

MARYLAND HEALTH CARE COMMISSION

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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need 

DATE: September 20, 2016

SUBJECT: Green Spring Station Surgery Center
Docket No. 15-03-2369

Enclosed is the staff report and recommendation for a Certificate of Need (“CON”) application filed by Johns Hopkins Surgery Centers Series (“JHSCS”), the ultimate owners of which are The Johns Hopkins University and The Johns Hopkins Health System Corporation, each of which owns a 50% share. JHSCS already operates surgery centers and/or health centers in Odenton and White Marsh.

The proposed project seeks to establish an ambulatory surgical facility (“ASF”) at Green Spring Station in Lutherville (Baltimore County) to be known as Green Spring Station Surgery Center (“GSSSC”). The project would occupy 27,238 square feet of newly constructed medical office building space and will be comprised of five operating rooms and four non-sterile procedure rooms, as well as shelled space for an additional operating room. Other anticipated tenants of this medical office building include a comprehensive radiology practice and a musculoskeletal center, other surgical specialist offices, and gastroenterology and medical oncology practices.

The total estimated project cost is \$16,340,840, funded with \$1,896,000 in cash; \$13,082,940 provided through loan agreements with Johns Hopkins Health System; and \$1,361,900 in “tenant allowances” from the MOB’s landlord, Johns Hopkins Suburban Health Center, LP.

Staff recommends APPROVAL of the project based on its conclusion that the proposed project complies with the applicable standards in COMAR 10.24.11, the State Health Plan for General Surgical Services Commission, and the other applicable CON review criteria at COMAR 10.24.01.08.

**IN THE MATTER OF
GREEN SPRING STATION
SURGERY CENTER
DOCKET NO. 15-03-2369**

*** BEFORE THE
* MARYLAND
* HEALTH CARE
* COMMISSION

STAFF REPORT AND RECOMMENDATION

September 20, 2016

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I. INTRODUCTION

THE APPLICANT

The applicant in this review is Johns Hopkins Surgery Centers Series ("JHSCS"). JHSCS is an independent series of JH Ventures, LLC.¹ The owners of both JHSCS and Johns Hopkins Ventures, LLC are The Johns Hopkins University and The Johns Hopkins Health System Corporation, each of which owns a 50% share of both entities. JHSCS operates surgery centers and/or health centers in Odenton and White Marsh.

THE PROJECT

The proposed project seeks to establish an ambulatory surgical facility ("ASF") at Green Spring Station in Lutherville (Baltimore County) to be known as Green Spring Station Surgery Center ("GSSSC").

Already in place at Green Spring Station is Johns Hopkins at Green Spring Station, a comprehensive outpatient campus where 65 primary care physicians and over 200 specialists handle over 400,000 patient visits annually. Green Spring Station, in addition to these medical office facilities, also includes retail and non-medical office space and is located near the junction of Falls Road, Interstate 83 (the Jones Falls Expressway), and the Baltimore Beltway (Interstate 695). Johns Hopkins Suburban Health Center, LP, an entity that is owned by Johns Hopkins Endowment Fund (80%), the Johns Hopkins Health System Corporation, (19%), and Johns Hopkins Medical Management Corporation (1%), will own the land on which the proposed ASF will be developed and will own and develop Pavilion III of Johns Hopkins at Green Spring Station. The proposed surgical facility will be located in Pavilion III in space leased to JHSCS, with lease approval by Johns Hopkins Ventures, LLC.

The proposed ASF will house five operating rooms and shelved space for an additional operating room ("OR"). The facility is also proposed to operate four non-sterile procedure rooms. It would occupy 27,238 square feet of newly constructed medical office building space, about 25% of the total space planned for Pavilion III. Other anticipated tenants of this medical office building include a comprehensive radiology practice and a musculoskeletal center (orthopedic surgeons and physical medicine and rehabilitation services), other surgical specialist offices, and gastroenterology and medical oncology practices. (DI #4, p. 10)

The applicant states that the expansion of the campus at Green Spring Station will address the following goals: (DI #4, p. 11)

- To provide space for surgical specialties and, in particular, ambulatory surgery.

¹ A series limited liability company, commonly known as a series LLC, is a form of a limited liability company that provides liability protection across multiple "series," each of which is theoretically protected from liabilities arising from the other series. In overall structure, the series LLC has been described as a master LLC that has separate divisions.

- To provide a low cost alternative in North Baltimore to Johns Hopkins East Baltimore services (The Johns Hopkins academic medical center campus and Johns Hopkins Bayview Medical Center are located in eastern Baltimore City).
- To maintain Green Spring's role as an important North Baltimore suburban complement to Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center.
- To allow program consolidation and multi-disciplinary service line development and advance comprehensive programmatic and functional integration of clinical services.
- To provide access and convenience to patients in a "one stop shopping" environment and continue Green Spring's positive patient/family culture and environment.
- To provide Hopkins' quality clinical services in the local North Baltimore community.
- To create improved clinical outcomes and enhance the health of the community by promoting preventive medicine, including community education and wellness programs.

The total estimated project cost is \$16,340,840. JHSCS expects to fund the project with \$1,896,000 in cash; \$13,082,940 provided through loan agreements with Johns Hopkins Health System; and \$1,361,900 in "tenant allowances" with the Pavilion III landlord, Johns Hopkins Suburban Health Center, LP.

STAFF RECOMMENDATION

Staff recommends approval of the project based on its conclusion that the proposed project complies with the applicable standards in COMAR 10.24.11, the General Surgical Services chapter of the State Health Plan and has been shown to be needed, viable, a cost-effective alternative for meeting project objectives, and a project with a positive impact on cost to the health care delivery system, in accordance with the Certificate of Need review criteria at COMAR 10.24.01.08G(3)(b)-(f). Staff concludes that projects authorized for related Johns Hopkins Health entities have an acceptable track record in being implemented consistent with terms and conditions of their approval. Staff also concludes that there will be little impact on other providers outside of the Johns Hopkins Health family of providers and that the project offers a cost effective alternative to the status quo with respect to outpatient surgical services in the Baltimore metropolitan area .

II. PROCEDURAL HISTORY

A. Record of the Review

See Appendix 1, Record of the Review.

B. Interested Parties

There are no interested parties remaining in this review. On February 18, 2016, Commissioner Jeffrey Metz recognized LifeBridge Health, Inc. ("LifeBridge") as an interested party because its hospitals provide the same service as that proposed by the applicant in the same planning region used for purposes of determining need under the State Health Plan. COMAR 10.24.01.08F and COMAR 10.24.01.01B(2) and (20)(e).

On July 26, 2016, LifeBridge withdrew its opposition to, and its comments regarding, the Green Spring Station Surgery Center CON application. (DI #32) Upon LifeBridge's withdrawal as an interested party, the review ceased to be a contested review, and a Commissioner serving as reviewer was no longer required. Accordingly, this became a staff review.

C. Support

Letters of support for the proposed project were received from individuals who wrote on behalf of: constituents residing in the Green Spring area, groups of physicians who practice at the Green Spring Station campus, and local community associations. Those letters are listed below. (DI #4, Exhibit 18)

District 2, Baltimore County Council

- Vicki Almond, Councilwoman, District 2, Baltimore County Council

Medical/Healthcare

- Mary M. Newman, M.D., MACP, President, Park Medical Associates
- Ira T. Fine, M.D., Board of Governors, Green Spring Station
- Stephen Krayet, M.D., FACP, President, Johns Hopkins Community Physicians
- William G. Nelson, M.D., Ph.D., Director, Sidney Kimmel Comprehensive Cancer Center
- Travis Ganunis, M.D., FAAP, President, Pavilion Pediatrics at Green Spring Station, P.A.
- Lisa Ishii, M.D., MHS, Medical Director, White Marsh Surgery Center

Community Associations

- Michael Friedman, Officer and Board Member, The Meadows of Green Spring Homeowners Association
- Thomas P. Finnerty, President, Greater Green Spring Association

Letters were also received from the following physicians who are department heads or members of Johns Hopkins Medicine. (DI #4, Exhibit 15)

- James Ficke, M.D., Director, Department of Orthopaedic Surgery
- David W. Eisele, M.D., F.A.C.S., Director, Department of Otolaryngology
- Alan W. Partin, M.D., Ph.D., Chairman, Department of Urology
- W.P. Andrew Lee, M.D., Director, Department of Plastic and Reconstructive Surgery
- Robert S.D. Higgins, M.D., Director, Department of Surgery
- Zachary L. Chatter, D.P.M., Chief, Division of Podiatry, Good Samaritan Hospital
- Allan J. Belzberg, M.D., George J. Heuer Neurosurgery Professorship
- Andrew J. Satin, M.D., Obstetrician/Gynecologist-in-Chief
- Samal A. Hamod, M.D, M.P.H., P.A., Assistant Professor Gynecologist/Obstetrician

Each of these letters provide the names of colleagues and physicians who have committed to perform outpatient surgical cases at GSSSC and the current and projected volume of outpatient surgical cases that each projects to be performed at GSSSC. (DI #4, Exhibit 15)

D. Local Government Review and Comment

On March 8, 2016, Gregory Wm. Branch, M.D., Director and Health Officer, submitted notification that the Baltimore County Health Department chose not to comment on this proposed project. (DI #26)

III. STAFF REVIEW AND ANALYSIS

The Commission considers CON applications using six criteria found at COMAR 10.24.01.08G(3). The first of these considerations is the relevant State Health Plan standards and policies.

A. The State Health Plan.

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan for Facilities and Services (“SHP”) chapter in this review is COMAR 10.24.11, General Surgical Services.

.05 STANDARDS

A. GENERAL STANDARDS. *The following general standards encompass Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in Health General §19-114(d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application*

(1) Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

JHSCS states that it “will make information regarding charges for the full range of surgical services provided readily available to the public, upon inquiry, or as required by applicable regulations or laws.”² (DI #4, p. 27) The applicant further states that for ASFs, the gross charge structure is not relevant to what patients (including private pay patients) pay. The GSSSC staff will assist the patients in determining their charges and copays for services received.

² Staff explored the performance in this area by the applicant’s affiliates and found that The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Suburban Hospital provide financial information to patients on their websites, which includes surgical charge rates. While Howard County General Hospital’s website provides financial information to patients, the hospital does not provide a list of surgical service charges. The applicant states that the hospital is taking steps to make the information available. (DI #34)

Staff concludes that JHSCS has stated its intent and commitment to provide charge information to the public and has met this standard.

(2) Charity Care Policy.

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.

The applicant states that the policy of Johns Hopkins Medicine is to provide financial assistance based on indigence or high medical expenses for patients who meet specific financial criteria and request such assistance. (DI #4, p. 29) GSSSC will provide medically necessary care, free of charge or at a reduced rate, for patients who meet the Johns Hopkins Surgery Center Series ("JHSCS") Charity Care/Financial Assistance Policy criteria. The applicant submitted a copy of this financial assistance policy with the CON application. (DI #4, Exhibit 7)

The policy states that a notice will be posted at all patient registration sites and in the business office of the facility. Prior to a patient's arrival for surgery, staff shall address any

financial concerns of patients, and individual notice regarding the facility’s Financial Assistance policy shall be provided to the patient. The ASC will provide a determination of probable eligibility within two business days of a patient’s request for charity care services.

The applicant states that the JHSCS Financial Assistance Policy is consistent with the current policy for The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Inc. Acute Care Hospital and Special Programs, and the Chronic Specialty Hospital of the Johns Hopkins Bayview Care Center. Patients who have health coverage and are at or below 200% of Federal Poverty Guidelines can ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care and shall be required to submit a Financial Assistance Application. The JHSCS sliding scale for financial assistance is shown below. (DI #4, p. 30)

Table 1: JHSCS Sliding Fee Scale

Table for Determination of Financial Assistance Allowances	
Effective 1/1/15	
# of Persons in Family	200% FPL
1	\$23,540
2	\$31,860
3	\$40,180
4	\$48,500
5	\$56,820
6	\$65,140
7	\$73,460
8*	\$81,780

*For family units with more than eight (8) members, add \$8,320 for each additional member.

(b) A hospital with a level of charity care . . . that falls within the bottom quartile... shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

This standard would only be applicable to existing hospitals seeking to add OR capacity. It does not apply to this project.

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

JHSCS states that it is committed to providing a level of charitable surgical services that either meets or exceeds the average amount of charity care provided by ASFs in Maryland, which the MHCC reported to be equivalent to 0.46% of total operating expenses in FY 2014. (DI #4, p. 32).

Staff explored the performance in this area by the applicant's affiliates and found that for FY2015, the HSCRC reported that the applicant's hospital affiliates performed as follows in charity care provision: Johns Hopkins Bayview Medical Center and The Johns Hopkins Hospital each provided charity care totaling 9.5% of total operating expense, placing them both within the second quartile of Maryland Hospitals; Suburban Hospital, at 8.1%, and Howard County Hospital (7.8%) placed in the third quartile.

MHCC staff concludes that the applicant has met this standard.

(3) Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs; and

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

Standards .05(A)(3)(a), .05(A)(3)(b) and .05(A)(3)(c) are not applicable to this CON application.

(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical

services, laboratory and radiologic services, medical records, and physical environment.

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility

JHSCS will employ licensed and credentialed health care professionals such as anesthesiologists, surgeons, CRNAs, and RNs, and states that the staff will follow evidence-based practice standards as adopted and used by their respective professional associations. (DI #4, p. 35)

The applicant states that the proposed ASC will be: licensed by the Office of Health Care Quality; certified by the Centers for Medicare and Medicaid Services; and obtain accreditation from The Joint Commission. JHSCS will comply with all mandated federal, state and local health and safety regulations.

Staff finds that the applicant has stated its intent to comply with this standard which is designed to ensure the provision of quality of care driven by appropriate licensure and accreditation. For more on quality, see the applicant's description of "a robust...patient safety and quality infrastructure for ambulatory surgery centers" discussed under the Patient Safety standard later in this section.

(4) Transfer Agreements.

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article, 19-308.2.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

JHSCS states that it intends to establish a formal transfer agreement with the Greater Baltimore Medical Center ("GBMC") that is comparable to the current "Patient Transfer Agreement" that Ophthalmology Associates, LLC (owned and controlled by Johns Hopkins Health System) has with GBMC. (DI #4, p. 36) A copy of this agreement is included with the original CON application as Exhibit 9. JHSCS will utilize ambulance services provided by Emergency Medical Services by calling 911.

MHCC staff concludes that the applicant complies with this standard.

³ Details regarding the minimum requirements in COMAR 10.05.05.09 can be viewed at: <http://www.dsd.state.md.us/comar/comarhtml/10/10.05.05.09.htm>.

B. PROJECT REVIEW STANDARDS. The standards in this section govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards.

(1) Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

The applicant projects the service area of the proposed surgery center will approximate the service area for outpatient surgery at Johns Hopkins Hospital (JHH). (DI #4, p. 37) Defining the service area as the region that delivered the first 85 percent of outpatient surgery cases performed at JHH in FY 2014 delineates a service area that includes a large portion of Maryland as well as contiguous areas located in Pennsylvania, Northern Virginia, Delaware, and the District of Columbia. (DI #4, Exhibit 10) This service area includes 10.3 million people in 2014, and is projected to add 500,000 additional residents by 2019. (DI #4, Exhibit 12⁴)

MHCC staff concludes that the applicant has identified GSSSC'S service area and complies with this standard.

(2) Need – Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following....

Because this application does not concern the establishment or replacement of a hospital, this standard is not applicable.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

⁴ Demographic information provided to JHSCS by Truven Health Analytics, Inc.

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

As required, JHSCS identified the surgeons who will be performing surgery at GSSSC in each specialty, provided historical volumes for these surgeons (documented in letters submitted in the CON application - DI #4, Exhibit 15), and estimated the number of surgical cases that each physician currently performs that would move to GSSSC.

Needs Assessment

JHSCS employed a needs assessment methodology to project surgical case volume at the proposed facility using the guidance in part (b) of this standard. That methodology is summarized in the following table.

Step	Approach	Result/Finding
1. Estimated number of referrals for surgery made by primary care physicians at Green Spring Station (GSS) campus to surgeons who would practice at GSSSC	a) Used actual referral data from electronic medical records (EMR) to determine the referral patterns of JHM primary care physicians at GSS to gain an understanding of: <ul style="list-style-type: none"> the proportion of patients being referred to JHM specialists the proportion of patients being referred to non-JHM specialists 	<ul style="list-style-type: none"> 62% of referrals were made to JHM physicians; 38% were made to non-JHM physicians; This ratio of 62% JHM referrals to 38% non-JHM referrals was consistent with the referral patterns reported in the FY 2012 Physician Survey (which included PCPs at GSS who were not JHM employees).
	b) Repeat study of EMR referral data for the Patient First physicians at Green Spring Station	<ul style="list-style-type: none"> 51% of referrals were made to JHM physician; 49% were made to non-JHM physicians
	c) Extrapolate the results from a) to non-JHM PCPs at GSS.	Assumed that the referral rates would be the same as for JHM PCPs, i.e., 62% JHM surgeon/38% non-JHM surgeon) referral distribution would apply.

<p>2. Determine the total number of referrals to surgical specialists made by GSS PCPs.</p>	<p>Sum the total estimated # of referrals made by JHM, non-JHM, and Patient First PCPs at Green Spring Station (GSS) campus to surgeons who would practice at GSSSC</p>	<ul style="list-style-type: none"> • An estimated 35,531 referrals were made to selected specialties by a JHCP, Patient First or other adult primary care provider • 61% WERE MADE TO JHM SPECIALISTS • 39% WERE MADE TO NON-JHM SPECIALISTS (details shown in Appendix 3) 																						
<p>3. Estimate the proportion of new patient visits that result in surgical cases.</p> <p>Apply these rates to estimated referrals to generate estimated surgeries. (DI#4, p.50)</p>	<p>JHSCS calculated the ratio between new patient visits and actual cases using FY 2014 EMR data.</p>	<table border="1"> <thead> <tr> <th>Specialty</th> <th>Ratio of new visits/cases</th> </tr> </thead> <tbody> <tr> <td>GYN</td> <td>20.0</td> </tr> <tr> <td>Podiatry</td> <td>10.0</td> </tr> <tr> <td>Neurosurgery</td> <td>5.1</td> </tr> <tr> <td>Urology</td> <td>4.0</td> </tr> <tr> <td>General Surgery</td> <td>3.7</td> </tr> <tr> <td>Vascular</td> <td>3.1</td> </tr> <tr> <td>Orthopedics</td> <td>3.0</td> </tr> <tr> <td>Plastics</td> <td>2.8</td> </tr> <tr> <td>ENT</td> <td>2.6</td> </tr> <tr> <td>Breast</td> <td>1.5</td> </tr> </tbody> </table>	Specialty	Ratio of new visits/cases	GYN	20.0	Podiatry	10.0	Neurosurgery	5.1	Urology	4.0	General Surgery	3.7	Vascular	3.1	Orthopedics	3.0	Plastics	2.8	ENT	2.6	Breast	1.5
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Orthopedics	3.0																							
Plastics	2.8																							
ENT	2.6																							
Breast	1.5																							
<p>4. Determine the referral retention rate for each surgical specialty to be represented at GSSSC; analyze in two groups – those with an existing full time presence at GSS and those with no current or limited presence.</p>		<ul style="list-style-type: none"> • Those with an EXISTING FULL TIME PRESENCE AT GSS HAD A REFERRAL RETENTION RATE RANGING BETWEEN 63% AND 87%, AND AVERAGING 71.8%; • Those with NO CURRENT OR LIMITED PRESENCE AVERAGED 30.1% (details shown in Appendix 3) 																						
<p>5. Project surgical volume at GSSSC for each specialty that is planned to practice there.</p>	<p>Start with the FY2015 (annualized as of March) volume by specialty; allocate the % of that volume that would be assigned to GSSSC to arrive at an "FY 2015 volume baseline assigned to GSSSC"; adjust the 2015 volume baseline at GSSSC by 1) volume increase attributable to population growth, and 2) a referral retention rate of 71.8 in 2018, 79% in 2019, and 85% in 2020.</p>	<p>See Table 2 below.</p>																						

Reviewing Step 5 from the table above, the applicant developed its projection by first adjusting the FY2015 outpatient volumes of the physicians who will staff GSSSC by the proportion of that volume that would be assigned to GSSSC (ranging from 7.2% for GYN to 100%

in several specialties). Next, the projected population growth and the referral retention rate assumption of 71.8%⁵ were factored in to establish a baseline projection of 4,346 cases in FY 2018. The final two columns in the table illustrate higher case volume projections in the second and third year of operation based on an assumption of higher referral retention rates (79% in 2019 and 85% by 2020).

This methodology leads to the applicant's projected surgical volumes of 4,346 in FY2018, 4,731 in FY2019, and 5,078 in FY2020.

⁵ 78.1% is the average referral retention rate of specialties with a full time GSS presence and compares to an overall referral retention rate of 61% at GSS.

Table 2: Projected Case Volumes for GSSSC, 2018 - 2020

Green Spring Station ASC CON - Volume (Case) Projections by Physician and Specialty									
Specialty	Historical Total Outpatient Volume				Proportion Volume Allocated to GSS		GSS FY2018 Projection (Pop. Adj. and 71.8% RR)	GSS FY2019 Projection (Pop. Adj. and 79% RR)	GSS FY2020 Projection (Pop. Adj. and 85% RR)
	FY2012	FY2013	FY2014	FY2015*	%FY2015 Total OP Volume Assigned to GSS	FY 2015 Volume Baseline Assigned to GSS			
Orthopaedics	964	850	851	906	62.6%	567	804	986	1,139
Otolaryngology	1,436	1,487	1,567	1,809	47.9%	866	891	956	1,028
Urology	1,533	1,740	1,837	1,722	49.0%	843	1,153	1,215	1,267
Vascular	248	255	225	235	100.0%	235	247	263	274
Breast	608	795	878	854	34.7%	296	339	352	365
Plastic	304	334	359	406	44.6%	181	213	220	228
General	114	159	252	329	58.7%	193	375	411	441
Gynecology	1,339	1,310	1,751	2,078	7.2%	150	155	156	160
Podiatry	44	50	30	50	100.0%	50	51	52	52
Neurosurgery	85	82	101	115	100.0%	115	118	120	124
Total	6,675	7,062	7,851	8,504	41.1%	3,496	4,346	4,731	5,078

*FY2015 March Annualized
Source: DI #4, p. 51.

Having projected surgical volumes for the proposed project, JHSCS converted those projections into the number of ORs required to service the volume as shown in the table below. The inputs to that calculation were:

- Total number of cases per year, projected as described above;
- The average number of minutes per case for ambulatory surgery centers in Maryland for the years FY2010-FY2013 (70.7 minutes per case);
- An assumed average of 25 minutes of room turnaround time;
- The State Health Plan's operating room capacity assumptions.

COMAR 10.24.11.06A(1)(b) assumes an optimal capacity level for operating rooms functioning in ambulatory surgical facilities to be 1,632 hours per year. Based on these assumptions, the applicant projects a need for five dedicated outpatient ORs by the first year of operation in FY 2018, reaching optimal capacity for all five ORs by FY 2020.

**Table 3: Green Spring Station Surgery Center
Projected Number of ORs Needed**

Fiscal Year	Cases	Operating Room and OR Cleaning/Preparation Time (Minutes)			ORs Needed
		Surgical Procedure Time	Turnover Time	Total Time	
2018	4,346	70.7	25	415,912	4.2
2019	4,731	70.7	25	452,757	4.6
2020	5,078	70.7	25	485,965	5.0

DI #4, p. 67

Staff concludes that the applicant's approach to forecast demand was logical, employed valid assumptions, and used relevant data to develop the forecasts.

The assumption that the project will achieve an 85% referral retention rate by Year 3, ramping up from a current 61% may be overly aggressive. However, even if the referral retention rate does not surpass the applicant's intermediate target rate of 71.8%, a capacity for five ORs would be needed.

Staff concludes that the applicant has met this standard.

Standards .05B(4), Design Requirements; and .05B(5), Support Services.

Among the remaining applicable standards are several that prescribe policies, facility features, and staffing and/or service requirements that an applicant must meet, or agree to meet prior to first use. Staff has reviewed the CON application and confirmed that the applicant provided information and affirmations that demonstrate full compliance with these standards:

- .05B(4), Design Requirements**
- .05B(5), Support Services**

The applicant has shown that the facility is designed in compliance with Section 3.7 of the 2014 Facilities Guideline Institute Guidelines and that the required support services (laboratory, radiology, and pathology) are available at the Green Spring campus and/or at JHH with courier support. The text of these standards and where that compliance is documented in the project file are attached as Appendix 2.

- (3) Design Requirements. See Appendix 2.
- (4) Support Services. See Appendix 2.

(5) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.

JHSCS states that the facility will include design features that:

- reduce communication errors that cause wrong-site surgeries by maintaining visual connections among staff work areas;
- reduce patient transfers by having three wall cubicles located in one location within the post-anesthesia care unit, thereby reducing communication breakdowns by limiting patient movement during the recovery process;
- incorporate antimicrobial surfaces to limit infections;
- utilize a same-handed operating room design to standardize the location of equipment and supplies in the ORs in order to eliminate a possible source of confusion and enhance staff efficiency. (DI #4, pp. 73-74)

In addition JHSCS described “a robust existing patient safety and quality infrastructure for ambulatory surgery centers that includes the JHM Ambulatory Surgery Coordinating Council (“ASCC”).” (DI #4, p. 72) That council is physician-led and includes the director of Johns Hopkins Medical Management Corporation, as well as representatives from a variety of functions, including quality, risk management, nursing, and infection control. There is representation from each of Hopkins’ seven ASCs.

The mission of JHM ASCC is to provide “exceptional high quality patient-centered care and consistent experiences at all JHM ASCs.” The council’s objectives are to oversee operations and standardization of Johns Hopkins ASC services, monitor regulatory compliance, and monitor and report quality measures from all of the Johns Hopkins ASCs.

While each center coordinates its own regulatory and quality compliance independently at the site level, the ASCC allows the sites to draw on best practices from across the health system, learning from each other to provide the safest, highest quality patient-centered care. (DI #4, p. 72) The ASCC is responsible for overseeing regulatory measurements from oversight bodies such as The Joint Commission, the Centers for Medicare and Medicaid Services, and the Maryland Department of Health and Mental Hygiene’s Controlled Dangerous Substances reporting.

The ASCC oversees quality reporting of ASC quality indicators, infection control reporting (including cleaning, disinfection, sterilization, and hand washing), and patient safety and risk reporting through an online patient safety reporting network. Using a web-based dashboard, the ASCC provides ongoing measurement reporting and monitoring on such items as surgical site infections ”SSI”), hand hygiene, burns, falls, unexpected transfers/admissions, wrong site

procedures, prophylactic antibiotic timing, adverse drug reactions, grievances, complications other than SSI, and code/cardiac arrest.

With the establishment of the proposed project, GSSSC will join the ASCC and have representation on the council through its medical director and nurse manager, and have site-level accountability for patient safety measures, infection control surveillance, and quality indicators.

The application demonstrates that JHSCS has considered patient and staff safety in designing GSSSC and meets this standard.

(6) Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

Subpart (a) does not apply because this is not a hospital project.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

This standard requires a comparison of the project's estimated construction cost with a benchmark cost derived from the Marshall Valuation Service ("MVS") guide. An MVS benchmark cost is typically developed for new construction based on the relevant construction characteristics of the proposed project. The MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses including outpatient surgical centers. The MVS guide also includes a variety of adjustment factors, including adjustments of the base costs to the costs for the latest month, the locality of the construction project, as well as factors for the number of building stories, the height per story, the shape of the building (such as the relationship of floor area to perimeter), and departmental use of space. The MVS Guide also identifies costs that should not be included in the MVS calculations. These exclusions include costs for buying or assembling land, making improvements to the land, costs related to land planning, discounts

or bonuses paid for through financing, yard improvements, costs for off-site work, furnishings and fixtures, marketing costs, and funds set aside for general contingency reserves.⁶

The applicant initially compared its estimated costs (\$7,230,541) of constructing the 27,238 square foot ("SF") ASF (\$265.46 per SF) to a benchmark cost (\$386.32 per SF) based on the Marshall Valuation Service ("MVS") cost for constructing a new freestanding outpatient surgical center rather than the cost of finishing space in a medical office building, which is the actual nature of this project. (DI #4, pp. 77-79)

In completeness review, the applicant revised the MVS benchmark for a more valid comparison. JHSCS used two methods to adjust the benchmark for a freestanding ambulatory surgery center to account for the fact that the proposed project only involves the finishing of building space and not construction of the space.

In both approaches, the applicant developed a benchmark cost per SF for shell space in a Class A, Good quality medical office building ("MOB") by multiplying the MVS base cost by the MVS hospital departmental cost differential factor of 0.5⁷ for unassigned space.⁸ This shell space benchmark was developed for a generic MOB, not an MOB with the specific building characteristics of the proposed GSSSC. (DI #14, pgs. 132-137)

In the first method, JHSCS subtracted the cost of the generic MOB shell from the cost of a generic ASC to arrive at an estimated cost of finishing a generic ASF in MOB shell space. JHSCS then calculated the cost of finishing the generic ASF in MOB shell space as a proportion of the MVS cost calculated for a generic ASF. Assuming that this proportion would apply to the proposed project, JHSCS multiplied this proportion by the MVS benchmark cost it calculated for GSSSC. The result is a benchmark cost of \$264.20 per SF. for the proposed project. Under this method the estimated cost of finishing the space (\$265.46 per SF) is 0.48% higher than the benchmark. (DI #14, pp 134-135)

Under the second method, JHSCS subtracted the MVS cost it calculated for the MOB shell space from the MVS benchmark value it calculated for GSSSC in the CON application. Using this approach, the benchmark for finishing the shell space is \$266.08 per SF and the estimated cost to finish the shell space is 0.23% less than the benchmark.

The standard requires that a project with projected cost per square foot exceeding the MVS benchmark cost for good quality Class A construction by 15% or more demonstrate that the construction costs are reasonable. Staff calculated that the project's construction cost is about 1.3% below the MVS benchmark, so no such demonstration is required. Therefore, Staff concludes that the application is consistent with this standard. (For a complete explanation of this calculation, see Appendix 4.)

⁶ Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2016).

⁷ MVS Guide, Section 87, page 8.

⁸ MVS does not include departmental differential cost factors for outpatient surgical centers.

(7) Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projects filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projects.

(a) *An applicant shall document that:*

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant facility or, if a new facility, the recent experience of similar facilities;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

JHSCS listed a comprehensive set of assumptions related to volume, revenues and expenses that staff considers to be rational and reasonable. (DI #4, pp. 81-82) Projected volumes were based on 2015 actual volumes by the surgeons who will be performing surgery at the center, adjusted for population growth, and the achievement of an 85% retained referral rate from referring Hopkins physicians who currently practice at Green Spring Station. Reimbursement by specialty is based on the standardized Medicare methodology and the applicant's historical experience in operating White Marsh Surgery Center ("WMSC").⁹ Similarly, many expenses including staffing, equipment maintenance, drugs and medical supplies, minor equipment, and other expenses are estimated based on the applicant's experience at WMSC. Depreciation is calculated as five years for major moveable equipment, and twenty five years (based on lease term) for building out the ASC and rent is based on the terms of the lease, which is 27,238 SF at \$34 per square foot.

⁹ Entirely staffed by Johns Hopkins providers, the Johns Hopkins Surgery Center-White Marsh is a multi-specialty outpatient surgery center with one operating room and two procedure rooms located at 4924 Campbell Boulevard, Suite 250 in White Marsh, Baltimore County. Further information on this facility is available at: http://www.hopkinsmedicine.org/patients/white_marsh/surgery_center/.

The applicant expects to generate excess revenues over total expenses if utilization forecasts are achieved for the specific services affected within two years of initiating operations.

Staff has determined that the applicant's utilization and financial projections are based on a well-documented and logical demand assessment and reasonable assumptions and concludes that the proposed project meets the financial feasibility standard

(8) Preference in Comparative Reviews.

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.

See the discussion of Need earlier in this recommendation at the State Health Plan standard (COMAR 10.24.11.05B(2)). This State Health Plan standard does not include a methodology that is officially established as a need projection for operating room capacity, the standard service capacity metric for regulating the supply and size of surgical facilities. Rather, it outlines the requirements that applicants must meet in developing their required project need assessment.

As staff found in its review of this standard, the project sponsor's project need assessment was logical, employing valid assumptions, and used relevant data to develop surgical demand forecasts at the proposed facility. It demonstrated that cases would likely be referred to the proposed ASF and used the SHP guidance in determining the OR capacity needed to handle projected levels of demand. Therefore, the applicant has established that the proposed project meets outpatient surgical needs that the applicant has defined as current levels of surgical facility demand in the Baltimore area that can be shifted to this new facility.

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.

JHSCS described a planning process which projected future utilization for its existing inpatient and outpatient regulated settings and a comprehensive review of its operating capacity, and concluded that it is essential to develop freestanding market-priced (i.e., non-hospital) operating and procedure room capacity to enable surgical care to be shifted to settings where it can be provided in the most cost effective manner. The applicant stated that locating this additional capacity at Green Spring Station "makes sense because of the number of physicians and variety of services already available there and the opportunity to take advantage of additional synergies and

efficiencies.” (DI #4, p. 90) It also states that “about 40% of the (patients who need) specialty care are referred to specialists in the community other than Hopkins due primarily to the lack of physician and patient access to Hopkins specialists at Green Spring Station.” (DI #4, p. 91)

Thus the applicant identified the following goals for the project:

1. Increase access to Johns Hopkins Medicine’s specialty physicians for Green Spring Station patients;
2. Increase the retention of patients within the Hopkins system;
3. Move care for patients who could be safely cared for in the community to a lower cost setting;
4. Improve convenience for Green Spring Station patients; and
5. Provide adequate space to accommodate existing patient volume as well as future growth.

(DI #4, pp. 91-92)

The applicant states that it considered the following alternatives.

Alternative	Applicant’s Evaluation and Comments
Do nothing	This alternative fails to meet any of the goals for this project and was quickly rejected.
Consider real estate options on the Interstate 83 corridor.	While the applicant considered several real estate options on the I-83 corridor within five minutes of Green Spring Station, this alternative was rejected due to the significantly higher costs and the bifurcation of clinical services between the new site and the Green Spring Station campus. The applicant states “dividing clinical care between the two geographic locations....would be a negative for patients and would compromise the overriding goal of providing convenient, efficient and consolidated services in one location.”
Build additional ORs at the White Marsh Surgery Center.	This alternative would bifurcate clinical services between White Marsh and Green Spring Station, reducing the potential success of increasing patient retention at Green Spring Station. Also, the White Marsh location limits any expansion plans to only one additional OR, which would not allow Johns Hopkins Medicine to meet the need for additional ambulatory surgery capacity.
Establish Green Spring Station Surgery Center (this project).	Establishing GSSSC provides the best opportunity to address each of the five goals used as criteria with regard to: increasing access to JHM specialty physicians; increasing the retention of patients within the Hopkins system; moving care for patients who could be safely cared for in the community to a lower cost setting; improving convenience for GSS patients; and providing adequate space to accommodate existing patient volume as future growth.

Comments made by JHSCS in the course of responding to comments made by Lifebridge Health (qualified as an interested party in this review that subsequently withdrew itself from that status) offer insights on its perspective on the cost-effectiveness of shifting outpatient surgery from the hospital setting to an unregulated outpatient setting.

Lifebridge suggested that costs would actually be added to the system because: “Johns Hopkins counts on its globally budgeted revenue (“GBR”) remaining unchanged and believes that redirecting patients to the GSSSC is consistent with the cost reduction goals of the new Medicare GBR waiver and population health. However, this tactic neglects to account for the fact that Johns Hopkins’ GBR will not change while it creates a new stream of revenue from its unregulated GSSSC.” (DI#19)

JHSCS responded that “JHM expects that there will be some change in the GBR, but the HSCRC has not yet addressed how it will account for shifting volume to a lower cost unregulated setting. Nevertheless, the Application demonstrates that outpatient surgery performed at GSSSC would be significantly less expensive than the same outpatient surgery performed at JHH.”

Although the applicant did not provide estimated costs for the alternatives it considered, it is clear to staff that the alternative selected was a sound choice given the stated goals of the project; the alternatives considered were either ineffective in meeting the project’s goals or likely to be at least as costly. Therefore, staff concludes that the applicant meets the cost effectiveness standard.

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.

Availability of Resources to Implement the Proposed Project

The Project Budget is \$16,347,560, and includes about \$7.2 million in interior construction, to finished built space, and \$6 million in equipment. The applicant will supply \$1.9 million in equity and the bulk of the funding -- a little over \$13 million -- will be borrowed from the Johns Hopkins Health System. (DI #4, Exhibit 1E) Approximately \$6.0 million is an equipment loan that will be for a five year term at an interest rate of 4% payable in 60 equal monthly installments; the remaining \$7.0 million is for the cost of renovations that will be amortized over 25 years at 4% payable in 300 equal monthly installments.

The applicant has demonstrated community support for the project. (DI #4, Exhibit 18)

Availability of Resources to Sustain the Proposed Project

As shown in Table 3, JHSCS projects profitability for the ambulatory surgery center in CY 2019, the second year (first full year) of operation. As discussed earlier in the Financial Feasibility

standard, MHCC staff concluded that these projections were supported by reasonable and well-documented assumptions.

**Table 4: Green Spring Station Surgery Center
Projected Revenues and Expenses, CY 2018-2020**

Revenue	CY 2018	CY 2019	CY 2020
Outpatient Services	\$17,850,750	\$19,602,750	\$21,280,025
Gross Patient Services Revenues	17,850,750	19,602,750	21,280,025
Allowance for Bad Debt	200,000	220,000	242,000
Contractual Allowance	10,410,450	11,436,650	12,415,765
Charity Care	100,000	105,000	110,250
Net Patient Services Revenue	7,140,300	7,841,100	8,512,010
Net Operating Revenues	\$7,140,300	\$7,841,100	\$8,512,010
Expenses			
Salaries, Wages, and Professional Fees	\$2,574,463	\$2,724,994	\$3,095,971
Contractual Services	364,209	389,733	414,495
Interest on Project Debt	500,799	450,394	397,935
Project Depreciation	1,448,558	1,468,558	1,508,558
Supplies	910,515	1,038,740	1,157,195
Other Expenses ¹	1,544,236	1,602,189	1,650,576
Total Operating Expenses	\$7,342,780	\$7,674,608	\$8,224,730
Income			
Income from Operations	(\$202,480)	\$166,492	\$287,280
Net Income (Loss)	(\$202,480)	\$166,492	\$287,280

¹Includes rent, drugs, minor equipment, equipment maintenance, office expense, laundry, insurance, telephones, meals & entertainment, training, information systems, licensure & accreditation, utilities, miscellaneous, and Medical Director Fee
Source: DI #4, p. 96.

Staff concludes that the proposed project is viable.

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.

This is the first time that Johns Hopkins Surgery Centers Series has submitted a CON application for review. However, over the last 15 years both Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center -- affiliates of the applicant under The Johns Hopkins University and The Johns Hopkins Health System Corp.—have had CONs approved. (DI #4, Exhibit 2)

Johns Hopkins Hospital (“JHH”) received CON approval for five projects, whereas Johns Hopkins Bayview Medical Center (“JHBMC”) received four approvals during this time period. JHH has completed four of the five CON approvals, with each of these projects receiving approval for first use review and subsequent licensure by the Office of Healthcare Quality.

The fifth project to receive a CON (Docket No. 03-24-2123) is an extensive project that is essentially a “replacement in place” of approximately half of the clinical facilities. It includes demolition to all or part of ten existing buildings, new construction for two ten-story clinical towers, and renovations to eight existing buildings. It was approved by MHCC on February 15, 2005 at an estimated cost of \$577,774,237.

Subsequently, JHH submitted three modifications that have each received MHCC approval. The first modification was on May 18, 2006, which consisted of changes to the original physical plant design configuration and the addition of floors to the new clinical towers that increased the total cost of the project to \$801,926,392. The second modification (in February 2008) increased the total capital cost for this project to \$1,054,234,941. These large cost increases did not increase the debt associated with this project. The third modification (in July 2010) amended a condition to extend the date by which JHH was required to submit final drawings for the renovation of two hospital buildings.

The project as originally approved was to be implemented in five phases: (1) initial demolition; (2) new clinical building; (3) post construction occupancy of the new clinical building; (4) renovation of retained space; and (5) final demolition. Each of the phases would have its own construction contract. As part of the Second Modified CON, the Commission approved JHH’s request to divide the modified Phase 2 into four sub-phases under a single construction contract in order to comply with the regulatory options for structuring performance requirements. These sub-phases include the original Phase 3 above, so the overall project implementation evolved from five- to a four-phase implementation process.

JHH requested partial first use review and approval for Phase 2 of the project on February 29, 2012. As of this date, the applicant reported cumulative expenditures of \$907,989,923.¹⁰ With respect to the two MHCC conditions associated with the project, JHH: (1) met the condition for providing to MHCC schematic design drawings for the new building and renovated space by the scheduled date; and (2) JHH has adopted a policy of notifying, annually, the hospital’s patient population in the Baltimore region of its charity care policies, through notices broadcast on radio, television, or through notices published in an area newspaper of general circulation. At that time MHCC determined that the project is partially complete and, on the basis of the information provided by JHH, had been implemented in a manner consistent with the terms of the Certificate of Need, as modified.

JHBMC received CONs: to construct an additional mixed-use operating room (originally approved for 4, but the project was scaled back); to establish a comprehensive cancer program; and for expansion of its emergency department.

Appendix 5 provides a list of the CONs issued to these two hospitals in the past 15 years.

¹⁰As of the date for this modification, the applicant projected that the project will cost \$1,324,328,752, an increase of \$270,093,811 above the approved total project cost of \$1.054 billion, which the applicant states is within the amount allowed due to inflation.

The applicant's performance on prior CONs is consistent with this standard.

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.

The State Health Plan chapter governing surgical services, at 10.24.11.06, provides guidance to applicants on how to assess impact of the proposed project and requires an applicant to provide:

- The number of surgical cases projected for the facility and for each physician and practitioner;
- A minimum of two years of historic case volume data for each physician or practitioner, identifying each facility at which cases were performed; and
- The proportion of case volume expected to shift from each existing facility to the proposed facility.

It also requires an applicant to assess the impact on an affected hospital.

Accordingly, JHSCS identified surgeons who would be performing surgery at GSSSC in each specialty, provided historical volumes for these surgeons, and estimated the number of surgeries that each physician performs at his/her current location that would move to GSSSC, and projected their future volume in the same manner.

Table 4 shows the FY2015 surgical case volume of the GSSSC-committed surgeons that would have been performed at GSSSC if it had been available in FY2015 (third column), and where they performed those cases in that year (subsequent columns). These facilities are the "affected facilities" expected to experience the highest level of impact.

The last two rows in the table show the total number of cases performed at the "affected facilities" and the percentage of cases that would have been expected to shift to GSSSC if it had been available in 2015, based on the applicant's need assessment.

**Table 5: Green Spring Station Surgical Center
Projected Surgical Case Volume Impact on Existing Surgical Providers**

Specialty	No. of Physicians	Total Cases FY2015	Affected Facilities							
			Johns Hopkins Medicine (JHM) Sites				Non-JHM Sites			
			JHH	JHBMC	OA at GSS	WMSC	Bellona [1]	GBMC	Good Samaritan	
Orthopaedics	7	567	567							
Otolaryngology	10	866	409		124	251	82			
Urology	4	843	720	123						
Vascular	2	235	47		188					
Breast	5	296	296							
Plastic	4	181	50		91	40				
General	4	193	193							
Gynecology	1**	150	50					100		
Podiatry	1	50								50
Neurosurgery	1	115	115							
Total		3,496	2,447	123	403	291	82	100	50	
% of Projected GSSSC cases		100.0%	70.0%	3.5%	11.5%	8.3%	2.3%	2.9%	1.4%	
CY 2015 Total Outpatient Cases Performed [2]			76,522	27,643	2,652	764	1,394³	31,649	12,595	
% Impact on Case Volume			3.2%	0.4%	15.2%	38.1%	5.9%	0.3%	0.4%	

DI #4, Exhibit 21

¹Bellona Surgery Center dba as Cosmetic SurgiCenter

²HSCSC Discharge Abstract, CY 2015 and MHCC Freestanding Ambulatory Surgical Facility Survey, CY 2015 and

m Source: MHCC Freestanding Ambulatory Surgical Facility Survey, CY 2014.

**Various JHM physicians

A very high proportion of the total cases (93%) are projected to shift from other Hopkins facilities and a very high proportion (70%) from one facility, The Johns Hopkins Hospital. The other affected Hopkins facilities are Johns Hopkins Bayview Medical Center, Ophthalmology Associates at Green Spring Station, and White Marsh Surgery Center Series.

The table below shows that the projected impact on both JHH and Johns Hopkins Bayview Medical Center in FY2015 would have been relatively small, about 4% of OR minutes at JHH and less than one percent at Bayview). (DI #14, Question #13, p. 141) Relatively high levels of impact are projected for two Hopkins affiliated ASFs, the eye surgery center currently operating at Green Spring Station (15.2%) and the White Marsh facility (38.1%). However, given that these are affiliated centers that are not rate regulated, staff does not find this level of impact to be troubling. The project is projected to have a relatively modest impact on an unaffiliated ASF, which is primarily a cosmetic surgery center, and two non-Hopkins general hospitals located in Towson and Baltimore City.

Table 6: (Hypothetical) Impact of OR Cases Moved to GSSSC from Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, Based on FY2015 Case Volume

	JHH ¹¹	JH Bayview ¹²
Outpatient OR Cases assumed to shift to GSSSC	2,447	123
Average OR Minutes/Case	95.7	95.7
OR Minutes Shifted to GSSSC	234,178	11,771
Total OR Minutes	5,872,436	1,279,528
% OR Minutes Shifted to GSSSC	4.0%	0.9%

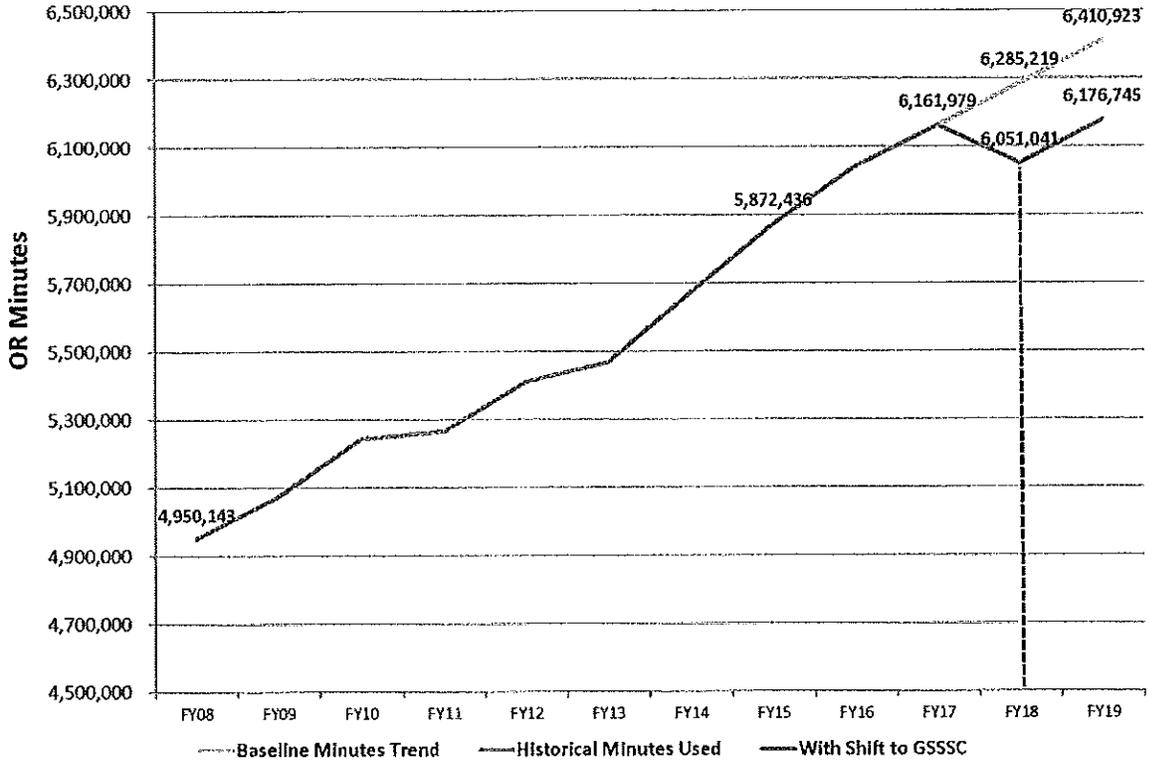
Source: DI #14, Question #13, p. 141.

JHSCS posited that the outpatient surgical volume at JHH would be replaced within a couple of years, based on the hospital's average annual growth rate of 2% in OR surgical minutes since FY 2008. The applicant projected this growth rate to continue at a rate of 2% annually between FY 2017 and FY 2019. (DI #4, p. 106) JHH expects to regain the outpatient surgical volume moved to GSSSC and return the hospital to previous levels of OR use by FY 2019, as shown in the graph below.

¹¹ MHCC's Supplemental Survey: Surgical Services Capacity by Hospital: Maryland Hospitals, June 1, 2015 reports that Johns Hopkins Hospital had a total of 61 ORs, with eight outpatient general purpose, 46 mixed-use general purpose, and seven outpatient special purpose operating rooms.

¹² MHCC's Supplemental Survey: Surgical Services Capacity by Hospital: Maryland Hospitals, June 1, 2015 reports that Johns Hopkins Bayview Medical Center had a total of 14 ORs, with 14 mixed-use general purpose operating rooms.

JHH OR MINUTE PROJECTIONS



Source: DI#4, p. 106.

Impact on Non-Hopkins Hospitals

Based on the physician-specific information provided by the applicant (Table 7), six non-Hopkins hospitals would have lost a total of 686 cases in FY2014. None would experience a large adverse impact as a result of the establishment of GSSSC.¹³

¹³ See COMAR 10.24.11.06 C. Assessing Impact.

**Table 7: Projected Impact of Green Spring Station Surgery Center
On non-JHM Hospitals in Service Area**

Hospitals FY 2014	Retained Referral & Physician Specific Cases	OR Minutes at 70.7 Minutes Per Case	Total OR Minutes	Percent Impact
Greater Baltimore Medical Center	259 ¹	18,311	1,986,967	0.9%
Mercy Medical Center	131	9,262	2,141,081	0.4%
UM St. Joseph Medical Center	92	6,504	1,336,224	0.5%
MedStar Good Samaritan Hospital	78 ²	5,515	795,970	0.7%
Northwest Hospital	74	5,232	727,992	0.7%
MedStar Union Memorial Hospital	52	3,676	1,553,426	0.2%
Total	686			

1 - Includes 159 retained referrals and 100 physician-specific cases

2 - Includes 28 retained referrals and 50 physician-specific cases

Source of OR Cases & OR Minutes: HSCRC FY 2014 Experience Report - Final

Source: DI #4, p. 112

Impact on other JHM Ambulatory Surgical Facilities (WMSC and Ophthalmology Associates at Green Spring Station)

JHSCS projects that significant volume would shift from both WMSC (38.1%) and OA (15.2%). However, the applicant states that the shifts from OA are all non-ophthalmic cases (otolaryngology, vascular, and plastic surgery) and that moving these cases will “create much-needed capacity in the OA ASC to accommodate ophthalmic cases shifting in turn from.... the JHH campus,” and “will have the additional benefit of creating efficiencies of operation at OA by removing the other specialties.” JHSCS states that shifting cases from JHH to OA will harmonize with payors’ incentives to move ophthalmic cases (cataracts in particular) to non-rate regulated freestanding ASF settings (DI #4, p. 107)

WMSC will shift a total of 291 outpatient surgical cases to GSSSC. WMSC is working with JHH’s Department of Orthopaedics’ to become a key source of outpatient OR capacity. (DI #4, p. 108) The Department is recruiting and hiring additional orthopaedic surgeons in a number of subspecialties who will practice at WMSC, and expects to shift future surgical volumes from JHH to this facility as it becomes “an important site for JHM Orthopaedic Surgery.”

While the 291 OR cases shifted from WMSC to GSSSC is a significant proportion of that facility’s cases, JHSCS indicates that WMSC is projected to experience an increase in surgical cases. (DI #4, p. 108) From FY 2015 to FY 2016, the applicant indicates the number of OR cases is projected to increase from 751 to 920 cases, an increase of 169 cases (about 22.5%). JHSCS states the projected growth of surgical cases performed at WMSC will help to offset the surgical cases that eventually move to GSSSC once it opens.

Impact on Non-JHM Ambulatory Surgical Centers (ASCs)

The non-JHM facilities projected to experience the most impact as a result of the project are Bellona Surgery Center, which primarily provides cosmetic plastic surgery, at around 6.9%, and nine Summit Ambulatory Surgical Centers¹⁴ at about 5.1%. JHSCS was not able to acquire the total surgical cases for OrthoMaryland, Towson Orthopaedic Associates, Greater Chesapeake Hand Specialists, and Colon Rectal Surgical Associates and therefore, did not project impact as a percentage of cases. MHCC staff did associate these names with ambulatory surgical facilities with respect to 2013 (although, in the case of physician groups, there is probably not a precise correspondence between the case numbers cited by JHSCs and the location of these cases in more recent years) and modified the following table, as presented by the applicant to include an impact calculation. COMAR 10.24.11 does not provide a threshold or level of surgical case volume that scores the level of impact on an ambulatory surgical facility. JHSCS argues that the level of impact projected for these ASFs does not rise to a level that would serve as a basis for denying approval of the proposed project.

**Table 8: Projected Impact of Green Spring Station Surgery Center
Non-JHM Ambulatory Surgery Centers in the Project Service Area (Based on 2013 Case Data)**

Health Care Facilities	Retained Referral & Physician Specific Cases	Total Surgical Cases	Percent Impact
Summit Ambulatory Surgical Center, LLC (9 Centers - Chesapeake Urology Associates)	290	5,646	5.1%
OrthoMaryland (Green Spring Surgery Center)	120	751	16.0%
Towson Orthopaedic Associates (Ruxton Surgi-Center, LLC)	114	1,455	7.8%
Ruxton SurgiCenter, LLC	28	1,455	1.9%
Colon Rectal Surgical Associates (Ruxton Surgi-Center, LLC)	26	1,455	1.8%
Total Ruxton Surgi-Center, LLC	168	1,455	11.5%
Bellona Surgery Center (Cosmetic Surgicenter of Maryland)	83 ³	1,210	6.9%
Greater Chesapeake Hand Specialists (Lutherville SurgiCenter)	73	2,810	2.6%
Surgicenter of Baltimore, LLP	35	2,668	1.3%
Ruxton SurgiCenter, LLC	28	1,455	1.9%
Surgical Specialty Suites, Inc.	11	1,199	0.9%
York Green Surgery Center	11	727	1.5%
(48 groups totaling 10 or fewer cases each)	119	na	na
Unknown	44 ⁴	na	na
Total	954		
Grand Total	1,640⁵		

3 - Includes 82 physician-specific cases and 1 retained referral case

4 - Unable to identify hospital, health care facility, or physician group

5 - Grand Total accounts for 1408 retained referrals and 232 Non-JHM Physician-Specific cases

Source of OR Cases: OR Cases in 2013 MHCC Public Use Database

Source: DI #4, p. 112. as modified by MHCC

¹⁴ JHM combined the utilization of nine separate specialty urology ASCs which are all a part of Chesapeake Urology Associates, d/b/a Summit Ambulatory Surgical Center, to arrive at the 5.1% impact.

Access and Cost Implications

The applicant cites a number of benefits to accessing health care services at the proposed Green Spring Station location. GSSSC “will provide more convenient access to needed and desired health care services for much of the service area population.” (DI #4, p. 113) In addition, JHSCS indicates that insurance companies are starting to restrict the choice and use of regulated hospital-based facilities for certain procedures, making the alternative of moving these outpatient surgical procedures to a non-rate regulated outpatient setting such as GSSSC more accessible and attractive. (DI #4, p. 113). For those patients paying for a procedure out of pocket or who have high deductibles and/or copays, having the surgical procedure performed at GSSSC will be a lower cost alternative to a hospital-based setting.

JHM compared the reimbursement actually received for outpatient procedures performed at JHH with similar procedures performed at WMSC and Ophthalmology Associates. The reimbursement at JHH was approximately four times greater than at these two ambulatory surgery centers. (DI #4, p. 113) This is significant when considering that the applicant’s projections show that about 2,720 cases would move from a hospital setting to the ASC in the first year of operation. (DI #4, p. 114) JHSCS calculates that shifting the projected 2,447 cases from JHH to GSSSC “will reduce the costs of the cases performed at GSSSC by 42% overall,” which represents a significant savings to the health care system.

Summary

Staff finds that the applicant has reasonably demonstrated that the impact on other health care facilities of the project will be limited, that the bulk of the impact will be on other facilities in its system, that any such impact is either relatively small and/or is part of a larger strategy to reallocate resources and patients to more efficient settings, that geographic and financial access to outpatient surgery will be improved by the project, and that health care system costs will be reduced.

IV. SUMMARY AND STAFF RECOMMENDATION

Staff recommends approval of the proposed project based on a finding that project complies with the applicable standards in COMAR 10.24.11, the State Health Plan for General Surgical Services (SHP) and comports well with the other review criteria at COMAR 10.24.01.08G. The project will provide outpatient surgery, much of which is now provided at rate regulated hospitals, in a lower charge setting. The project will not have an impact on other hospitals’ case volumes that is likely to cause significant revenue loss.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: Record of the Review

Docket Item #	Description	Date
1	Anne Langley, Senior Director for Health Planning and Community Engagement at Johns Hopkins Medicine, submitted a notice of the intent of Johns Hopkins Surgery Centers Series to apply for a CON for the establishment of an ambulatory surgery facility at 10803 Falls Road, Lutherville, Maryland 21093 in Baltimore County. The proposed freestanding ambulatory surgery facility will locate on the third floor within a newly-constructed medical office building that would also provide space for Johns Hopkins Imaging, outpatient offices for Orthopedics and Physical Medicine and Rehabilitation, and physician office space for a number of specialties. Commission staff acknowledged receipt of this Letter of Intent on June 11, 2015.	6/4/2015
2	Vicki Almond, District 2 Councilwoman, Baltimore County, submitted a letter of support for the establishment of the Green Spring Station Surgery Center.	7/2/2015
3	James R. Ficke, M.D., Director, Department of Orthopaedic Surgery, Johns Hopkins Medicine, submitted a letter of support for the establishment of the Green Spring Station Surgery Center.	7/31/2015
4	Anne Langley submitted a Certificate of Need application proposing the establishment of Green Spring Station Surgery Center ("GSSSC"), consisting of 5 operating rooms and 4 procedure rooms (Docket No. 15-02-2369) located in Lutherville, Baltimore County.	8/7/2015
5	Commission acknowledged receipt of the CON application in a letter to GSSSC.	8/11/2015
6	Commission requested publication of notification of receipt of the GSSSC proposal in the <i>Baltimore Sun</i> .	7/19/13
7	Commission requested publication of notification of receipt of the GSSSC proposal in the <i>Maryland Register</i> on September 4, 2015	8/11/2015
8	The <i>Baltimore Sun</i> provided certification that the notice on receipt of application was published on August 18, 2015.	8/18/2015
9	Following completeness review, Commission staff requested additional information needed before the application can be docketed as complete.	9/18/2015
10	Patricia Cameron, MedStar Health, requests that MHCC add MedStar Health to list of persons to receive copies of ongoing correspondence, notices or other documents between the Commission and the CON applicant. Ruby Potter sent acknowledgement to Patricia Cameron that MHCC will send information relevant to this review and keep MedStar Health informed of the application's progress during the review.	9/22/2015
11	Michael Ruby, <i>County Crier</i> , requests that MHCC send copies of relevant notices concerning this CON application to this community newspaper. Ruby Potter sent acknowledgement to Michael Ruby that MHCC will send information relevant to this review and keep <i>County Crier</i> informed of the application's progress during the review.	8/28/2015

12	Anne Langley requested via email an extension of the deadline for the submission of responses to the September 18 th completeness questions. Kevin McDonald submitted response via email that an extension was granted until 10/30/2015.	10/5/2015
13	After meeting with applicant to gain "better understanding of this proposed project," Commission staff sent modification of the September 18 th completeness questions, with this modification replacing the previous set of completeness questions.	10/20/2015
14	Commission received responses to the October 20, 2015 request for additional information.	10/25/13
15	Commission notified GSSSC that its application is docketed for formal review with a notice in the <i>Maryland Register</i> published on December 11, 2015.	11/30/2015
16	Commission requested publication of the docketing notice in the next edition of the <i>Baltimore Sun</i> .	11/30/2015
17	Commission requested publication of notification of formal start of review for the GSSSC proposal in the <i>Maryland Register</i> with the date of publication on December 11, 2015.	11/30/2015
18	<i>Baltimore Sun</i> sent notification that notice of docketing was published on Thursday, December 10, 2015.	12/10/2015
19	John T. Brennan, Jr., Esq., on behalf of LifeBridge Health, Inc., submitted written comments and requesting "interested party" status regarding this CON application.	1/11/2016
20	MHCC sent copy of the application to the Baltimore County Health Department for review and comment	1/20/2016
21	John T. Brennan, Jr., Esq., requests on behalf of LifeBridge Health, requests an evidentiary hearing or at least an oral argument on the merits of the proposed CON application.	1/25/2016
22	Marta D. Harting, Esq., on behalf of applicant Johns Hopkins Surgery Center Series, submitted response to interested party written comments from LifeBridge Health, Inc.	1/27/2016
23	Marta Harting, Esq., submitted Applicant's opposition to request for Evidentiary Hearing and Oral Argument by LifeBridge Health.	2/10/2016
24	Jeffrey Metz, MHCC Commissioner, sent notification of his appointment as Reviewer for the Johns Hopkins Surgery Centers Series CON application, and ruled that LifeBridge Health qualified for interested party status.	2/18/2016
25	Marta Harting, Esq., submitted request that MHCC provide clarification as to the basis for the appointment of a Reviewer with regard to this CON application and COMAR 10.24.01.10D(2).	2/24/2016
26	Gregory Wm. Branch, M.D, Director and Health Officer, submitted notification that the Baltimore County Health Department "choose not to comment on this proposed project."	3/8/2016
27	John Brennan, Esq., submitted via email the intention of LifeBridge Health "to respond to Hopkins' evidentiary hearing pleading and follow up letter concerning the reviewer."	3/8/2016
28	John Brennan, Esq., submitted LifeBridge Health's reply "to Applicant's Opposition to Its Request for Evidentiary Hearing and/or Oral Argument and Reply to Applicant's (sic) Letter Opposing the Commission's Appointment of a Reviewer in this Case."	3/15/2016

29	Marta Harting, Esq., submitted the Applicant's reply to LifeBridge Health's response "to Applicant's Request for Clarification Concerning Appointment of Reviewer."	3/25/2016
30	Ben Steffen, Executive Director, submitted his determination that "the appointment of a Commissioner to serve as the reviewer of a contested application to establish an ambulatory surgical facility is permitted and appropriate."	3/30/2016
31	John T. Brennan, Jr., Esq., provided notice that Crowell & Moring, LLP, has withdrawn its representation of LifeBridge health, Inc. in this matter. Joel Suldan, Vice President and General Counsel, LifeBridge Health, Inc. is the future contact on this matter.	6/24/2016
32	Joel, I. Suldan, Esq., Vice President and General Counsel, submitted notice that LifeBridge Health withdraws its opposition to the JHSCS' Green Spring Station Surgery Center.	7/26/2016
33	Jeffrey Metz notified Marta D. Harting, Esq., with LifeBridge Health's withdrawal as interested party, he would not continue as the Reviewer in JHSCS' application.	7/27/2016
34	E-mail from Anne Langley in response to MHCC follow-up on information regarding charges.	9/13/2016

MARYLAND HEALTH CARE COMMISSION

APPENDIX 2:

**Excerpted CON standards for
COMAR 10.24.11, General Surgical Services**

Appendix 2: Excerpted CON Standards for General Surgical Services

From State Health Plan Chapter 10.24.11

Each of these standards prescribes policies, services, staffing, or facility features necessary for CON approval that MHCC staff have determined the applicant has met. Bolding added for emphasis. Also included are references to where in the application or completeness correspondence the documentation can be found.

<u>STANDARD</u>	<u>APPLICATION REFERENCE (Docket Item #)</u>
<p>(4) <u>Design Requirements.</u></p> <p><i>Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.</i></p> <p><i>(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.</i></p> <p><i>(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.</i></p>	<p>DI #4, Exhibit 16</p>
<p>(5) <u>Support Services.</u></p> <p><i>Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.</i></p>	<p>DI #4, p. 71</p>

MARYLAND HEALTH CARE COMMISSION

APPENDIX 3:

Retained Referral Projections by Specialty

FY 2018 through FY 2020

FY 2018 Referral Retention Rate at 71.8%

	Total FY 2014 Referrals	Referred to JHM	FY 2014 Retention Rate	Expected Referrals to JHM at 71.8%	Potential Additional FY 2014 Referrals	Referrals: Case*	Potential Additional FY 2014 Cases	Population Change 2015-2018	2018 Retained Cases w Pop Growth
Podiatry	2,508	2,176	86.8%	1,800	-376	10.0	-	-	-
Gynecology	1,586	1,328	83.7%	1,138	-190	20.0	-	-	-
Neurosurgery	348	283	81.3%	250	-33	5.1	-	-	-
Otolaryngology	2,719	2,012	74.0%	1,951	-61	2.6	-	-	-
Vascular	508	347	68.3%	365	18	3.1	6	2.9%	6
Orthopaedic	6,920	4,322	62.5%	4,965	643	3.0	214	2.9%	220
Breast	186	84	45.2%	133	49	1.5	33	3.3%	34
General	1,570	493	31.4%	1,127	634	3.7	171	2.9%	176
Plastic	182	57	31.3%	131	74	2.8	26	2.9%	27
Urology	2,557	717	28.0%	1,835	1,118	4.0	279	2.9%	287
Total	19,084	11,819	61.9%	13,702	1,883		729		750

FY 2019 Referral Retention Rate at 79.0%

	Total FY 2014 Referrals	Referred to JHM	FY 2014 Retention Rate	Expected Referrals to JHM at 79.0%	Potential Additional FY 2014 Referrals	Referrals: Case*	Potential Additional FY 2014 Cases	Population Change 2015-2019	2019 Retained Cases w Pop Growth
Podiatry	2,508	2,176	86.8%	1,981	-195	10.0	-	-	-
Gynecology	1,586	1,328	83.7%	1,253	-75	20.0	-	-	-
Neurosurgery	348	283	81.3%	275	-8	5.1	-	-	-
Otolaryngology	2,719	2,012	74.0%	2,148	136	2.6	52	3.9%	54
Vascular	508	347	68.3%	401	54	3.1	18	3.9%	19
Orthopaedic	6,920	4,322	62.5%	5,467	1,145	3.0	382	3.9%	397
Breast	186	84	45.2%	147	63	1.5	42	4.4%	44
General	1,570	493	31.4%	1,240	747	3.7	202	3.9%	210
Plastic	182	57	31.3%	144	87	2.8	31	3.9%	32
Urology	2,557	717	28.0%	2,020	1,303	4.0	326	3.9%	339
Total	19,084	11,819	61.9%	15,076	3,257		1,053		1,095

FY 2020 Referral Retention Rate at 85.0%

	Total FY 2014 Referrals	Referred to JHM	FY 2014 Retention Rate	Expected Referrals to JHM at 85.0%	Potential Additional FY 2014 Referrals	Referrals: Case*	Potential Additional FY 2014 Cases	Population Change 2015-2020	2020 Retained Cases w Pop Growth
Podiatry	2,508	2,176	86.8%	2,132	-44	10.0	-	-	-
Gynecology	1,586	1,328	83.7%	1,348	20	20.0	1	5.6%	1
Neurosurgery	348	283	81.3%	296	13	5.1	3	4.9%	3
Otolaryngology	2,719	2,012	74.0%	2,311	299	2.6	115	4.9%	121
Vascular	508	347	68.3%	432	85	3.1	27	4.9%	28
Orthopaedic	6,920	4,322	62.5%	5,882	1,560	3.0	520	4.9%	546
Breast	186	84	45.2%	158	74	1.5	49	5.6%	52
General	1,570	493	31.4%	1,335	842	3.7	227	4.9%	238
Plastic	182	57	31.3%	155	98	2.8	35	4.9%	37
Urology	2,557	717	28.0%	2,173	1,456	4.0	364	4.9%	382
Total	19,084	11,819	61.9%	16,221	4,402		1,341		1,408

Source: DI #4, p. 50

*From DI #4, p. 45.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 4:

MVS BENCHMARK VALUE CALCULATIONS AND ANALYSIS

GSSSC MVS BENCHMARK VALUE CALCULATIONS

GSSSC MVS Benchmark Value	New Construction	
Class	A	
Type	good	
Square Footage (sq. ft.)	27,238	
Perimeter (ft.)	1,027	
Wall Height (ft.)	15.33	
Stories	1	
Average Area Per Floor (sq. ft.)	27,238	
	ASC	MOB
Net Base Cost	\$ 369.05	\$ 229.45
Elevator Add-on	0	0
Adjusted Base Cost	\$ 369.05	\$ 229.45
Departmental Cost Diff.	1	0.5
Gross Base Cost	\$ 369.05	\$ 114.73
Perimeter Multiplier (a)	0.943	0.943
Story Height Multiplier (b)	1.077	1.077
Multi-story Multiplier (c)	1	1
Multipliers (a * b* c)	1.016	1.016
Refined Square Foot Cost	\$ 374.98	\$ 116.57
Sprinkler Add-on	0	0
Adjusted Refined Square Foot cost	\$ 374.98	\$ 116.57
Current Cost Modifier (d)	1.02	1.02
Local Multiplier (e)	1.02	1.02
CC x Local Multipliers (d * e)	1.040	1.040
MVS Building Cost Per Sq. Ft.	\$ 390.13	\$ 121.28
GSSSC MVS Building Cost Per Sq. Ft.	\$268.85	

Source: DI #14, Question #9, pp. 132-137, and Marshall Valuation Service.

Analysis and Discussion

This standard requires a comparison of the project's estimated construction cost with an index cost derived from the Marshall Valuation Service ("MVS") guide. For comparison, an MVS benchmark cost is typically developed for new construction based on the relevant construction characteristics of the proposed project. The MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses including outpatient surgical centers. The MVS guide also includes a variety of adjustment factors, including adjustments of the base costs to the costs for the latest month, the locality of the construction project, as well as factors for the number of building stories, the height per story, the shape of the building (such as the relationship of floor area to perimeter), and departmental use of space. The MVS Guide also identifies costs that should

not be included in the MVS calculations. These exclusions include costs for buying or assembling land, making improvements to the land, costs related to land planning, discounts or bonuses paid for through financing, yard improvements, costs for off-site work, furnishings and fixtures, marketing costs, and funds set aside for general contingency reserves.¹⁵

In addition to the typical adjustment to the base cost provided in the MVS guide, an adjustment is required to account for the fact that the project budget only includes the cost of finishing the space in a medical office building. Staff considered the two methods used by JHSCS to make this adjustment and found them less than ideal. The basic weakness in method 2 is that JHSCS calculated the square foot cost of the shell based on a generic medical office building and used the results to adjust a benchmark developed for the specific characteristics of the proposed project. While JHSCS compensated for this weakness in method 1 by calculating the proportion of the square foot cost of a generic surgical center attributable to the shell and multiplying the benchmark for GSSSC by that proportion, staff found this method unnecessarily complex.

Therefore, staff calculated a benchmark for the proposed project using the most recent MVS base costs (November, 2015)¹⁶ for a Class A-B outpatient surgical center and Class A MOB both adjusted for the shape and height of the proposed GSSSC.¹⁷ These costs were updated to July 2016 using the MVS current cost multiplier and to Baltimore using the July 2016 local multiplier. The benchmark does not include a sprinkler add-on as is usually done because the landlord and not JHSCS is responsible for installing the sprinkler system as part of lease for the space. Staff did not include such an add-on to the benchmark for the MOB, as was done by JHSCS, because to do so would have produced too low of a benchmark for finishing the shell space. Since the applicant did not provide any information on the type of sprinkler system installed for the building, the cost for this system was not included with the benchmark costs. The result is a benchmark cost of \$268.85 per square foot for the proposed project. This is \$4.65 per sq. ft. more than the applicant's method 1 and \$2.77 per sq. ft. more than applicant's method 2. While some of this difference is attributable to the differences in methodology, most is a result of using the latest base costs and update factors from MVS that were not available to the applicant at the time the CON application was prepared.

A comparison of GSSSC's estimated cost for finishing the space for the proposed facility to the calculated MVS benchmarks is detailed in the following table.

¹⁵ Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2016).

¹⁶ The applicant used the prior November 2013 base costs

¹⁷ Please see Appendix 4 for my MVS calculations.

**Table 9: Comparison of GSSSC's
Construction Budget to Marshall Valuation Service Benchmark**

Project Construction Costs	Construction
Building	\$ 7,009,541
Fixed Equipment	0
Site Work	0
Architect/Engineering Fees	211,000
Permits	10,000
Capital Construction Interest	\$0
Total Construction Costs	\$ 7,230,541
<hr/>	
Square Feet ("SF")	27,238
Cost Per SF	\$265.46
Benchmark (Adj. MVS Cost/SF for finishing the space)	\$268.85
Over(Under)	(\$3.40)
Percent Under Benchmark	(1.3%)

Source: DI #14, Question #9, pp. 132-137, and Marshall Valuation Service.

The standard requires that an applicant's ambulatory surgery center whose projected cost per square foot exceeds the MVS benchmark cost for good quality Class A construction by 15% or more demonstrate that the construction costs are reasonable. Because the project's construction cost is about 1.3% below the MVS benchmark no such demonstration is required. Therefore, Staff finds the application consistent with this standard.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 5:

COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

Docket No.	Project Description	Project Costs	Status
Johns Hopkins Hospital			
#02-24-2110	Implement state-of-art patient care information systems, Clinical Information System, Operating Room Management System, and Anesthesia Data Record.	\$27,057,596	Complete and granted first-use approval
#03-24-2119	Renovations to exterior of Billings, Wilmer, Marburg, and Phipps buildings; rehabilitation of the steam generating plant; replace 2 electrical chillers; and replace emergency electric engine generators.	\$25,649,233	Complete and granted first-use approval
#03-24-2123	<p>New Construction: Construct two 10-story "clinical towers" which will have MSGA, pediatric, obstetric, and acute psychiatric nursing units totaling 515 beds, replace adult and pediatric EDs with expansion of service capacity to 104 treatment spaces, including observation beds; replace and expand surgical facilities with 30 ORs in new construction and a net increase of 6 ORs, replace and expand diagnostic imaging and invasive procedure facilities.</p> <p>Renovation: Renovate space in eight existing buildings (Blalock, Children's Center, Marburg, Meyer, Nelson/Harvey, Halsted, Osler (basement only), Park (basement only), and Phipps) for hospital use.</p> <p>Demolition: Demolish all or part of ten existing buildings. The hospital will have a physical capacity of 959 beds upon completion of the project.</p> <p>Modification #1: 5/18/06 - Changes to physical plant design to reconfigure and add floors to the new clinical towers; and change project budget from \$577,774,237 to \$801,926,392 (increase of \$224,152,155).</p> <p>Modification #2: 2/21/08 - Increase capital costs from \$801,926,392 to \$1,054,234,941 (increase of \$252,308,549).</p>	\$1,054,234,941	Partial first use review and approval for Phase 2 of Project

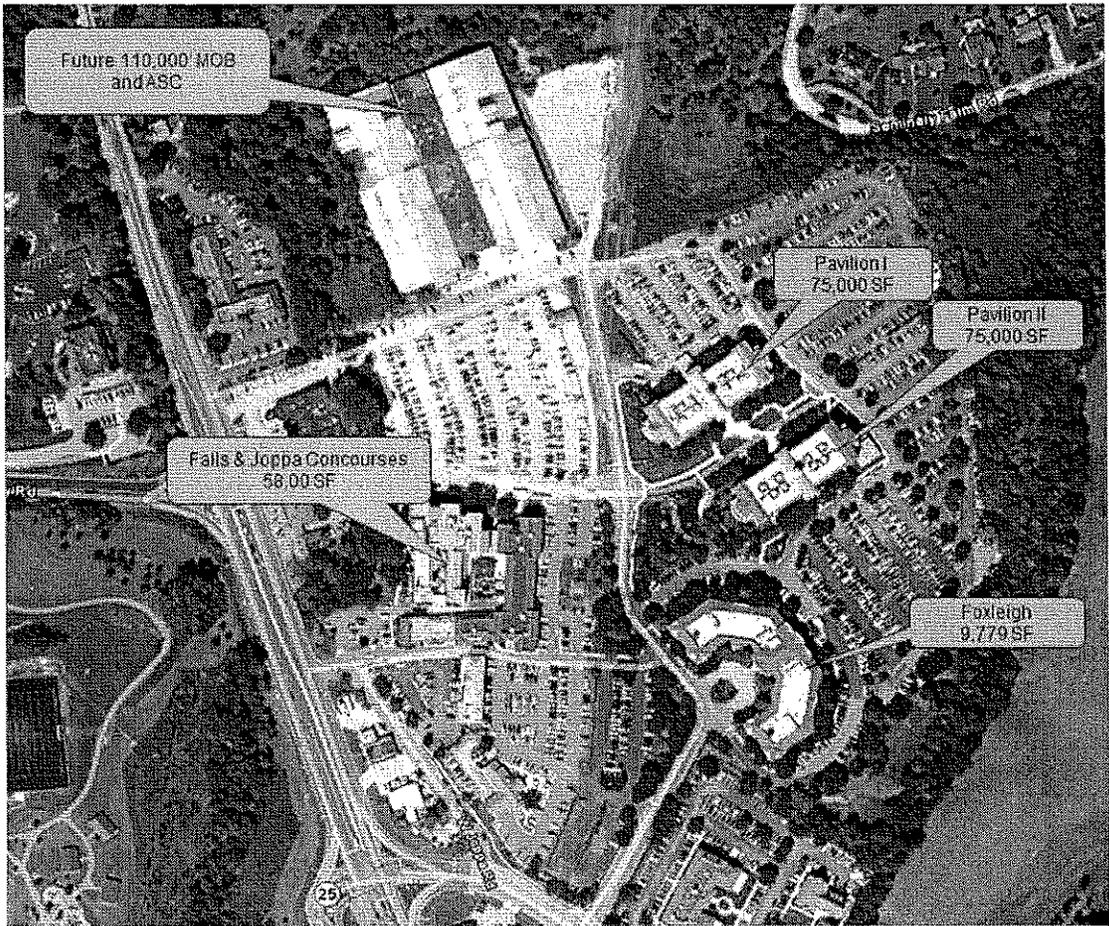
	Modification #3: 7/15/20 - Modify condition placed on original CON on dates to provide schematic design drawings to extend filing period by one year.		
#07-24-2189	Relocate 6 ORs from the hospital to a new building constructed at the corner of Broadway and Orleans Street.	\$20,940,177	Complete and granted first-use approval
#11-24-2320	Wilmer Eye Institute - Expansion of outpatient special-purpose OR capacity in the Bendann Outpatient Surgical Center by one OR.	\$1,430,037	Complete and granted first-use approval
Docket No.	Project Description	Project Costs	Status
Johns Hopkins Bayview Medical Center			
#05-24-2165	Construction of 4 new mixed-use ORs in general OR suite; relocation and redesign of the pre- and post-operative areas and support areas; relocation and redesign of the waiting areas; and construction of a mechanical penthouse. Modification #1: Increase capital cost of \$8,036,129 and a change in design.	\$17,862,708	Replaced by CON Docket No. 08-24-2289
#08-24-2289	Construction of 4 new mixed-use ORs in general operating suite. 5/22/09 - Partial Prelicensure for only 1 OR.	\$24,352,934	Complete and granted first-use approval
#11-24-2322	Creation of comprehensive cancer program.	\$26,057,437	Complete and granted first-use approval
#11-24-2321	Capital project for expansion of the emergency department.	\$40,098,889	Complete and granted first-use approval

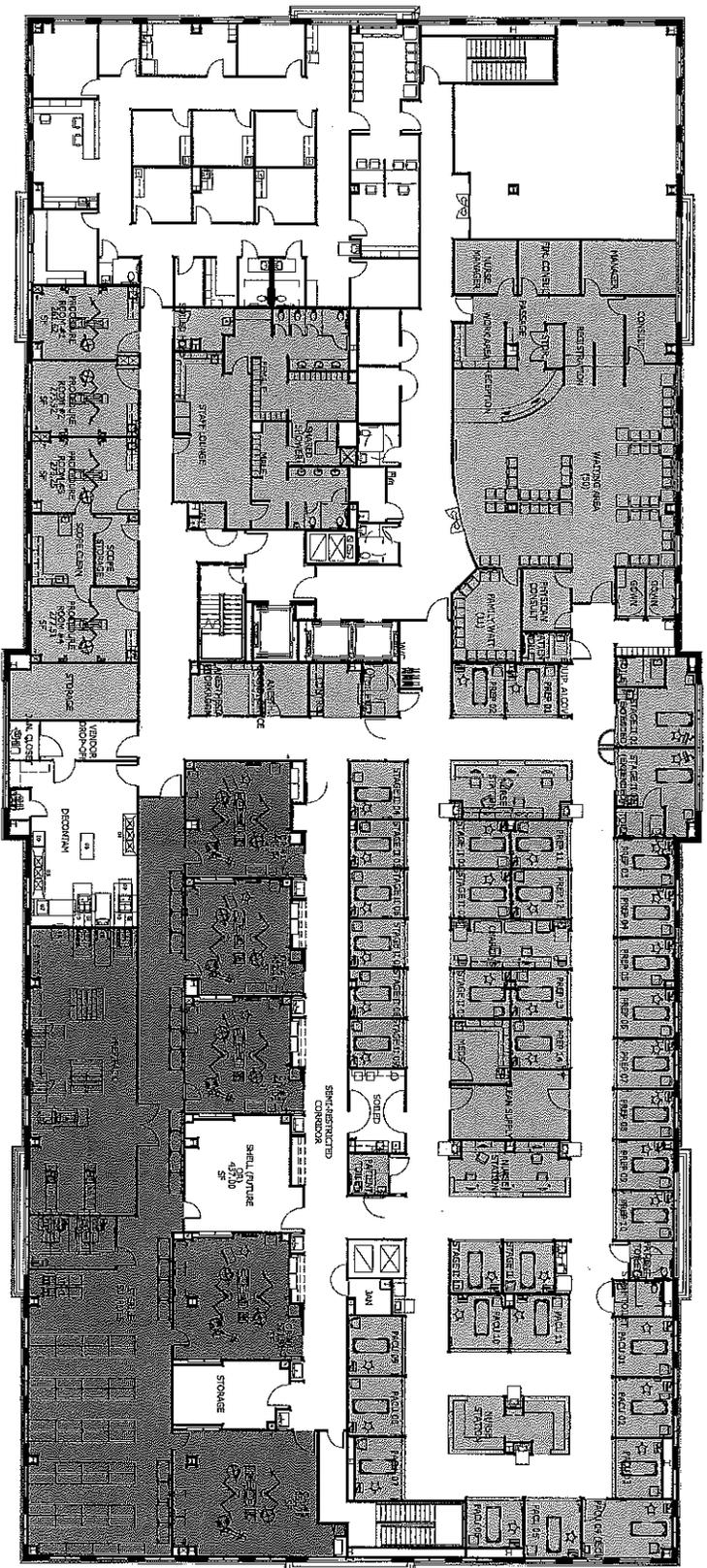
Source: MHCC Certificate of Need Status Report - Commission Decisions

MARYLAND HEALTH CARE COMMISSION

APPENDIX 6:

Site Plan and Floor Plan





Green Spring Station Surgery Center

CON Submission
August 7, 2015

WILMOT SANZ
ARCHITECTURE
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