BEFORE THE MARYLAND HEALTH CARE COMMISSION

IN THE MATTER OF ANDOCHICK SURGICAL CENTER LLC d/b/a PHYSICIANS SURGERY CENTER OF FREDERICK CON APPLICATION TO ADD OUTPATIENT OPERATING ROOMS IN FREDERICK COUNTY	Docket No. 21-10-2451

INTERESTED PARTY FREDERICK HEALTH HOSPITAL, INC.'S RESPONSE TO ANDOCHICK SURGICAL CENTER LLC'S RESPONSE TO COMPLETENESS QUESTIONS

Frederick Health Hospital, Inc. ("FHH" or the "Frederick Hospital") hereby submits comments to the Response to Completeness Questions dated June 23, 2022 (the "June 23 Response") of Andochick Surgical Center LLC d/b/a Physicians Surgery Center of Frederick (collectively, "Applicant" or "PSCF").[1] The Applicant carries the burden of proof that its proposed project meets the criteria for review by a preponderance of the evidence. COMAR 10.24.01.08G(1). The role of the Applicant is to provide facts that correspond to the State Health Plan requirements for General Surgical Services and demonstrate that a Certificate of Need ("CON") is warranted. COMAR 10.24.11. In its June 23 Response, the Applicant still does not offer substantiated and reliable data, and has not responded fully to the Commission's questions. Accordingly, Frederick Hospital respectfully asks that the Commission deny the Application.

[1] The Commission granted FHH a chance to respond the Applicant's June 23 Response within ten business days of its submission.

Frederick Hospital has three primary concerns with the June 23 Response. First, in the interest of process integrity, the Applicant must satisfy the CON baseline requirements with reliable information. The information provided by the Applicant is inconsistent and often lacks typical verification. Second, the Applicant's charity care response indicates an apparent misunderstanding of the charity care requirement. Despite a second request, the Applicant still has not explained why its low historical level of performance was appropriate to the needs of its service area (as required by the State Health Plan), or how it will achieve its expected charity care obligation in the future. Third, the Applicant has not addressed fully the impact its proposal will have on other providers. The Applicant simply repeats – in one form or another – that the project will have no impact on Frederick Hospital. In fact, the Applicant's materials, which include submissions by its own surgeons, show a significant impact on Frederick Hospital (and others). Each of these concerns is addressed below.

A. <u>The Applicant's Responses do not Satisfy its Regulatory Burden</u>.

The continued integrity of the CON process requires that the Applicant fully and accurately complete the CON application, and that the Applicant be held to the same historical rigor applied to prior applicants in the CON process. As a result, the Commission has asked a series of follow up questions to the Applicant in an attempt to ensure full compliance with the CON application requirements. Unfortunately, the Applicant's most recent responses either are incomplete or create direct conflicts with other information provided to the Commission.

For example, in the Applicant's response to the Commission's request for historic and projected surgical volumes, (Applicant's Tab 4), the Applicant's entire basis for its projected volume, which, in turn, provides the basis for its anticipated revenue, appears to

be based upon their surgeons' best guesses.[2] The Applicant provides no data analytics or authoritative resource to support the projected volume. Instead, the Applicant projects an increasing number of procedures at PSCF in 2022, 2023, and 2024 – long before PSCF even projects to have completed construction on its two new operating rooms by April 2024. (*See* Applicant's Tab 5, Ex, 21, Table 1.) The individual projections are presumptions as to each surgeon's anticipated cases and minutes three years into the future. For example, it is unclear if the 2022 cases and minutes for each surgeon are based upon actual data for the first half of 2022. While the Applicant does provide "assumptions," the assumptions confirm that the volume projections simply are based upon a surgeon "interview." Moreover, it appears that, per Exhibit 15 (assumptions #9 and #13), the surgeons' projections are only based upon the surgeons' self "confidence" and, apparently, for some of the surgeons, the assumption that PSCF will have two additional operating rooms as early as 2023- even though Applicant's own construction schedule would have them ready by no earlier than April 2024.[3] This information does not support the Applicant's burden of demonstrating sufficient anticipated volume.

Another example is the Applicant's updated construction timeline and its impact on the budget when the "first use" date shifted to April of 2024. (*See* Applicant's Tab 2.) The construction budget was not modified to account for the impact a six-month delay will have on budget projections made months ago, which is difficult to understand given the present fluctuations in the economy. For example, despite a six month change in the timeline and a dramatically different economic climate, the renovation budget of $167,800 has not changed

[2] Projections are to be "fully explained, and the basis for each such assumption shall be explicit and described in detail." COMAR 10.24.11.05B(4); *see also*, COMAR 10.24.11.05D.

[3] In filling out the individual volume projection forms, it is unclear what understanding the surgeons had with regard to when the new operating rooms will be fully functional (e.g., in 2022, 2023, or 2024).

since it was first submitted in July of 2021. Capital Costs remained unchanged as well. The Marshall Swift Valuation costs per square foot, (originally quoted as $354.13 sq./ft. for the combined costs, but included as only $180.50 for the "internal build and renovation"), are not provided in the updated table. An updated Marshall Swift Valuation should accompany a six month change in anticipated first use. The six month delay naturally impacts the Applicant's other responses. For example, although the revenue projections provided in Table 4 are very different than those first submitted with the original Application (presumably due in part to the six month change in the construction schedule), there is no explanation for the changes and nothing to support the figures submitted.

Similar issues arise with the updated financials, (Applicant Tab 5).[4] In Exhibits 18 and 19 the "bad debt" and "charity care" rows are blank. Exhibit 21 should represent statistical projections for the entire facility updated as of June of 2022. The updated construction timeline has the new facility not operational until April of 2024, yet Exhibit 21 has four operating rooms beginning in 2022. Not surprisingly, the total anticipated surgical minutes provided in the handwritten forms from the surgeons (under Tab 4) do not match the anticipated total surgical minutes in the operating rooms in Exhibit 21.

Additionally, the Commission notes a discrepancy in the projected budget between the Use of Funds and the Source of Funds. Although the Applicant resolves the Use of Funds and Source of Funds discrepancy on paper by changing one value so that the values are equal, the Applicant does not explain the reason for the discrepancy or how the discrepancy was corrected other than to state that the figures are now "balanced."

[4] Applicant's financial feasibility, even if accepted at face value, is questionable. The Applicant was asked to provide assumptions supporting the data on the financial feasibility of the project. (Applicant's Tab 6). The response was that Applicant expects an increase in revenue by 20%. Missing is any explanation or support for the anticipated 20% increase (For example, why 20%? As the State Health Plan directs – what are the "expense trends"? What was the "percentage of revenue" used for the personnel / supplies and what are the "current factors"?)

Finally, the Applicant's answer regarding the proposed project's ability to enhance and improve the quality of care didn't squarely address the Commission's question. The Applicant was asked specifically how the addition of two operating rooms will enhance and improve the quality of care (Applicant's Tab 8). In response, the Applicant explains how new renovations will enhance the overall patient experience for PSCF patients, but falls short of explaining how additional operating capacity will enhance care.[5] There is no doubt that new ventilation, redesigned waiting rooms, and a patient-appealing environment may enhance the patient experience, but the proposed renovations are easily accomplished without obtaining a CON, and without the addition of two new operating rooms.[6]

All in all, the volume projections are not substantiated, the construction timeline is inconsistent, the revenue projections were not updated, and the Applicant does not explain how two additional operating rooms will enhance the quality of care in Frederick County. The responses and information supplied to date appear to fall short of the baseline requirements to satisfy the Applicant's regulatory burden of proof or the standard of information and support historically required by the Commission.

B. The Applicant has not Demonstrated Compliance with the Charity Care Standards.

[5] Point number six in Exhibit 28 appears to come close to responding to the question, as it does mention the addition of two operating rooms - but the Applicant never actually describes how two additional operating rooms will improve patient care. There is some reference to a reduction of wait times, but there is no further explanation or data identifying surgical wait times as an issue in need of resolution in Frederick County.

[6] A change in the interior layout for a Physician Outpatient Surgery Center (using the terminology of January 15, 2018 State Health Plan for General Surgical Services) might require the Applicant to submit a "Requesting and Obtaining a Determination of Coverage to Establish a Freestanding Ambulatory Surgical Facility in Maryland" under COMAR 10.24.11.04A- a far simpler process.

The Applicant makes three errors in its response regarding the regulatory charity care standards. First, the Applicant appears to confuse the Health Services Cost Review Commission's (HSCRC) comments about hospital uncompensated care (UCC) with its own ambulatory surgical facility's (ASF) charity care obligations, resulting in an incorrect and potentially overinflated historical charity care percentage. Second, the Applicant has not responded to how it will satisfy future charity care requirements. Third, and lastly, the Applicant has yet to provide a cogent argument as to why its level of charity care in the past was appropriate for the needs of the nearby community.

The Applicant cannot include bad debt in its charity care volumes. The State Health Plan includes the following in the definition of charity care: "[c]harity care does not include bad debt." COMAR 10.24.11.08B(3). Although the Applicant tries to rely on HSCRC commentary, the HSCRC's explanation of UCC is unique to hospitals because it recognizes the distinct financial burden hospitals experience. The HSCRC tracks UCC to ensure that the burden of providing services to patients regardless of their ability to pay is shared equitably among Maryland hospitals. By statute, the HSCRC's regulations apply only to HSCRC rate-regulated space in a hospital, and may not be used to regulate an ambulatory surgical facility.[7] The HSCRC regulations simply do not support the Applicant's position that the definition of "charity care" includes bad debt[8] in the context of an ASF.

[7] In fact, many ASFs in Maryland might be surprised to hear of an ASF promoting application of the more stringent hospital standards to an outpatient only facility.

[8] Even assuming the Commission accepts the "bad debt" presented by the Applicant in Exhibit 5 at face value, the Applicant does not define what standard it uses to define "bad debt". Instead, it provides only the requirements that hospitals must meet when defining bad debt. For example, does the Applicant's "bad debt" include the write off between what was charged to any payor and what was actually collected (contractual write-offs); or write-offs associated with personal injury settlements? Note that the "bad debt" numbers were provided without any meaningful explanation or supporting documentation.

The State Health Plan charity care standards are important because without a meaningful demonstration by the Applicant that it takes its charity care obligations seriously, a risk occurs that lucrative surgical cases will be performed in a for-profit entity that has failed to ensure access for those patients who are economically vulnerable in the past. If past performance is an indicator of the future, this will not ensure access for the economically vulnerable in the future. If a specialized outpatient facility only performs lucrative cases to those who can afford them, existing health outcome disparities for those who are economically vulnerable will be maintained or widened, unless the economically vulnerable have some level of access to that outpatient facility. The impact on the community's most needy patients will also impact FHH. FHH will have an increased cost of care for these patients combined with a sharp revenue decrease because of the absence of reimbursable procedures that could otherwise be performed at FHH, which adversely effects long-term sustainability.

The Commission has requested that the Applicant provide a justification as to why its historically low level of charity was appropriate to meet the needs of PSCF's service area. Instead of answering this question, the Applicant altered its significantly low levels of historic level of charity care by including its "bad debt". This raised PSCF's "charity care" percentages to quadruple those percentages of other ASFs as indicated in the ASF surveys. There is no discussion of how the Applicant's actual charity care percentages, which historically have been low, were appropriate to meet the needs of PSCF's service area.

PSCF may assume that there is no need for charity care in the applicable service area, but that assumption would be incorrect. The Frederick County Community Health Needs Assessment[9] surveyed the community's needs by looking retrospectively at Fredrick

[9] https://health.frederickcountymd.gov/DocumentCenter/View/7489/2022-Frederick-County-CHNA-final, (referred to herein as the "Health Needs Assessment").

County residents. It concluded that poverty and the impact of poverty on health remains one of the top challenges facing Frederick County. (Health Needs Assessment, p. 18.) Low income, poverty, and a lack of health insurance are significant factors in the physical health and well being of at risk county residents. (*Id*., p. 20.) While roughly 6% of the population either lives in poverty or does not have health insurance county-wide, (*id*., p. 8), certain census tracts indicate that the local poverty level is as high as 25%, including Census Tract 7505.03, which is roughly three miles from PSCF. Lastly, a full 13% of the county residents that were surveyed indicated that they were "impoverished and struggling to make ends meet." (*Id*., p. 22.) These are the types of needs in the local service area that should be addressed.

Furthermore, the Applicant previously represented that its future charity care goals are .68% of its operating expenses. The Applicant did not address, however, how it plans to achieve those goals. In fact, as demonstrated in Tab 5, (ex. 18 and 19), which exhibits purport to provide reliable and accurate data on actual and projected revenue, the Applicant does not include values for bad debt or charity care, which, if factored, would reflect a decrease in the anticipated net operating revenue.

C. <u>The Applicant does not Address the Impact on Frederick Hospital.</u>

Frederick Health remains concerned about one of the most important elements of the CON process – impact on existing providers. Despite the ever-increasing evidence of the significant impact the Applicant's proposal will have on Frederick Health, the Applicant simply reiterates that there will be "no impact". To support this conclusion, the Applicant relies on surgeon representations that they will not "take" patients from Frederick Hospital. The standard is not whether a provider will "take" an individual patient or patients, the standard is case volume and its impact on existing health care facilities.

COMAR 10.24.11.05.B(9). PSCF's own numbers indicate that the proposed project will impact Frederick Hospital.

In fact, the data provided by the surgeons demonstrates that each surgeon who currently performs surgery at Frederick Hospital anticipates a dramatic decrease in surgeries at the Hospital, and an increase at PSCF. This evidences a huge impact on Frederick Hospital.

Each physician has only a finite capacity to do a number of surgical cases per year. For example, according to Dr. Gupta's form, (Applicant's Tab 4), Dr. Gupta only performed surgery either at PSCF or Frederick Hospital for a total annual surgical capacity of 278 surgeries. The table below demonstrates the anticipated evolution of Dr. Gupta's practice:

FHH - Table 1			
Year	Surgeries at FHH[10]	Surgeries at PSCF	Total Surgeries
2020	271	5	278
2021	267	11	278
2022	206	72	Est. 278
2023	140	138	Est. 278
2024	88	190	Est. 278

Relying on Applicant's own data, the Commission must assume that Dr. Gupta's annual capacity is roughly 278 cases per year. Over the course of four years, the Applicant's data does not demonstrate that Dr. Gupta intends to increase his annual volume of cases because, in all likelihood, he cannot or he will not. As a result, by 2024, if he performs his obligatory 278 cases per year and increases his cases at PSCF to 190, the volume of his

[10] The Applicant did not provide data on the number of surgeries the surgeons anticipate continuing to provide at the Hospital in 2022 through 2024. So for these years, the anticipated surgeries were subtracted from the total historical number surgeries. To the extent Dr. Gupta intends to increase his overall total surgeries in a given year, there is no explanation as to whether, why, or how his schedule will allow him to do this- or if the basic physical limitations of a human being would allow him to increase his surgical case load. For example, Dr. Gupta would have to go from an average of only 278 surgeries a year, to over 461 surgeries (271 + 190) a year as of 2024 (if that is even possible), if Dr. Gupta intends to keep his current number of surgeries at FHH consistent with prior years.

caseload at Frederick Hospital must decrease from 271 in 2020 to 88 by 2024. This is a significant, and material, decrease.

According to Frederick Hospital's independent data, there are other inaccuracies in the Applicant's reported data. The Applicant asserts that there is no impact on Frederick Hospital because it will "only" be outpatient cases (*see, e.g.*, Ex. 16, Dr. Levine attestation). Frederick Hospital's own data, however, shows conclusively that the involved surgeons historically have had large volumes of both inpatient and outpatient cases at Frederick Hospital. Dr. Levine himself performed 66 outpatient cases alone at Frederick Health, collectively, in 2021 and 2022. As demonstrated in Table 2 below and taking only the subset of orthopedic surgeons reported by PSC for conciseness purposes, approximately 59% of those physicians' cases at Frederick Hospital were outpatient cases when taking the average of calendar year 2020 and 2021 combined.[11]

FHH – Table 2							
Orthopedic	***CY20***				***CY21***		
	I/P	***O/P***	***Total***		***I/P***	***O/P***	***Total***
COPAKEN, L	3	49	***52***		3	55	***58***
GUPTA, R	164	61	***225***		55	173	***228***
HORTON, S	6	18	***24***		6	23	***29***
LEVINE, M	35	28	***63***		23	38	***61***
NESBITT, K	0	0	***0***		0	0	***0***
STEINBERG, J	127	46	***173***		73	64	***137***
WALSH, C	116	50	***166***		36	157	***193***

Furthermore, while the Applicant states that Dr. Gupta and other surgeons will "absorb" part of Dr. Steinberg's caseload (not indicating how many cases or how this will occur), a surgeon is only capable of performing a certain number of surgeries in a given time period. There is no explanation of how the Dr. Gupta's current schedule (or any of the

[11] Frederick Hospital reports cases on a per patient use, not per procedure.

surgeons' schedules) will allow for such a dramatic caseload increase without the anticipated shift away from FHH.[12]

While we point out specific discrepancies for Dr. Gupta and Dr. Levine, these discrepancies are true for virtually all of the surgeons identified. Any outpatient volume shift certainly will create an impact.

Conclusion

In addition to the concerns outlined in Frederick Hospital's prior Interested Party Comments, the proposed project does not muster sufficient reliable data to comply with CON regulations. The project still does not anticipate the provision of charity care consistent with the State Health Plan, which may be the reason why there is not a more tangible demonstration of community support specifically for this project.[13] The project still does not adequately address the significant impact the addition of two new operating rooms will have on Frederick Hospital and other existing surgical facilities in Frederick County. The Commission is left to infer data that does not exist in the Application and overlook the Applicant's unreconciled financial information in order to conclude that the Applicant has met its burden.

[12] Another concern with the anticipated surgical volumes presented by the surgeons is their inconsistency with the new construction timeline (Applicant's Tab #2). The Applicant's updated construction timeline projects construction to be complete in April of 2024, and the proposed operating rooms and procedure room will not be used until April 2024. Nevertheless, surgical volume projections by the surgeons reflect using two additional operating rooms as early as 2022. This data, therefore, is unreliable because the two ORs will not exist at that time.

[13] Consistent and further evidencing Frederick Health's concerns about impact on other community providers is the Applicant failure to provide any expression of general community support for the project (Applicant's Tab #7). The documents provided by the Applicant are not what the Commission typically would expect to see to demonstrate the continuing viability of the project. Other than the first letter, which is signed multiple times by the same people, none of the documents even mention the anticipated expansion. The community's largest health care facility, FHH, cannot fully support this project because it has serious concerns about its viability, and there are better and more cost effective alternatives to provide more efficient care tailored to serve Frederick County residents.

Frederick Hospital requests that the Commission take the above Response, as well as FHH's previously filed Interested Party Comments, into consideration and **deny** PSCF's CON Application.

Respectfully submitted,

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AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this Interested Party Response are true and correct to the best of my knowledge, information, and belief.

James B Sherwood
Signature

James B Sherwood
Printed Name

VP, Business Development & Strategy
Title
Frederick Health