STATE OF MARYLAND

Robert E. Moffit, Ph.D.
CHAIRMAN

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

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

MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: November 16, 2017

SUBJECT: Bethesda Chevy Chase Surgery Center, LLC.
Docket No. 17-15-2401

Enclosed is the staff report and recommendation on a Certificate of Need ("CON") application filed by Bethesda Chevy Chase Surgery Center, L.L.C. ("BCCSC").

BCCSC is a physician outpatient surgical center, performing orthopaedic, neurosurgery, and pain management services in Bethesda (Montgomery County) that was established in 2010.[1] It has one operating room ("OR") and one non-sterile procedure room. BCCSC proposes to establish itself as an ambulatory surgical facility by adding a second operating room.

The estimated project cost is $1,759,618.

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, and with other applicable CON review criteria in COMAR 10.24.01.08.

[1] A "physician outpatient surgical center" is defined in the Surgical Services Chapter as an ambulatory surgical center that operates no more than one sterile operating room. Such surgical centers can be established without CON review and approval.

IN THE MATTER OF	*	**BEFORE THE**
	*	
BETHESDA CHEVY CHASE	*	**MARYLAND HEALTH**
	*	
SURGERY CENTER, L.L.C.	*	**CARE COMMISSION**
	*	
Docket No. 17-15-2401	*	

* *

Staff Report and Recommendation

November 16, 2017

(released November 9, 2017)

TABLE OF CONTENTS

I. INTRODUCTION

A. The Applicant

Bethesda Chevy Chase Surgery Center, LLC ("BCCSC" or "the Center") is a physician outpatient surgery center ("POSC") with one operating room ("OR") and one non-sterile procedure room located at 6931 Arlington Road, Suite E, in Bethesda (Montgomery County). The Center performs orthopaedic and neurosurgical procedures and also provides pain management services. The Commission issued a determination of coverage to establish this POSC on September 20, 2010. POSCs may be established in Maryland without CON review and approval.[2]

BCCSC is owned by: Surgical Center Development #3, LLC (33.8%); and by 16 physicians and one single-physician-owned LLC (ownership interests range from .97% to 6.28%). The Center draws patients from Montgomery County, Frederick County, and Prince George's County in Maryland and also serves patients residing in Washington, D.C. and northern Virginia. This service area reflects the office locations of the physicians who staff the Center.

B. The Project

The proposed project will renovate and convert the existing procedure room at BCCSC to create a second sterile OR. It will also include renovation of the adjacent space to create a replacement non-sterile procedure room. Upon completion, the facility will have two operating rooms and one procedure room. The Center reports that growth in demand for surgery and projected additions of surgeon practitioners are the bases for the proposed expansion of the center.

BCCSC has placed additional adjacent space (3,027 square feet) under lease to allow for the project. (DI #2, Exhibit 5). The total estimated capital cost of the project is $1,759,618, which the applicant plans to fund with $620,618 in cash and a $1,139,000 loan. The project is expected to take six months to complete.

II. PROCEDURAL HISTORY

A. Record of the Review

Please see Appendix 1, Record of the Review.

---

[2] Individuals or organizations seeking to establish a facility with only one operating room or no operating rooms (i.e., with one or more non-sterile procedure rooms) are required to receive a determination of coverage from the Maryland Health Care Commission confirming that a Certificate of Need is not required. COMAR 10.24.01.05A(5) identifies the requirements needed to establish a physician outpatient surgery center or POSC; COMAR 10.24.11 contains the standards for establishment of an "ambulatory surgical facility," which has two or more operating rooms and requires certificate of need approval by the Commission.
(http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_amsurg/documents/con_notification_requirements_ambsurg_coverage_20130821.pdf)

B. Interested Parties

There are no interested parties in this review.

C. Local Government Review and Comment

No comments were received regarding this project.

D. Community Support

Six letters of support were received for this project; four from surgeons credentialed at BCCSC, and two from patients who have received services at BCCSC. (DI#9, Exhibit 21)

III. STAFF REVIEW AND ANALYSIS

The Commission reviews 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 ("SHP") regulations for review of this project are found in the General Surgical Services Chapter, COMAR 10.24.11 ("Surgical Services Chapter").

COMAR 10.24.11.05 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.

BCCSC reports that it provides information regarding charges for the range and types of services it provides, upon request. A copy of BCCSC's Facility Fee Schedule was submitted with its CON application. (DI #2, Exh. 6).

BCCSC complies with this standard.

(2) Charity Care Policy

(a) Each hospital and ASF 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:

BCCSC submitted a copy of its policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and provides ambulatory surgical services on a charitable basis to qualified indigent persons consistent with the charity care standard. (DI #9, Exh. 16).

(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.

The applicant's Financial Assistance Policy includes a provision that a determination of probable eligibility for financial assistance will be made within two business days to a patient who submits an application for financial assistance or for reduced fee arrangements.

(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.

BCCSC states that public notice of its financial assistance policy will be disseminated, on an annual basis via the Washington Post and that its policy is also posted on its website, located at: http://www.bethesdaccsc.com/files/items/charity-care-policy-for-bccsc.pdf. (DI #9, Exh. 16, and DI #17). Notices regarding the policy are also posted in the Admissions and Business Offices (DI #9, Exh. 16). In compliance with the charity care policy, BCCSC states that it addresses any financial concerns of patients prior to a patient's arrival for surgery. (DI #9, Exh. 16).

(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.

BCCSC's Financial Assistance Program policy includes the following income eligibility guidelines, which meet the benchmarks set by the standard:

> Persons with a family income below 100% of the current federal poverty level are eligible for services free of charge; and
>
> Persons with incomes above 100% but below 200% of the current federal poverty level are eligible for services discounted on a sliding scale.
> (DI#9, Exhibit 16).

(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.

As a POSC, BCCSC had no charity care obligation. However, BCCSC's financial records indicate that it provided charity care in the amount of 0.15% and 0.46% of total operating expenses in 2015 and 2016 respectively. (DI #2, pp.18-19). As an applicant BCCSC states a commitment to provide charitable surgical services to indigent patients at a level that is at least equivalent to the average amount of charity care provided by ASFs in the most recent year reported. That amount is currently 0.46% of total operating expenses.

BCCSC has demonstrated compliance with the Charity Care standard.

Standards .05A(3) Quality of Care, .05A(4) Transfer Agreements, and .05B(4) Design Requirements.

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 the following standards:

.05A(3) Quality of Care,
.05A(4) Transfer and Referral Agreements, and
.05B(4) Design Requirements,

Staff has concluded that the proposed project meets the requirements of these standards. The applicant is licensed, in good standing, with the Maryland Department of Health; is in compliance with the conditions of participation of the Medicare/Medicaid program; and is accredited by the Accreditation Association for Accreditation of Ambulatory Surgical Facilities.[3] BCCSC has a written transfer agreement with Suburban Hospital, and the applicant states that the facility is designed in compliance with Section 3.7 of the 2014 Facilities Guideline Institute's Guidelines for Design and Construction of Healthcare Facilities. The text of these standards and the locations within the application where compliance is documented are attached as Appendix 2.

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.

BCCSC defined its existing service area as the zip code areas from which the first 75% of its discharges originated. That service area includes zip code areas in Montgomery County, Prince George's, and Frederick Counties in Maryland, District of Columbia zip code areas, and Fairfax and Arlington County zip code areas in Virginia. (DI #2, pp.21-24). Residents of Montgomery County and the District of Columbia account for approximately half of the facility's case volume.

The applicant meets 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 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 of 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:

[3] Barbara Fagan, who oversees ambulatory care facility licensure for the Maryland Department of Health, informed MHCC staff that BCCSC is licensed in good standing, with no outstanding deficiencies or problems, and is in compliance with the conditions of participation of the Medicare and Medicaid programs. (DI #10).

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii)In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

This standard is not applicable as this proposed project does not involve the establishment of surgical capacity at a hospital.

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

(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.

To meet this standard, the applicant must demonstrate that the existing OR was utilized optimally over the past 12 months and that the expanded two-OR capacity is likely to be used at optimal capacity[4] or higher levels of use within three years of the completion of the project. BCCSC provided historical and projected data on surgical volume to demonstrate its ability to meet this standard, which is examined below.

Volume trends and projections

BCCSC's operating room case volume grew from 1,199 in 2012 to 1,335 in 2016 and it projects OR volume to grow to 1,871 cases by 2020. BCCSC attributes its current and projected growth to:

- **Extending the Hours of Operation:** In order to meet the current demand for OR time, BCCSC has extended its hours of operation from 5:30 am to 7:00 pm during the week and is also scheduling cases on Saturday.

[4] "Optimal capacity" is defined in the General Surgical Services Chapter, COMAR 10.24.11.06A(1)(b), as 80% of "full capacity use." "Full capacity" (for a general purpose outpatient OR) is defined as operating for a minimum of 255 days per year, eight hours per day, which results in an available full capacity of 2,040 hours per year. Thus, optimal capacity is 1,632 hours per year.

- **Inclusion in more insurance plans:** BCCSC has augmented the number of commercial insurers it contracts with, adding United Healthcare in January 2017 and Cigna in March 2017, and states that it anticipates going in-network with Aetna before the end of 2017. (DI #2, pp. 26-27).

- **Growth in the Number of Providers.** Two orthopedic surgeons were credentialed at BCCSC in the Fall of 2017, bringing the total number of credentialed surgeons to nineteen. These two surgeons each currently perform three to four outpatient surgical cases per week at a number of hospitals in northern Virginia, and both plan to bring all of their outpatient cases to BCCSC. (DI #2, p. 27).

Table III-1, below, presents BCCSC's recent and projected surgical volume and room utilization statistics.

Table III-1: Historic and Projected OR Utilization at BCCSC, CY 2015-2020

Year	OR Cases	Operating Room and OR Cleaning/Preparation Time (Hours)			Historic and Projected OR Time as % of		ORs	ORs Needed
		Surgical Time	Turnover Time	Total Time	Full Capacity[1]	Optimal Capacity[1]		
2015	1,342	1,959	559	2,518	123%	154%	1	**1.54**
2016	1,335	1,763	556	2,319	114%	142%	1	**1.42**
2017 projected	1,521	2,114	568	2,682	66%	82%	2	**1.64**
2018 projected	1,831	2,546	573	3,119	76%	96%	2	**1.91**
2019 projected	1,851	2,573	579	3,152	77%	97%	2	**1.93**
2020 projected	1,871	2,601	584	3,185	78%	98%	2	**1.95**

Source: DI #2, p.27.
[1]COMAR 10.24.11.06A(1)(b) provides that a dedicated outpatient operating room utilized at full capacity is 2,040 hours per year, and at optimal capacity of 80 percent of full capacity is 1,632 hours per year, which includes the time during which surgical procedures are performed and room turnaround (turnover) time between surgical cases.

BCCSC operated at 154% of optimal capacity in 2015 and 142% of optimal capacity in 2016 by extending its hours of operation. It projects an ability to increase its OR case load from 1,335 in 2016 to 1,871 in 2020 (an increase of approximately 40%) with the addition of a second OR, based on the addition of providers and an expansion of the number of insurers with whom the facility and its providers will be recognized as in-network.

The project's proposed addition of a second OR is consistent with this standard.

(3) Need - Minimum Utilization for the Expansion of Existing Facilities
An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall . . .

This standard is not applicable. The proposed project involves establishment of an ambulatory surgical facility through expansion of a POSC.

(5) Support Services.
Each applicant shall agree to provide, either directly or through contractual agreements, laboratory, radiology, and pathology services.

The applicant states that it will continue providing laboratory, radiology, and pathology services, either directly or through contractual agreements with GenPath and Bio-Reference Laboratories, Inc. (DI #2, p.28; DI #9, p.3).

(6) 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;

The applicant states that the room design will maintain the recommended clearances and space requirements outlined in the FGI Guidelines. It notes that patient safety modifications will include adjusting the heating, ventilation, and air conditioning systems to control air flow and temperature in the new OR. The applicant states that it will assure that the medical gases, call systems, and power system meet the applicable FGI requirements. (DI#2, p.29).

Staff concludes that the applicant has demonstrated that the planning of the proposed renovation took patient safety into account, and recommends that the Commission find that the applicant has met the requirements of this standard.

(7) 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.

Paragraph (b) of this standard requires a comparison of the project's estimated construction cost with a benchmark (i.e., expected) cost derived using the Marshall Valuation Service ("MVS") Guide. For a more complete explanation of the Marshall Valuation System and how a benchmark is calculated, see Appendix 3.

The methodology of making this comparison is as follows:

- Step 1: arrive at an *adjusted project cost* (i.e., adjusted for the costs MVS allows);
- Step 2: Develop an MVS benchmark, using the rules defined in the MVS Guide;
- Step 3: Compare the adjusted project cost as calculated with the MVS benchmark.

As applied to this project:

Step 1: Both BCCSC and MHCC staff performed independent analyses comparing the applicant's estimated project cost to the MVS benchmark calculated for the proposed project. (See Appendix 3) The applicant calculated the adjusted project cost to be $421.87 per square foot ("SF"), while MHCC staff calculated a value of $421.64 per SF. The small difference between these respective adjusted project costs is that BCCSC mistakenly included the entire $3,000 of Loan Placement Fees instead of the share of those costs that are attributable to the allowable cost categories as defined by MVS. (See Table A in Appendix 3.)

Step 2: BCCSC and MHCC staff arrived at different MVS benchmark values, BCCSC calculating it at $440.53 per SF and MHCC staff calculating it to be $509.70 per SF (see Table B in Appendix 3). The difference is attributable to the method used by each to account for the renovation work that will occur in existing space. MHCC staff arrived at its value by subtracting the cost per square foot related to the shell of the renovated space (since it was already existing and not built as part of this project) from the total renovation cost. The applicant arrived at its benchmark value by subtracting 50% of the total cost on the apparent rationale that half of the construction cost is attributable to the shell.

Step 3: MHCC staff's analysis found the estimated project cost to be $88.06 per SF (about 17.3%) below its calculated MVS benchmark, while BCCSC calculated the project costs to be $18.66 per SF (about 4.2%) below the MVS benchmark (Table C in Appendix 3). In each case, the project came in within the bounds of the construction cost standard.

The applicant has met this standard.

(8) 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;

BCCSC states that it based its projected utilization on its historic physician utilization trends and population growth.

(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;

Revenue estimates are based on the utilization projections and current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity provisions as experienced by BCCSC.

(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

Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and anticipated future staffing needs to meet growth at BCCSC.

(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.

BCCSC reported net income of $6,339,582 in 2015 and $5,338,262 in 2016. As shown in Table III-2 below, BCCSC projects that net income will continue to grow at an increasing rate over the first three years following implementation of the project. (DI #9, Exh. 19, Table 3).

Table III-2: BCCSC Net Operating Revenues and Operating Expenses CY 2015-2020

	Actual		Projected			
	2015	2016	2017	2018	2019	2020
Cases	1,342	1,335	1,521	1,831	1,851	1,871
Net Revenue	$11,957,421	$10,736,698	$11,536,029	$13,886,873	$14,038,230	$14,189,832
Expenses	$5,617,839	$5,399,085	$6,040,704	$7,074,456	$7,119,199	$7,204,849
Net Income	***$6,339,582***	***$5,338,262***	***$5,495,325***	***$6,812,417***	***$6,919,031***	***$6,984,983***

Source: DI #9, Exh. 19, Table 3.

BCCSC complies with this standard.

(9) Preference in Comparative Review

This is not a comparative review, so this standard does not apply.

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.

This criterion directs the Commission to consider the "applicable need analysis in the State Health Plan," which, in this instance, is found in the Surgical Services Chapter at COMAR 10.24.11.05B(2), Need–Minimum Utilization for Establishment of a New or Replacement Facility . As previously outlined and supported by the data provided in Table III-1, the proposed project is consistent with the Chapter's need standard for OR additions.

Staff has concluded that the applicant has provided documentation that its volume projections are reasonable, and that two operating rooms are likely to be used at or very close to optimal capacity levels within three years of expansion of the center. Staff recommends that the Commission find that the applicant has demonstrated a need for the project.

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.

The alternatives to the proposed project reviewed by the applicant were: providing services at an alternate location, such as a new POSC, or continuing to expand service capacity through further extension of hours of operation. As for alternate sites, the applicant found no other sites of adequate size available in the same building, and the cost associated with constructing a new facility was estimated to be more than $2 million, which exceeds the cost of the proposed project. BCCSC rejected the alternative of continuing with extended hours because of its budgetary impact, which would require extensive overtime at premium pay rates and/or the hiring of additional personnel. (DI #9, p. 4).

Staff concludes that the applicant has made a reasonable demonstration that the decision to renovate and convert an existing procedure room into a second OR and constructing a procedure room is the most cost effective alternative for meeting the applicant's goals. The capital cost is well within the benchmarks calculated for this kind of project, and the project provides BCCSC with additional OR space to meet the demands associated with current volumes, the addition of practitioners and anticipated growth in case volume.

Staff recommends that the Commission find the project to be the only practical alternative available to BCCSC.

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 estimate is $1,759,618 and 1would be funded with $620,618 in cash and a $1,139,000 loan. In lieu of audited financials, the applicant provided a letter from PKS& Company, P.A., Certified Public Accountants, attesting to the availability of sufficient cash flow for the equity portion of project funding and a letter from Durbin P. Vido, Senior Vice President, at SunTrust attesting to the bank's interest in the debt financing component.[5] (DI #9, Exh. 20; DI #2, Exh. 12).

The applicant submitted six letters of support for this project, four from surgeons credentialed at BCCSC, and two from patients. (DI #9, Exh. 21).

The applicant has demonstrated that it has the financial resources and other support needed to undertake this project.

Availability of Resources to Sustain the Proposed Project

Table III-3 below is the applicant's projection of incremental revenues and expenses associated with the additional operating room. As discussed earlier in the Financial Feasibility standard, MHCC staff concluded that these projections were supported by reasonable and well-documented assumptions.

Table III-3: BCCSC Projected Revenues and Expenses
Proposed Project Only, CY 2018-2020

Revenue	CY 2018	CY 2019	CY 2020
Gross Service Revenue	$42,874,517	$43,341,849	$43,809,941
Contractual Allowance	(35,916,286)	(36,307,907)	(36,700,067)
Charity Care	(15,280)	(15,313)	(15,444)
Other Operating Revenues	486	486	486
Net Operating Revenues	**$6,943,436**	**$7,019,114**	**$7,094,916**
Expenses			
Salaries, Wages, and Pro. Fees	$1,158,503	$1,158,503	$1,158,503
Contractual Services	137,723	139,224	154,260
Interest on Project Debt	27,481	21,847	16,005

[5] The anticipated terms of the loan would be six years at an interest rate of 4.15% (fixed) and a repayment schedule of interest draw in the first year, followed by 60 months of principal and interest payments.

Current Depreciation	16,542	9,397	8,338
Project Depreciation	69,297	69,297	69,297
Current Amortization	4,859	4,859	4,859
Supplies	1,641,649	1,659,542	1,677,466
Other Expenses	481,176	496,931	513,698
Total Operating Expenses	**$3,537,228**	**$3,559,600**	**$3,602,424**
Income			
Net Income from Operations	**$3,406,209**	**$3,459,515**	**$3,492,492**

Source: DI #9, Exh. 19, Table 4.

With the completion of the renovations, BCCSC expects to hire an additional 1.0 FTE nurse and 1.0 FTE scrub tech at a cost of $224,225 in salaries and benefits.

Staff concludes that the proposed project is financially 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 criterion is not applicable as the applicant has not pursued a CON prior to this application.

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.

BCCSC stated that the expansion proposed will not adversely impact other existing providers in any significant way since it serves to meet volumes experienced by BCCSC. This project will allow the established surgeons an opportunity to schedule cases during normal business hours. The two new surgeons would shift only a small number of patients from a number of other surgical sites, with negligible impact on these facilities. There would be very little impact on the volumes or payor mix of other providers.

Staff concludes that the impact of this project is positive for BCCSC and that it will not have a substantial negative impact on existing providers or on the cost of care.

IV. SUMMARY AND STAFF RECOMMENDATION

Based on its review of the proposed project's compliance with the Certificate of Need review criteria in COMAR 10.24.01.08G(3)(a)-(f) and the applicable standards in COMAR 10.24.11, the General Surgical Services Chapter of the State Health Plan, Commission staff recommends that the Commission approve the project. It complies with the applicable State Health Plan standards, is needed by BCCSC to handle existing and anticipated growth in demand, is a cost-effective approach to meeting the project objectives, is financially viable, and will have a positive impact on the applicant's ability to provide outpatient surgery without adversely affecting costs and charges or other providers of surgical care.

Accordingly, Staff recommends that the Commission **APPROVE** the application of the Bethesda Chevy Chase Surgery Center, LLC for a Certificate of Need authorizing the establishment of an ambulatory surgical facility through the addition of a second operating room by converting an existing non-sterile procedure room to a sterile operating room, and construction of a procedure room using currently leased space.

IN THE MATTER OF	*	**BEFORE THE**
	*	
BETHESDA CHEVY CHASE	*	**MARYLAND HEALTH**
	*	
SURGERY CENTER, L.L.C.	*	**CARE COMMISSION**
	*	
Docket No. 17-15-2401	*	

* *

FINAL ORDER

Based on the analysis and conclusions contained in the Staff Report and Recommendation, it is this 16th[th] day of November, 2017, by a majority of the Maryland Health Care Commission, **ORDERED:**

That the application of Bethesda Chevy Chase Surgery Center, L.L.C., an existing physician outpatient surgery center, for a Certificate of Need to establish an ambulatory surgical facility through the additional of a second operating room in leased space at 6931 Arlington Road, Suite E, in Bethesda, at a estimated cost of $1,759,618, is **APPROVED.**

Maryland Health Care Commission

APPENDIX 1

RECORD OF THE REVIEW

Record of the Review

Item #	Description	Date
1	John J. Eller, Esq., on behalf of Bethesda Chevy Chase Surgery Center (BCCSC"), submits letter of intent to acquire additional adjacent space, convert the existing procedure room to a second operating room, and create a new replacement procedure room. Commission staff acknowledges receipt of Letter of Intent on 5/11/2017.	5/5/17
2	John J. Eller, Esq., filed their Certificate of Need ("CON") application for completeness review.	7/7/17
3	Commission staff acknowledges receipt of the CON application.	7/13/17
4	Commission staff requested the *Washington Times* publish notice of receipt of CON application.	7/13/17
5	Commission staff requested that the *Maryland Register* publish notice of receipt of application.	7/13/17
6	Notice of receipt of application was published in the *Washington Times*.	7/27/17
7	Following completeness review, Commission staff requested additional information.	7/28/17
8	In an exchange of e-mails, Commission staff received request and granted an extension to file completeness information until 9/5/17 from applicant's counsel.	8/21/17
9	Commission staff received responses to additional information request of 7/28/17..	9/5/17
10	In an exchange of e-mails, Commission staff received responses from Barbara Fagan, Office of Health Care Quality, regarding the license and compliance of BCCSC.	9/8/17
11	After review of completeness responses, Commission staff requested additional information.	9/11/17
12	Commission staff sent notice of the docketing of BCCSC's CON application.	914/17
13	Commission staff requested the *Washington Times* publish formal start of review of CON application.	9/14/17
14	Commission staff requested the *Maryland Register* publish notice of formal start of review of CON application.	9/14/17
15	Commission staff sent copy of CON application to the Montgomery County Health Department for review and comment.	9/14/17
16	*Washington Times* sent affidavit of publication regarding formal start of review.	9/21/17
17	John J. Eller, Esq., submits response to request for additional information of 9/11/17.	9/18/17

APPENDIX 2

Excerpted CON Standards for General Surgical Services From COMAR 10.24.11

Excerpted CON standards for General Surgical Services
COMAR 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.

STANDARD	**APPLICATION REFERENCE (Docket Item #)**
.05A(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. (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. (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, and 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.	DI#10 DI#2, Exhibit 8
.05A(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.	DI #2, Exhibit 9
.05B(4) Design Requirements. Floor plans submitted by an applicant **must be consistent with the current FGI Guidelines.**	DI #2, Exhibit 10

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines. (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.	

APPENDIX 3

Marshall Valuation Service Review

Marshall Valuation Service Review

The Marshall Valuation System – what it is, how it works

In order to compare the cost of a proposed construction project to that of similar projects as part of a cost-effectiveness analysis, a benchmark cost is typically developed using the Marshall Valuation Service ("MVS"). 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.

The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs do not include costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, general contingency set aside for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[6]

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs, the base costs are adjusted for a variety of factors (e.g., an add-on for sprinkler systems, the presence or absence of elevators, number of building stories, the height per story, and the shape of the building. The base cost is also adjusted to the latest month and the locality of the construction project.)

Calculating the Adjusted Project Cost in this Application

BCCSC and MHCC staff calculated the adjusted project cost per square foot ("SF") based on the actual costs of renovating 3,027 square feet, excluding those costs categorized in the introduction above. Table A shows the calculation of the adjusted project cost made by the applicant and by MHCC.

Table A: Respective Adjusted Project Cost Developed by BCCSC and MHCC Staff

Project Budget Item	BCCSC Estimate	MHCC Staff Estimate
Building	$ 1,139,000	$ 1,139,000
Architectural Fees	$ 85,000	$ 85,000

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

Permits	$ 50,000	$ 50,000
Cap Construction Interest and Financing Fees	$ 3,000	$ 2,305
Renovation Subtotal	$ 1,277,000	$ 1,276,305
Adjusted Total for MVS Comparison	**$ 1,277,000**	**$ 1,276,305**
Total Additional Square Footage	3,027	3,027
Adjusted Project Cost per SF	**$ 421.87**	**$ 421.64**

Source: DI #3, p. 29-31 and MHCC Staff calculations

The only difference between the two project costs is that BCCSC included the entire $3,000 in Loan Placement Fees with the project cost, while staff included just the share of those costs that are attributable to the allowable cost categories as defined by MVS.

Developing an MVS Benchmark for This Project

Bethesda Chevy Chase Surgical Center calculated the benchmark to be $440.53 per SF by making the following adjustments to the most current Marshall Valuation Service base cost for good quality Class A-B construction of an outpatient surgical center ($369.05 per SF as of November 2015).

1. Adjusting for departmental cost differences using the departmental cost factor for hospital operating rooms (1.89), the most expensive hospital space.
2. BCCSC then adjusted the square foot cost for the shape of area affected (perimeter multiplier) and ceiling height of the area affected using information obtained from the MVS guide.
3. BCCSC then brought the cost up to date at the time of application preparation using the MVS current cost multiplier and further adjusted for local cost variations using a local multiplier to arrive at a benchmark of $881.07 per SF for newly constructed operating room space.
4. As a last step BCCSC applied a factor of 50% in recognition of the fact that the construction work will take place in existing space to arrive at the final benchmark of $440.53 per SF.

MHCC staff calculated an MVS benchmark of $509.70 per SF by adjusting the same MVS base cost for outpatient surgical centers used by the applicant as follows:

1. Using a departmental cost factor of 1.59 for a hospital operating room suite instead of the 1.89 factor used by the applicant to account for the fact that the construction will create supporting spaces such as a new procedure room, PACU, nursing station, recovery rooms, and equipment storage as well as a new operating room.
2. The same perimeter and height multiplier used by the applicant.
3. Staff updated the square foot cost as of October 2017 by applying the MVS current cost multiplier of 1.04 for Class A health care buildings.

4. Staff then adjusted the cost to the location of the project by applying the MVS local multiplier for Bethesda (1.06) as of October 2017 (the most current available) to arrive at an initial benchmark square foot cost of $749.34 per SF if this project was for totally new construction in this space.
5. As a last step to account for the fact that the project involves renovations of existing space and not construction of new space, staff subtracted a benchmark for the construction of outpatient surgical shell space ($239.64 per SF from the initial benchmark of $749.34 per SF for a final benchmark for this project of $509.70 per SF. Staff calculated the benchmark for constructing the shell space by applying the hospital departmental cost factor for vacant space to the base cost for an outpatient surgical center and then applying the same multipliers as used in calculating the initial benchmark.[7]

The following table identifies select building characteristics, the MVS base cost and the adjustments and calculations made by BCCSC and MHCC staff for this analysis:

Table B: Marshall Valuation Service Benchmark – BCCSC and MHCCStaff's Calculations

Building Characteristics			
Construction Class/Quality	Class A-B/Good, Outpatient Surgery Center		
Number of Stories	1		
Square Feet	3,027		
Average Perimeter	354		
Weighted Average Wall Height	12		
Average Area Per Floor	3,027		
Marshall Valuation Service Benchmark Calculations			
	Calculations by BCCSC for Outpatient Surgical Space	**Calculations by MHCC for New Outpatient Surgical Suite**	**Calculations by MHCC for Outpatient Surgical Center Shell Space**
Base Cost per SF	**$ 369.05**	$ 369.05	$ 369.05
Adjustment for Departmental Cost Differences	**1.89**	1.59	0.5
Adjusted Base Cost per SF	**$ 697.50**	$ 586.79	$ 184.53
Multipliers			
Perimeter Multiplier	1.149	1.14937882	1.14937882
Story Height Multiplier	1.0	1.0	1.0
Multi-Story Multiplier	1.0	1.0	1.0
Refined Cost per SF	**$ 801.70**	$ 674.44	$ 212.09
Sprinkler Add-on per SF	5.29	5.29	5.29

[7] Staff calculated the cost of the shell space by applying the hospital differential cost factor for unassigned space (0.5) to the adjusted base cost for an outpatient surgical center and subtracted this value ($239.64 per SF) from the initial benchmark to arrive at an adjusted benchmark for this project of $509.70 per SF

Adjusted Refined Square Foot Cost	$ 806.99	$ 679.73	$ 217.38
Update/Location Multipliers			
Current Cost Modifier	1.03	1.04	1.04
Local Multiplier	1.06	1.06	1.06
MVS Building Cost per Square Foot	**$ 881.07**	**$ 749.34**	**$ 239.64**
	50.0%		
Final MVS Benchmark for Project	**$ 440.53**	**$**	**509.70**

Source: DI #3, pp. 29-31, and Marshall Valuation Service® published by Core Logic, and Commission Staff Calculations

While, as indicated in the table above, staff used higher current cost and local multipliers than those used by the applicant, the major reason for the higher benchmark calculated by staff is the method used to account for the fact that the renovation work will occur in existing space. Both the applicant and MHCC attempted to account for this by adjusting the benchmark each calculated for new construction by subtracting the cost of existing space as though it is constructed in shell space. The applicant's calculation treated the existing space as though it had been specifically constructed as shell space for operating rooms only. Staff's calculation treated the existing space as though it was constructed as shell space for a complete outpatient surgical center. The reasons for the differences in the current and local cost multipliers used cannot be fully explained because staff does not know the time frame of the current multiplier and the local multiplier used by the applicant. Of course it is reasonable to assume that the difference in the current cost multiplier is the use by staff of the latest available value from MVS while the applicant used information that was available during preparation of the CON application.

Comparing the Estimated Project to the MVS Benchmark

MHCC staff's analysis found the estimated project cost to be $88.06 per SF (about 17.3%) below its calculated MVS benchmark, while BCCSC calculated the project costs to be $18.66 per SF (about 4.2%) below the MVS benchmark.

Table C: Comparison of Adjusted Project Cost as Calculated with the MVS Benchmark

	BCCSC Calculation	MHCC Staff Calculation
Adjusted Project Cost per SF	$ 421.87	$ 421.64
BCCSC and MHCC calculated MVS Benchmark Cost per SF	$ 440.53	$ 509.70
Total Over (Under) MVS Benchmark	$ (18.66)	$ (88.06)
Over(Under) %	**-4.2%**	**-17.3%**

Source: DI #3, p. 29-31 and MHCC Staff calculations

APPENDIX 4

Floor Plan Drawings

Appendix 4

Shaded area is space being renovated for project