FINANCIAL FEASIBILITY STANDARDS (COMAR 10.24.17.05A(7)).

A. Discounts the Possibility That PGRMC's Growing Cardiac Surgery Program Will Promote the Cost-Effectiveness of Cardiac Surgery Services in Maryland.

The Recommended Decision fails to assess the cost-effectiveness of AAMC's program under the scenario of maintaining the status quo number of cardiac surgery programs. The Commission has the option to deny both cardiac surgery proposals submitted in this review, particularly given the presence of the growing PGRMC cardiac surgery program and public

investment. The Recommended Decision forecloses this option by excusing AAMC from having to account for any impacts to PGRMC, and stating that "each project is likely to create a more cost-effective alternative for the delivery of cardiac surgery in Maryland than is possible under the status quo." *Id.* at 99.

As stated in Section III.B, however, the Commission has not yet had the opportunity to actually evaluate whether this is true with respect to the existing, expanding PGRMC cardiac surgery program. The Recommended Decision ignores the requirement to "compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities" under COMAR 10.24.01.08G3(c). Recommended Decision at 105-109. The focus, however, should have been on whether the Applicants will have lower charges than existing providers for lower intensity cases, rather than on whether the Applicants could best achieve minimum surgery volume as a sufficient measure for basic quality of cost-effectiveness. The evaluation of charges for the same low intensity cases that are planned for AAMC appears nowhere in the analysis of the cost-effectiveness requirement. Because there is no factual support for the conclusion that AAMC will be a more cost-effective alternative than other existing facilities, and particularly PGRMC once it is relocated, the Commission must find that AAMC has failed to meet the cost-effectiveness standard.

B. Financial Feasibility Should Be Determined on a Service Line Basis.

The Recommended Decision determines, without authority in the SHP, "that the Commission would not have adopted a [financial feasibility] standard that required a new [cardiac surgery] service line, on a stand-alone basis, to generate revenue over expenses." *Id.* at 98. MedStar disagrees that "[a]ssessment at the program level . . . is a reasonable and conventional interpretation of the standard's requirements." *Id.* at 97. The SHP is quite clear: "A proposed new or relocated cardiac surgery program shall be financially feasible and shall not

jeopardize the financial viability of the hospital." COMAR 10.24.17.05A(7) (emphasis added). This standard requires that "within three years or less [an applicant shall document that] it will generate excess revenues over total expenses for cardiac surgery." COMAR 10.24.17.05A(7)(b)(iv) (emphasis added). The Commission should find that AAMC has failed to meet this standard and provides an additional reason to reject AAMC's new cardiac surgery service at this time.

V. FAILURE TO FOLLOW THE RULES ESTABLISHED FOR THIS CARDIAC SURGERY SERVICES REVIEW.

The Commission had an extensive process to develop the rules to be used for the assessment of new cardiac surgery services applications in this case. The process culminated with the publication in the Maryland Register of unique and special rules creating a review framework to be applied. The 2015 Notice, published in accordance with COMAR 10.24.17.08F, reflects the ground rules, review framework, the utilization analysis, and planning horizon by which potential parties could determine whether they wanted to file applications for a CON in the upcoming review. The Reviewer has no discretion to change those parameters.

A. The Commission Must Utilize the Planning Horizon, Utilization Projections, and Review Framework Published in the 2015 Notice.

COMAR 10.24.17.08F(1) states clearly that, "[u]tilization projections calculated using the methodology in this [SHP] chapter are to be used by the Commission in evaluating Certificate of Need applications to establish cardiac surgery services." Furthermore, COMAR 10.24.17.08F(4) states that "published utilization projections remain in effect until the Commission publishes updated projections." (emphasis added). *See also* 2015 Notice ("this Notice will apply . . . and remain in effect until [the Commission] publishes updated projections.") (emphasis added).

Specifically, the 2015 Notice establishes a 2019 planning horizon for this review cycle, premised on the Commission's "staff analysis of [HSCRC] discharge abstract data for CY 2008-2013 and District of Columbia discharge abstract data. . . [and] for years 2014 and 2019 . . . population estimates from Nielsen . . . assuming the same rate of change from year-to-year [sic]." *Id.* The 2015 Notice further states that no other approach is to be used unless and until new projections (and presumably a new planning horizon) are published in the Register.

However, the Recommended Decision fails to abide by the parameters and projections set by the 2015 Notice. The Reviewer, *sua sponte*, impermissibly extends the planning horizon beyond 2019 and relies upon data outside of those authorized by the 2015 Notice to inform an "alternative forecast model" to evaluate the applications under the CON review standards. Recommended Decision at 11-13 and 29-34. Given the restrictions imposed by the 2015 Notice, the Reviewer erred by introducing data other than those reflected in the projections in the 2015 Notice in his "alternative" forecast model to predict future utilization, and thus, need.

Having noticed to the public the applicable data/projections in this cardiac surgery review process on February 6, 2015, the Commission cannot in the case of this review change those data/projections without full rule-making. The Commission must therefore reject the approach used in the Recommended Decision.

B. Improper Reliance Upon Utilization Projections, Extended Planning Horizon, Unpublished Data, and New Framework Not Referenced in the 2015 Notice.

As stated previously, the 2015 Notice assumed a future of declining population use for cardiac surgery services based on population and utilization data through 2013, and population projections limited to 2014 through 2019. Recommended Decision at 13. The Recommended Decision does not restrict its analysis in the alternative forecast model to comparing the applicants' projections to the data underlying the 2015 Notice's declining projections.

Recommended Decision at 30-32. Instead, unpublished 2014-2015 data was inserted and applied in the background to the analysis and the Reviewer's alternative forecast model within the analysis and findings. *Id.* at 11-13 and 30-32 (referencing cardiac surgery volumes and population, respectively).

The Recommended Decision further applies the conclusions made regarding these unpublished data in the alternative forecast model to find whether the Applicants met the minimum volume standard at COMAR 10.24.17.05A(1). Recommended Decision at 29-35. The Recommended Decision then concludes that meeting the minimum volume standard is tantamount in proving an unmet need in this case. *Id.* at 105. This shows that the unpublished population and utilization data has a clear and material bearing on the current Recommended Decision, and its use taints that Recommended Decision.

The public was not made aware that these 2014-2015 data would be utilized in this review cycle. Simply allowing the parties to this review to comment on these new data does not cure the deficiencies to broader rule-making procedures and the SHP. Recommended Decision at 5-6 and 11-12. Therefore, the Commission should reject the inclusion of these data that informed the Recommended Decision's findings regarding need and minimum volume.

C. Violations of Due Process.

Furthermore, MedStar notes that some potential applicants likely chose not to participate in this cardiac surgery review cycle based on this declining utilization rate predicted in the 2015 Notice. Noticing only the parties in a contested case does not constitute public notice or proper rule-making, nor may it expand the stated authority of the Commission beyond the bounds it itself established for this review on February 6, 2015, which the Reviewer himself

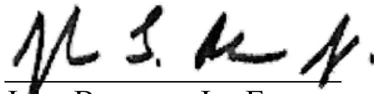
acknowledged.[4] *Id.* at 5-7. Therefore, the continued use of the 2014-2015 data and related projections in this review violates due process.

The Reviewer has exceeded the scope of his authority by failing to heed the express constraints established for this specific review cycle by the Commission, to wit, that the data, projections and methodology published in February 2015 will be used in consideration of the applications filed in this review batch unless and until other data is published. Because this taints the Recommended Decision with due process and procedural deficiencies, the Recommended Decision must be rejected.

VI. REQUESTED ACTIONS

Based on the foregoing, the Commission should reject the Recommended Decision or, in the alternative, delay implementation of AAMC's CON approval to allow PGRMC to complete its relocation and establish its program.

Respectfully submitted,



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[4] MedStar's arguments regarding the use of data from beyond those authorized by the COMAR in this review are not unique. First, BWMC argued that the reliance on the November 9, 2015 edition of the SHP was improper given that the applications in this review were filed while the August 18, 2014 edition of the SHP was in effect. Docket No. #112 GF at 5. Furthermore, BWMC objected to the use of the forecast model as a method to determine minimum volume in this review and to the admission of any data used in the model for such review. Docket No. #106 GF at 1-2 and Docket No. #112 GF at 1-3.

CERTIFICATE OF SERVICE

I hereby certify that on the 10th day of March 2017, a copy of MedStar Health, Inc.'s Exceptions to the Reviewer's Recommended Decision was sent via email and first-class mail to:

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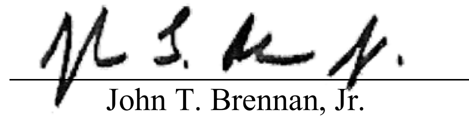

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