

STATE OF MARYLAND

Craig Tanio, M.D.
CHAIR



Ben Steffen
ACTING EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

MEMORANDUM

TO: Commissioners

FROM: Paul E. Parker, Director *pep*
Center for Hospital Services

DATE: July 19, 2012

SUBJECT: Massachusetts Avenue Surgery Center, LLC
Addition of an Operating Room
Docket No. 12-15-2328

Massachusetts Avenue Surgery Center, LLC (“MASC”) is a licensed ambulatory surgery center located in Bethesda, Montgomery County. MASC requests CON approval to add a third operating room through conversion of 435 square feet of “shell space.”

MASC is owned by 25 physicians and their specialties include general surgery, gynecology, orthopedics, pain management, plastic surgery, podiatry, and urology. The Center expects to add three new physicians whose applications for privileges are currently in process and expected to be approved this Summer. MASC operates a non-sterile procedure room in addition to its two operating rooms. The total estimated project cost is \$780,682. The anticipated source of project funding is a mortgage loan of \$730,682 and \$50,000 in cash.

Staff recommends approval of this project.

IN THE MATTER OF
MASSACHUSETTS AVENUE
SURGICAL CENTER, LLC
DOCKET NO. 12-15-2328

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BEFORE THE
MARYLAND HEALTH
CARE COMMISSION

Staff Report and Recommendation

July 19, 2012

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I. INTRODUCTION

Project Description

Massachusetts Avenue Surgery Center, LLC (“MASC” or the “Center”) is a licensed ambulatory surgery center located at 6400 Goldsboro Road, Suite 400, Bethesda, Montgomery County, Maryland. Established in 2004 through a Certificate of Need (“CON”) exemption, with one operating room and two procedure rooms, MASC received a CON in 2006 to convert one of the procedure rooms into a second operating room and is now requesting the addition of a third operating room through conversion of 435 square feet of “shell space.” Appendix 1 shows the facility with the project area designated as one of the three storage areas, immediately adjacent to an existing OR and across the hall from sterile processing. (DI#4, Exhibit 1).

MASC is owned by 25 physicians, one of whom is a part owner in Fairfax Surgery Center and three others have small equity positions at various other surgery centers based in Virginia. Currently, 48 physicians either have or had privileges during the past 12 months or are just joining MASC. These surgeons’ specialties include: general surgery, gynecology, orthopedics, pain management, plastic surgery, podiatry, and urology. The Center expects to add three new physicians whose applications for privileges are currently in process and expected to be approved this summer.

MASC leases the surgery center for \$29.83 per square foot. Its current lease expires on February 28, 2025 with an option to renew for an additional ten years. MASC’s capacity before and after the project is summarized in Table 1 below. The project is expected to take 12 months to complete.

**Table 1: Existing and Proposed Capacity
at Massachusetts Avenue Surgery Center**

Room Type	Current Capacity	Proposed Capacity
Operating Room	2	3
Procedure Room	1	1

Source: MASC’s application, DI#4, page 3.

The total estimated capital cost of the project is \$710,682, with almost \$565,000 being for major and minor movable equipment. Loan placement fees of \$5,000 and consulting and legal fees of \$65,000 increase the total project cost to \$780,682. No new lease costs are projected. The source of project funding is \$730,682 in a mortgage and \$50,000 in cash. (DI#13, Exhibit 2). BB&T Bank is the source for MASC’s mortgage.

Summary of Recommended Decision

Commission staff has evaluated the proposed project’s compliance with the Certificate of Need CON review criteria at COMAR 10.24.01.08G(3)(a)-(f) and the applicable standards in COMAR 10.24.11, the State Health Plan (“SHP”) chapter for Ambulatory Surgical Services. Commission staff has concluded, based on this review, that the project is compliant with the applicable SHP standards, that the applicant has documented a need for the project, and the project should not have a significant negative impact on existing surgical facilities. Commission

staff recommends approval of the project. A summary of the Commission staff's analysis is provided below.

Projected Utilization

- Community support and recent growth in surgical case volume for the operating rooms at MASC, driven by growth in physicians' practices and the acceptance of additional insurance carriers, suggests that MASC will be able to operate its proposed operating room capacity at an optimal level of utilization, as defined in the SHP, within two years of opening a third operating room.

Impact on Existing Programs

- The impact of the proposed new facility on existing surgical facilities in Montgomery County is likely to be minimal because the facility's primary service area will not change, and the cases expected to be transferred from other facilities represent only a very small proportion of the case volume for those facilities.

Availability of More Cost-Effective Alternatives

- Commission staff evaluated the cost-effectiveness of the alternatives proposed by the applicant, acquiring either a freestanding ambulatory surgery center with one operating room or a low-volume facility with multiple operating rooms. This analysis suggests that building a third operating room at MASC is more cost-effective. Both alternatives would add to the cost of the proposed project because the cost of acquiring another facility would not offset the construction costs for the proposed project.

Viability of the Proposal

- MASC has demonstrated that its charges for the most frequently performed procedures are in line with the charges for facilities that frequently perform similar surgical procedures. MASC has operated profitably for the past two years. In addition, MASC has demonstrated the financial feasibility of the proposed project.

II. PROCEDURAL HISTORY

Review of the Record

Massachusetts Avenue Surgery Center, LLC filed a letter of intent for this project on October 7, 2011; staff acknowledged receipt of the letter of intent on October 12, 2011 (Docket Item ["D.I."] #1).

On October 27, 2011, a Request for Determination of Non-Coverage was filed by John J. Eller, Esq. on behalf of Massachusetts Avenue Surgery Center, LLC regarding the leasing of and the capital costs of renovating adjacent space to expand the operations of the existing surgery center (D.I. #2).

On January 20, 2012, staff filed a memo for the record that clarifies Massachusetts Avenue Surgery Center is an existing ambulatory surgery center that did not have to file a certificate of need application in accordance with the MHCC's review schedule for new ambulatory surgery projects, and had 180 days from the filing date of the letter of intent to submit the CON application (D.I. #3).

On January 20, 2012, John J. Eller, Esq., filed a CON application on behalf of Massachusetts Avenue Surgery Center, LLC (D.I. #2) and assigned Matter No. 12-15-2328.

On January 18, 2012, the accounting firm of Snyder Cohn submitted a letter on behalf of Massachusetts Avenue Surgery Center confirming the availability of financial resources for the proposed CON application (D.I. #5).

On January 26, 2012, staff acknowledged receipt of the CON application. (D.I. # 6). On that same day, staff requested that the *Washington Examiner* and the *Maryland Register* publish notice of receipt of the application. (D.I. #s 7-8).

On February 2, 2012, the *Washington Examiner* sent confirmation regarding publication of the notice of receipt for the application on February 6, 2012. On February 27, 2012, the *Washington Examiner* submitted proof of publication regarding receipt of the application (D.I. # 9).

On February 7, 2012, staff asked completeness questions (D.I. # 10).

On February 22, 2012, staff received an email from John J. Eller, Esq. in response to a question regarding patient utilization at the surgery center (D.I. # 11).

On February 14, 2012, the applicant requested an extension to respond to the completeness questions until March 16, 2012. On February 24, 2012, staff granted the extension of time to respond to completeness questions to March 16, 2012 (D.I. # 12).

On March 16, 2012, the applicant submitted responses to MHCC completeness questions from February 7, 2012 (D.I. # 13).

On April 23, 2012, staff requested the *Maryland Register* publish notice of the docketing of the application. (D.I. #14)

On May 2, 2012, staff sent a letter informing the applicant that the CON application would be docketed for formal review on May 4, 2012 and a request for additional financial information (D.I. # 15).

On May 3, 2012, staff requested that the *Washington Examiner* publish notice of docketing of the application (D.I. # 16).

On May 3, 2012, staff submitted a request for review and comment, along with a copy of the application, to the Montgomery County Health Department (D.I. #17).

On May 8, 2012, the *Washington Examiner* submitted confirmation regarding the publication of the notice of docketing on May 10, 2012 (D.I. #18)

On May 11, 2012, the Montgomery County Health Officer submitted a fax response indicating no comment to the MHCC's request on May 3, 2012 for review and comment on the application (D.I. # 19).

On May 14, 2012, John J. Eller, Esq. submitted the response to the May 2, 2012 request for additional financial information (D.I. #20).

On May 24, 2012, the *Washington Examiner* submitted proof of publication regarding notice of docketing on notice of docketing of the CON application (D.I. #21).

Local Government Review and Comment

The Montgomery County Health Department did not provide comments on the application.

Community Support

Twenty five letters of support were received from the following physicians who perform surgery at MASC:

John Losee, MD; Urologic Surgeons of Washington
Peter E. Lavine, MD; Orthopedic Surgery and Sports Medicine
James Francis Barter, MD
Lee E. Firestone, DPM; DC Foot and Ankle
Jason E. Engel, MD; Urologic Surgeons of Washington
Marc B. Danziger, MD; Office of Orthopaedic Medicine and Surgery, PC
Murray Lieberman, MD; Urological Consultants, PA
Mark Rosenblum, MD; Urological Consultants, PA
Pamela Coleman, MD; Assistant Professor of Urology, Howard University Hospital
Paul Shin, MD; Urologic Surgeons of Washington
Edward Dunne, Jr., MD; Foxhall Urology
Joseph Shrout, MD; Metro Orthopedics & Sports Therapy
Lewis R. Townsend, MD; Capital Women's Care
James Gilbert, MD; Metro Orthopedics & Sports Therapy
Mark Scheer, MD; Office of Orthopaedic Medicine and Surgery, PC
Louis Levitt, MD; Office of Orthopaedic Medicine and Surgery, PC
Derek Ochiai, MD; Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction
Bartholomew Radolinski, MD; Urological Consultants, PA
Matthew Buchanan, MD; The Orthopaedic Foot & Ankle Center

Steven K. Neufeld, MD; The Orthopaedic Foot & Ankle Center
Eric Guidi, MD; Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction
James M. Weiss, MD; Specialist in the Practice of Orthopaedic Surgery
Juan Litvak, MD; Urological Consultants, PA
Nizamuddin Maruf, MD; Urological Consultants, PA
Andrew Wolff, MD; Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction

IV. COMMISSION REVIEW AND ANALYSIS

The Commission reviews projects proposed for CON authorization under six criteria outlined at COMAR 10.24.01.08G (3):

- Consideration of the relevant standards, policies, and criteria of the State Health Plan;
- Consideration of the applicable need analysis of the State Health Plan or the applicant's demonstration of an unmet need of the population to be served and the project's capability and capacity to meet that need;
- Comparison of the cost effectiveness of providing proposed services through the proposed project with the cost effectiveness of providing the service at alternative existing facilities or alternative facilities submitting a competitive application for comparative review;
- Consideration of the availability of financial and nonfinancial resources, including community support, necessary to implement the project on a timely basis and the availability of resources necessary to sustain the project;
- Consideration of the compliance of the applicant in all conditions applied to previous CONs and compliance with all commitments made that earned preference in obtaining CONs; and
- Consideration of the impact of the proposed project on existing health care providers in the proposed project's service area, including the impact on access to services, occupancy, and costs and charges of other providers.

A. The State Health Plan

The relevant State Health Plan chapter is COMAR 10.24.11, Ambulatory Surgical Services.

COMAR 10.24.11.06 A. System Standards: All hospital-based ASFs and all freestanding ambulatory surgical facilities (FASFs) including HMOs sponsoring an FASF, shall meet the following standards, as applicable.

(1) Information Regarding Charges

Each hospital-based ASF and each FASF shall provide to the public, upon inquiry, information concerning charges for and the range and types of services provided.

The applicant states that it “provides to the public, upon inquiry, information concerning charges and the range and types of services provided.” MASC provided a copy of its Facility Fee Statement. (DI#4, Exhibit 2). MASC complies with this standard.

(2) Charity Care Policy

(a) Each hospital-based ASF and FASF shall develop a written policy for the provision of complete and partial charity care for indigent patients to promote access to all services regardless of an individual's ability to pay.

(b) Public notice and information regarding a hospital or a freestanding facility's charity care policy shall include, at a minimum, the following:

(i) Annual notice by a method of dissemination appropriate to the facility's patient population (for example, radio, television, newspaper);

(ii) Posted notices in the admission, business office, and patient waiting areas within the hospital or the freestanding facility; and

(c) Within two business days following a patient's request for charity care services, application for Medicaid, or both, the facility must make a determination of probable eligibility.

MASC provided a copy of its charity care policy and a copy of a public notice regarding the availability of financial assistance. (DI#4, Exhibit 3). The applicant stated that this notice is run annually in the *Washington Post*. MASC also stated that it “posts notices in the admission, business office, and patient waiting areas.” In addition, its policy states that a determination of probable eligibility is made within two business days. MASC is consistent with this standard.

(3) Compliance with Health and Safety Regulations

Unless exempted by an appropriate waiver, each hospital-based ASF and FASF shall be able to demonstrate, upon request by the Commission, compliance with all mandated federal, State, and local health and safety regulations.

The applicant provided a copy of its Maryland Department of Health and Mental Hygiene's letter licensing MASC as a freestanding ambulatory surgery center and stated that it is “in compliance with all mandated federal, State and local health and safety regulations.” (DI#4, Exhibit 4). MASC is consistent with this standard.

(4) Licensure, Certification and Accreditation

(a) Existing FASFs and HMOs that sponsor FASFs shall obtain state licensure from the Maryland Department of Health and Mental Hygiene, certification from the Health Care Financing Administration as a provider in the Medicare program, and from the Maryland Department of Health and Mental Hygiene as a provider in the Medicaid program.

(b) Except as provided in (c), existing FASFs and HMOs that sponsor FASFs shall obtain accreditation from either the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC).

(c) If another accrediting body exists with goals similar to JCAHO and AAAHC, and is acceptable to this Commission, accreditation by this organization may be substituted.

MASC is licensed by the Maryland Department of Health and Mental Hygiene and certified as a provider in the Maryland Medicaid program. It is also certified by the Health Care Financing Administration (CMS) as a provider in the Medicaid program and has received documented accreditation by the Accreditation Association for Ambulatory Health Care, Inc. ("AAAHC") until February 22, 2014. (DI#4, Exhibit 5). MASC complies with this standard.

(5) Transfer and Referral Agreements

(a) Each hospital-based ASF shall have written transfer and referral agreements with:

- (i) Facilities capable of managing cases which exceed its own capabilities; and***
- (ii) Facilities that provide inpatient, outpatient, home health, aftercare, follow-up, and other alternative treatment programs appropriate to the types of services the hospital offers.***

(b) Written transfer agreements between hospitals shall meet the requirements of the Department of Health and Mental Hygiene regulations implementing Health-General Article, §19-308.2, Annotated Code of Maryland.

(c) Each FASF shall have written transfer and referral agreements with one or more nearby acute general hospitals.

(d) For both hospital-based ASFs and FASFs, written transfer agreements shall include, at a minimum, the following:

- (i) A mechanism for notifying the receiving facility of the patient's health status and services needed by the patient prior to transfer;***
- (ii) That the transferring facility will provide appropriate life-support measures, including personnel and equipment, to stabilize the patient before transfer and to sustain the patient during transfer;***
- (iii) That the transferring facility will provide all necessary patient records to the receiving facility to ensure continuity of care for the patient; and***
- (iv) A mechanism for the receiving facility to confirm that the patient meets its admission criteria relating to appropriate bed, physician, and other services necessary to treat the patient.***

(e) If an FASF applying for a Certificate of Need has met all standards in this section except (c)-(d) of this standard, the Commission may grant a waiver upon:

- (i) Demonstration that a good-faith effort has been made to obtain such an agreement; and***
- (ii) Documentation to the Commission of the facility's plan regarding transfer of patients.***

(f) An FASF shall establish and maintain a written transportation agreement with an ambulance service to provide emergency transportation services.

MASC provided a copy of a signed transfer agreement with Sibley Hospital. (DI#4, Exhibit 6). The applicant indicates that ambulance service is provided by the local Emergency Medical System by calling 911. MASC is compliant with this standard.

(6) Utilization Review and Control Program

Each hospital and FASF shall participate in or have utilization review and control programs and treatment protocols, including a written agreement with the Peer Review Organization contracting with the Health Care Financing Administration, or other private review organizations.

MASC states that it has utilization review and control programs and treatment protocols, as well as a "Performance Improvement Plan." (DI#4, Exhibit 7). The applicant did not include a written agreement with a Peer Review Organization or other private review organization. Such an agreement is no longer required by Delmarva, the Medicare Quality Improvement Organization for the District of Columbia and Maryland. MASC is consistent with this standard.

2. COMAR 10.24.11.06 B. Certificate of Need Standards. An applicant proposing to establish or expand a hospital-based ASF or an FASF, including an HMO sponsoring and FASF, shall demonstrate compliance with the following standards, as appropriate:

(1) Compliance with System Standards

(a) Each applicant shall submit, as part of its application, written documentation of proposed compliance with all applicable standards in section A of this regulation.

(b) Each applicant proposing to expand its existing program shall document ongoing compliance with all applicable standards in section A of this regulation, including meeting standard A(4) within 18 months of first opening.

The applicant complies with all system standards and is, therefore, consistent with this standard.

(2) Service Area

Each applicant shall identify its proposed service area, consistent with its proposed location.

The primary service area, which is defined as the most frequent zip codes where patients reside, covering 60% of patients served, spans a large geographic area of 42 zip code areas. It includes portions of Montgomery County, Washington, D.C., Northern Virginia, and Prince George's County, as shown in Exhibit 1. (DI#4, page 29). None of the aforementioned areas represents more than a quarter of the utilization at MASC.

Exhibit 1: Map of the Primary Service Area of MASC (Shaded Area)



Source: DI#4, page 6.

The applicant states that the primary service area for the expanded MASC will remain the same. (DI#4, page 18). The applicant notes that its expansive service area reflects the locations of the physicians practicing at MASC. The largest number of patients currently come from Washington, D.C. (465) with Montgomery County being a close second (445), as shown in Table 2. These two areas represent slightly less than half of MASC’s patients.

Table 2: MASC Patient Origin, CY2010

Patient Residence	Number of Cases	Percent of Total
District of Columbia	465	23.5%
Montgomery County	445	22.5%
Prince George’s County	29	1.5%
Virginia	50	2.5%
All Others	990	50.0%
Total	1,979	100%

Source: MHCC Freestanding Ambulatory Surgery Survey, 2010

(3) Charges

Each applicant shall submit a proposed schedule of charges for a representative list of procedures and document that these charges are reasonable in relation to charges for similar procedures by other freestanding and hospital providers of ambulatory surgery in its jurisdiction.

In response to this standard, the applicant provided a proposed schedule of charges and its average revenue collections for the 25 most frequent procedures performed at MASC for the period from November 2010 to October 2011. (DI#4, page 20). Often, the average revenue collection was a quarter to a third of the average charge, or even less. The applicant explained that “the Gross Charge is not meaningful as payors will continue to reimburse at the lesser of billed charges or reasonable and customary rates.” MASC also provided comparative gross charge information for two ambulatory surgical facilities in Montgomery County for some of the 25 most frequent procedures performed at MASC. (DI#4, pages 21-22).

In order to assess the reasonableness of charges for MASC further, Commission staff compared MASC’s average charge per case with other facilities that appeared to have a similar case-mix, based on the specialties reported on the Maryland Health Care Commission’s Survey of Freestanding Ambulatory Surgical Facilities for 2011. This analysis is shown in Table 3. Commission staff also compared the average charge per case to those for outpatient surgeries at hospitals in Montgomery County, as shown in Table 3.

Although there are not any directly comparable data for MASC and a similar ASC within Montgomery County, the available comparative information suggests that the charges for a representative list of procedures is reasonable in relation to other freestanding facilities with a similar case-mix. The project is consistent with this standard.

Table 3
Charge and Revenue Comparisons, Proposed Facility and Selected Hospitals,
CY 2009 and 2010, and Montgomery County FASFs, CY 2010

Hospital Charges from the HSCRC Ambulatory Surgery Data Set, 2009 and 2010		
Facility	Average Outpatient Surgery Charge/Case CY 2009	Average Outpatient Surgery Charge/Case CY 2010
Holy Cross	\$3,401	\$3,441
MedStar Montgomery General	\$3,345	\$3,808
Shady Grove Adventist	\$3,426	\$3,232
Suburban	\$3,557	\$4,179
Washington Adventist	\$4,466	\$3,831
Average Montgomery County	\$3,639	\$3,698
All Maryland hospitals	\$2,716	\$2,834
Montgomery County freestanding ambulatory surgical facilities reporting 6 or more specialties from MHCC FASF Survey, 2005		
Average Billed Charges per Case, CY 2010		
Facility A		\$8,702
Facility B		\$7,179
Facility C		\$5,344
Facility D		\$1,906
Facility E		\$4,449
Facility F		\$2103
Average of 6 reporting facilities		\$4,956
Average Net Revenue per Case, CY 2010		
Facility A		\$2,016
Facility B		\$1,779
Facility C		\$1,143
Facility D		\$1,011
Facility E		\$2,014
Facility F		\$1,474
Average of 6 reporting facilities		\$1,573

Source: MHCC, Annual FASF Survey CY2010, and HSCRC, Hospital Ambulatory Surgery Data Base
Hospital Charges are from the HSCRC Ambulatory Outpatient Data Set, 2009 and 2010,

(4) Minimum Utilization for the Expansion of Existing Facilities

Each applicant proposing to expand its existing program shall document that its operating rooms have been, for the last 12 months, operating at the optimal capacity stipulated in Regulation .05A(3) of this Chapter, and that its current surgical capacity cannot adequately accommodate the existing or projected volume of ambulatory surgery.

Based on 2011 utilization data reported to MHCC and detailed in this report, MASC's two operating rooms are currently utilized at 98% of capacity, based on a 40 hour work week per operating room and the applicant's estimated 30 minutes per case clean up time. MASC is consistent with this standard.

Table 4: Operating Room Cases and Utilization Measures, CY2011

Number of Cases	2,161
Surgical Hours	2,392
Surgical Minutes	143,520
Clean Up Minutes	64,830
Total Minutes Utilized	208,350
Full Capacity Operating Room Standard (2 ORs)	244,800
Percent Utilization	98.0%

Source: DI#4, page 35; MHCC Ambulatory Surgery Survey Data 2011

(5) Support Services.

Each applicant shall agree to provide, either directly or through contractual agreements, laboratory, radiology, and pathology services.

MASC states that it uses the services of Landauer for Radiation Dosimetry services, Labcorp for laboratory services, and Dianon for pathology services. MASC reports that it provides its own radiology services. (DI#4, page 25).

(6) Certification and Accreditation

Except as provided in (c), each new FASF applicant or HMO that sponsors a new FASF shall agree to seek and to obtain, within 18 months of first opening, licensure, certification and accreditation from the following organizations:

(a) The Maryland Department of Health and Mental Hygiene for state licensure, the Health Care Financing Administration for certification as a provider in the Medicare program, and the Maryland Department of Health and Mental Hygiene for certification in the Medicaid program; and

(b) Accreditation from either the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care.

If an applicant can demonstrate that an alternative accrediting body exists with goals similar to JCAHO and AAAHC, and is otherwise acceptable to the Commission, accreditation by this organization may be substituted

The applicant is appropriately licensed, accredited, and certified. (DI#4, pages 25-26). MASC complies with this standard.

(7) Minimum Utilization for New Facilities

Each FASF applicant shall demonstrate, on the basis of the documented caseload of the surgeons expected to have privileges at the proposed facility, that, by the end of the second full year of operation, the facility can draw sufficient patients to utilize the optimal capacity of the proposed number of operating rooms, measured according to Regulation .05A of this Chapter.

This standard is not applicable. MASC is an existing facility.

(8) Reconfiguration of Hospital Space

Each hospital applicant proposing to develop or expand its ASF within its current hospital structure shall document plans for the reconfiguration of hospital space for recovery beds, preparation rooms, and waiting areas for persons accompanying patients.

The proposed project is a freestanding ambulatory surgical facility. This standard is not applicable.

B. Need

COMAR 10.24.01.08G(3)(b) requires that the Commission 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.

Applicant Response

MASC projects a need for operating room capacity at its facility based on three factors: population growth, growth in the physicians' practices that utilize MASC, and acceptance of more insurance carriers. MASC also explains that physicians want to put their patients on the surgery schedule as soon as possible and will seek operating room time at another facility if their requests for posting times cannot be met. According to MASC, the Center has increasingly been unable to meet physicians' requests for posting time. Furthermore, the applicant states that patients experiencing higher deductibles and co-insurances are looking for "a less costly option than utilizing a hospital for their outpatient surgery" as well as trying to avoid exposure to a sicker patient population and "increased hospital infection rates." (DI#4, pages 27-28).

With regard to population growth, MASC presents data for those ages 15 and older residing in the zip code areas comprising its service area. (DI#4, pages 29-30). The data shows overall estimated population growth of 12% from 2010 to 2011 and projected growth of 3.3% from 2011 to 2016. However, MASC notes that its case volume is primarily driven by factors other than population growth. (DI#4, page 29).

MASC states that it has experienced case volume growth since opening in 2005, as shown in Table 5. MASC attributes the case volume growth to population growth, growth in physicians' practices, and acceptance of more insurance plans. (DI#4, page 27).

Table 5: MASC OR Cases, CY2005-11

Year	Cases
2005	844
2006	975
2007	1,396
2008	1,523
2009	1,495
2010	1,529
2011	2,161

Source: DI#4, page 27.

For 2012, MASC projects an increase of 618 operating room cases compared to the number of cases performed in 2011 (2,079 cases). MASC justifies the anticipated growth case volume by showing the number of cases performed by 34 physicians with privileges at MASC in the last 12 months, as well as their projected new cases for the coming year and case volume expected to be transferred from other locations. (DI#4, pages 31-32). These projections show a total of 2,907 cases are expected to be performed at MASC by these physicians, with approximately half of the increase stemming from new cases and half stemming from cases transferred from other facilities. (DI#4, page 32).

MASC states that the projected case volumes of 2,779 cases in 2012 and 2,797 cases in 2013 exceed the SHP optimal utilization standard of 1,152 cases per operating room. MASC also notes that the average time per operating room case at MASC of 65.3 minutes is comparable to the average time per case of multi-specialty ambulatory surgery centers in Montgomery County that it calculated from the Maryland Health Care Commission's public use data set of ambulatory surgery centers for 2009 (1.08 hours). (DI#4, pages 32-35).

MASC concludes that three operating rooms are needed in 2012 based on its current average case time of 65.3 minutes, assumed turnaround time of 30 minutes, a projected case volume of 2,779 cases, and the optimal capacity standard for dedicated outpatient operating rooms (97,920 minutes) in the SHP. These assumptions and the calculated need for three operating rooms are shown in Table 6 below.

Table 6: Projected Operating Room Cases, Surgical Time, and Capacity Utilization, CY2012

Surgical Minutes per Case	65.3
Clean-up Minutes per Case	30
Total Time per Case	95.3
Number of Cases	2,779
Total Minutes	264,838.7
Optimal Capacity per Operating Room (minutes)	97,920
Number of ORs Needed at Optimal Capacity	2.7

Source: DI#4, page 35

Staff Analysis

In order to evaluate the need for a third operating room at MASC, Commission staff examined each of the factors cited by MASC to justify the need for a third operating room. These factors were population growth in the primary service area of MASC, growth in physicians' practices, and acceptance of more insurance carriers. Of the three factors cited by MASC to justify a third operating room, population growth appears to have the least influence. In contrast, it appears that growth in physicians' practices and acceptance of more insurance carriers are regarded as the primary drivers of growth.

With regard to population growth, as shown below in Table 7, the areas in which almost half of MASC's patients reside (District of Columbia and Montgomery County) are growing more than twice as fast as the State of Maryland and the nation's population. In addition, approximately three-quarters of MASC's patients are adults between the ages of 18-64 years, and

the District of Columbia's representation of this age group is significantly higher than other jurisdictions. Although strong population growth in MASC's primary service area is a reasonable basis for some growth in case volume, the case volume increase projected by MASC far exceeds the approximate 2% growth expected for its service area. As noted previously, appropriately, MASC did not state that its projected surgical case volume is based primarily on population growth.

Table 7: Current and Projected Population for Select Jurisdictions, 2010 and 2011

Jurisdiction	2010 Population	2011 Population Estimate	% Change 2010-11	% Pop 18-64 Years (2011)
District of Columbia	601,723	617,996	2.7%	71.6%
Montgomery Co.	971,777	989,794	1.9%	63.7%
Maryland	5,773,552	5,828,289	0.9%	64.4%
United States	308,745,538	311,591,917	0.9%	63.0%

Source: US Census Bureau QuickFacts

In large measure, MASC relies on the significant jump in operating room utilization from 2010 to 2011 to justify the need for a third operating room. As shown in Table 8, the number of operating room cases increased from 1,529 cases in 2010 to 2,161 cases in 2011. MASC primarily attributes the large increase in operating room case volume to physician referrals and becoming "in network" with CareFirst early in 2011. To the extent that MASC's surgical case volume growth is driven by accepting additional insurance carriers, MASC may be expected to again dramatically increase its surgical case volume in 2012 and 2013 because MASC expects to become "in network" with two additional insurers, United and Cigna, in 2012.

Table 8: MASC Surgical Utilization, CY2009-2011

Year	Total Cases	OR Cases	OR Hours	OR Hours /Case	PR Cases	PR Hrs	PR Hours/ Case
2009	2,160	1,495	1,594	1.07	665	233	0.35
2010	1,979	1,529	1,775	1.16	450	127	0.28
2011	2,671	2,161	2,392	1.11	510	178	0.35
Percent Change	23.7%	44.5%	50.1%	3.8%	-23.3%	-23.6%	-0.4%

Source: MHCC Freestanding Ambulatory Surgery Survey, 2009-11

In addition to MASC becoming "in network" with more insurance carriers, MASC attributes its projected surgical case volume growth to physicians' referral practices. MASC presents historical and projected case volume data for 34 individual physicians with privileges at MASC to justify the need for a third operating room. These projections show a total of 2,907 cases committed to MASC by these physicians, with approximately half of the increase stemming from new cases and half stemming from cases transferred from other facilities. (DI#4, pages 31-32). In addition, MASC submitted letters of support from physicians practicing at MASC attesting to the number of surgeries that they had performed at MASC and other surgical facilities and making projections of their future case volume and utilization of MASC's operating rooms. (DI#4, Exhibit 9). The letters are compelling evidence of MASC's ability to realize its future projections for surgical case volume.

Although MASC anticipates large increases in surgical case volume, it does not expect the average case times to change in its projections for 2012 and 2013. As shown in Table 8, the time per operating room case did not appear to change significantly between 2009 and 2011. The average operating room time of 1.11 hours in 2011 is slightly higher than for 2009 (1.07 hours), but less than the average time in 2010 (1.16 hours). The historic average cases times are consistent with the surgical case time used by MASC for its projections of future utilization of its operating rooms. In addition, MASC examined the surgical case times for other Maryland FASFs that had a comparable case-mix to MASC. As shown in Table 9, more than 50% of MASC's cases are orthopedic, so it analyzed the average operating room time for Maryland FASFs with at least one OR and a mix of between 30% and 70% orthopedic specialty cases. This analysis of FY2010 utilization shows an average case time of 1.11 hours per case. This analysis resulted in exactly the same average operating room case time as MASC used in the development of its projections. Therefore, Commission staff concludes that the projected time per case is reasonable.

Table 9: MASC Cases by Specialty, CY2010

Specialty	Number of Cases	Percent of Cases
OB/GYN	172	8.7%
Orthopedics	1,042	52.7%
Pain Management	360	18.2%
Plastic Surgery	1	0.1%
Podiatry	93	4.7%
Urology	311	15.7%
Total	1,979	100.0%

Source: MHCC Freestanding Ambulatory Surgery Survey 2010.

As shown in Table 10, MASC projects 2,779 cases in 2012. This would be an increase of 618 cases compared to 2011 or a case volume increase of 29%. The projected number of additional cases for 2012 is similar to the actual increase in case volume from 2010 to 2011 (632 cases). Although the projected case volume growth for the next two years is very aggressive, the applicant has presented sufficient evidence to justify such increases. The growth projections are supported by the apparent boost in case volume due to accepting additional insurance carriers and physicians' letters of support attesting to their historic case volumes and commitment to use MASC for future surgical cases.

Table 10: MASC Surgical Utilization & Projections, CY2011-2013

Year	Total Cases	OR Cases	OR Hours	PR Cases	PR Hours
2011	2,671	2,161	2,392	510	178
2012 (projected)	3,229	2,779	3,089	450	158
2013 (projected)	3,261	2,797	3,110	463.5	162
% Change 2011-13	22.1%	29.4%	30.0%	-9.1%	-8.9%

Sources: MHCC Freestanding Ambulatory Surgery Survey, 2011; DI#4, page 36.

In evaluating the need for a third operating room at MASC, Commission staff relies on the State standard for optimal capacity of a dedicated outpatient general-purpose operating room, which is 80% of full capacity. The State Plan defines the full capacity of such operating rooms as 2,040 hours, so the optimal capacity standard is 1,632 hours. Commission staff accepts the applicant's projected case volume, clean-up time, and time per case as reasonable. As illustrated below, based on Staff's analysis, the 2012 projections would result in a need for 2.7 operating rooms at optimal capacity. Therefore, the applicant has demonstrated a need for a third operating room at its facility.

Table 11: Projected Operating Room Cases, Surgical Time, and Capacity Utilization, CY2012

Operating Room Cases	2,779
Operating Hours (1.11/case)	3,085
Clean Up Hours (0.5/case)	1,390
Total Hours	4,475
Optimal Capacity in Hours per Operating Room	1,632
Number of ORs Needed at 80% of Capacity	2.7

Source: DI#4, pages 25-36; DI#13, page 7.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3)(c) requires the Commission to compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Applicant Response

MASC outlines three different alternatives to the proposed project. The first alternative would be to purchase a single-OR freestanding ASC and re-locate it to the MASC site. This option was rejected because the proposed project would still require a CON and would cost more than the proposed project due to the added cost of acquisition. The second alternative presented is to purchase a low volume existing facility with multiple operating rooms in MASC's service area, closing it, and re-locating the multi-OR ASC to the MASC site. The applicant notes that this would be higher cost for the same reason as the first alternative.

A third alternative outlined by the applicant is to do nothing. MASC states that it is not cost effective for surgeons to perform surgeries at many sites. MASC cites the burden of travel time on physicians' efficiency and the impact of limited capacity on patient choice and delays in scheduling.

MASC also notes that the project has a cost of \$638,250, with only \$555,750 for capital costs. It also states that the project cost per square foot (\$204.60) is lower than the MVS benchmark for outpatient surgery centers (\$478.88). (DI#4, pages 39-40).

Staff Analysis

Commission Staff notes that it is highly unlikely that many of MASC's physicians are performing the majority of their surgeries at MASC. Only four physicians are performing 100 or more surgeries annually at MASC and only thirteen projected that they will perform 100 or more surgeries in 2012. In fact, given the distance that many patients travel from areas outside of Montgomery County, it may be more convenient for their physicians to practice at multiple locations.

The capital costs associated with this project are minimal because of existing shell space at MASC. As noted by the applicant the cost per square foot of the project is well below the MVS benchmark. In addition, the transfer of cases away from other facilities is expected to have minimal financial impact on those facilities. Therefore, the applicant has demonstrated that the proposed project appears is the most cost effective alternative.

D. Viability of the Proposal

COMAR 10.24.01.08G(3)(d) requires the Commission to consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

MASC states that it does not have audited financial statements but did include its Profit and Loss and Balance Sheets for 2009 and 2010. (DI#4, Exhibit 8). MASC has net income of \$1.88 million in 2009 and \$1.90 million in 2010 on revenue of \$6.04 in 2009 and \$6.45 in 2010. In both years MASC realized significant profit margins. The 2010 Balance Sheet shows assets of \$2.35 million, with \$1.66 million being fixed assets, with \$669 thousand in liabilities and \$1.68 million in equity. In addition, a letter from MASC's Certified Public Accountant states that the cash for the project is on hand and the bank for loan financing and concludes that adequate financial resources for the operating room project. (DI#4, Exhibit 8).

The project will require only a few additional staff including one administrative full-time equivalent employee (FTE), 2.65 FTE clinical staff, and 0.5 FTE support staff. (DI#13, Exhibit 5). Given the current economic environment and the relatively few additional staff required, Commission Staff do not anticipate that the applicant will have difficulty procuring these

resources. Moreover, MASC states that “working in an ASC often affords an opportunity for a surgical nurse who has taken a sabbatical from the field to reenter.” (DI#4, page 59). The applicant notes that the best source for recruitment has been from its physician members, and open positions usually fill within one or two weeks. MASC states that it has a quarterly bonus plan that it offers to key employees and makes “a substantial annual profit sharing contribution to all of the employees that participate in the company’s retirement plan” in which they are vested after five years. Commission staff concludes that MASC has reasonably demonstrated that the project is viable and financially feasible.

E. Compliance with Conditions of Previous Certificates of Need

COMAR 10.24.01.08G(3)(e) requires the Commission to consider the applicant’s performance with respect to all conditions applied to previous Certificates of Need granted to the applicant.

MASC received a condition with the approval of its 2006 CON for its second operating room (Docket No. 06-15-2181) requiring it to obtain accreditation by the JCAHO or the Accreditation Association for Ambulatory Health Care and become a participating Maryland Medicaid provider within 18 months of approval. The applicant provided copies documenting compliance with this standard. (DI#4, Exhibit 5).

Commission Staff concludes that MASC is compliant with this standard. However, Commission Staff notes that while the applicant obtained a Maryland Medicaid provider number as required to meet the condition of its 2006 CON, only \$6,780 of its revenue, or 0.11% of total revenues came from Maryland Medicaid. Medicaid patients comprise only a small proportion of MASC’s patients (0.5%).

F. Impact on Existing Providers

COMAR 10.24.01.08G(3)(f) requires the Commission to consider information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

In responding to this criterion, the applicant states that the project “will not materially affect any other facility.” (DI#4, page 54). The applicant reports that it projects 368 cases will be transferred from other facilities, and no one facility will be significantly adversely affected. The applicant provided, by physician and facility, the projected cases to be transferred. Those facilities most likely to be impacted include Suburban Hospital (172 cases), Surgery Center of Chevy Chase (53 cases), and Washington Adventist Hospital (37 cases). The applicant provided ambulatory surgical case data for hospitals from MHCC’s 2005 Guide to Ambulatory Surgery Facilities which showed Suburban’s outpatient surgical utilization at 9,216 cases and Washington Adventist Hospital’s utilization at 7,213. (In 2010, Suburban Hospital

reported an outpatient caseload of 9,024 cases; Washington Adventist Hospital reported 4,387 in that year.) The applicant shows that the projected transferred cases from The Surgery Center of Chevy Chase represent 1.3% of that facility's 2009 utilization. (This percentage would be very similar, considering 2010 case volumes reported by this facility.) Therefore, the cases to be transferred would have minimal impact on these facilities use.

Commission staff concludes that the proposed project will not have a substantial negative impact on existing health care providers in the service area or on geographic and demographic access to ambulatory surgical services. It is not likely to have a negative impact on costs and charges of other providers of ambulatory surgical services.

**IN THE MATTER OF
MASSACHUSETTS AVENUE
SURGICAL CENTER, LLC
DOCKET NO. 12-15-2328**

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**BEFORE THE
MARYLAND HEALTH
CARE COMMISSION**

FINAL ORDER

Based on the analysis and findings contained in the Staff Report and Recommendation, it is this 19th day of July 19, 2012, by a majority of the Maryland Health Care Commission, **ORDERED:**

That the application for a Certificate of Need to add a third operating room at the Massachusetts Avenue Surgical Center LLC, an existing freestanding ambulatory surgery facility, in leased space at 6400 Goldsboro Road, Suite 400, Bethesda, Maryland, at a cost of \$780,682 is **APPROVED**.

Maryland Health Care Commission

APPENDIX
FLOOR PLAN

