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December 30, 2021

**ELECTRONIC DELIVERY**

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**RE: *In the Matter of Andochick Surgical Center LLC d/b/a Physicians  
Surgery Center of Frederick, Certificate of Need Application, Docket  
No. 21-10-2451***

Dear Mr. Steffen, Ms. Hawk, and Ms. Potter:

Please accept the accompanying Interested Party Comments of Frederick Health Hospital, Inc. in opposition to Andochick Surgical Center LLC's Application for Certificate of Need to increase outpatient operating room capacity in Frederick County, Maryland. Paper copies of the Interested Party Comments will be submitted by close of business January 3, 2021, if necessary, pending confirmation from Ms. Potter.

In addition, on behalf of our client, Frederick Health Hospital, we request to be copied on all correspondence with respect to the above certificate of need application in accordance with COMAR 10.24.01.08. Frederick Health Hospital is a provider that has legitimate concerns with regard to the provision of health care in the impacted area. We would appreciate copy via email ([cdean@milesstockbridge.com](mailto:cdean@milesstockbridge.com); [jcoyne@milesstockbridge.com](mailto:jcoyne@milesstockbridge.com)) due to the present unreliability of the mail process.

Sincerely,

A handwritten signature in blue ink, appearing to read 'C. Dean', is written over a light blue horizontal line.

Christopher P. Dean



cc: Katie Wunderlich, HSCRC ([Katie.wunderlich@maryland.gov](mailto:Katie.wunderlich@maryland.gov))  
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**BEFORE THE MARYLAND HEALTH CARE COMMISSION**

IN THE MATTER OF

ANDOCHICK SURGICAL CENTER  
LLC d/b/a  
PHYSICIANS SURGERY CENTER OF  
FREDERICK

Docket No. 21-10-2451

CON APPLICATION TO ADD  
OUTPATIENT OPERATING ROOMS  
IN FREDERICK COUNTY

**INTERESTED PARTY COMMENTS OF FREDERICK HEALTH HOSPITAL, INC.  
IN OPPOSITION TO ANDOCHICK SURGICAL CENTER LLC'S  
APPLICATION FOR A CERTIFICATE OF NEED  
TO INCREASE OUTPATIENT OPERATING ROOM CAPACITY IN  
FREDERICK COUNTY, MARYLAND**

In accordance with §10.24.01.08F(1)(a)&(b) of the Code of Maryland Regulations (COMAR), Frederick Health Hospital, Inc. ("FHH" or the "Frederick Hospital") requests interested party status in the above captioned matter. Furthermore, as an interested party Frederick Hospital submits these comments in opposition to the application by Andochick Surgical Center LLC d/b/a Physicians Surgery Center of Frederick (collectively, "Applicant" or "PSCF") for a certificate of need to expand its operating room capacity in Frederick County, Maryland.

**Introduction**

PSCF's Application for a Certificate of Need ("CON"), (the "Application") proposes the addition of two operating rooms and one procedure room to PSCF's existing facility, resulting in a total of four operating rooms and two procedure rooms (the "Project"). (App. p. 6.)<sup>1</sup> This expansion includes the construction of a new 11,222 square foot extension to its building and the renovation of 6,300 square feet of existing space. (App. p. 6.)

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<sup>1</sup> PSCF's CON Application, docketed on December 3, 2021, is referenced herein simply as "App. p. \_\_\_".

Applicant carries the burden of proof that its proposed Project meets the applicable criteria for review by a preponderance of the evidence. COMAR 10.24.01.08G(1). The most concerning issue in its Application is the inaccuracy of its volume projections, which serve as the basis for both its need determination and revenue projections. Establishing need and portraying accurate revenue projections are critical to Applicant meeting its burden of proof. Applicant relies heavily on several incorrect assumptions that, unfortunately, are no longer valid. Frederick Hospital also is concerned about the impact this proposed project will have on the availability and safety of surgical services throughout Frederick County, even though Applicant dismisses this impact as “minimal.” These concerns warrant careful consideration prior to moving forward.

Accordingly, Frederick Hospital respectfully asks that the Commission deny the Application. In the alternative, the Applicant should be required to amend its Application with the appropriate data as explained in more detail below.

### **Statement of Interested Party Status**

#### **A. Interested Party Standards.**

An “interested party” includes “[a] person who can demonstrate to the reviewer that the person would be adversely affected, in an area over which the Commission has jurisdiction, by the approval of a proposed project.” COMAR 10.24.01.01(B)(20)(e). An “adversely affected” person includes an entity that “[i]s authorized to provide the same service as the applicant, in the same planning region used for purposes of determining need under the State Health Plan [(or “SHP”)]”. Alternatively, an “adversely affected” entity is one that “[c]an demonstrate to the reviewer that the person could suffer a potentially detrimental impact from the approval of a project before the Commission, in an issue area over which the Commission has jurisdiction.” COMAR 10.24.01.01(B)(2)(a) & (d).

- B. Frederick Hospital and the Applicant both provide general surgical services in the Western Maryland planning region and Frederick Health would suffer a detrimental impact if the Project is approved.

Frederick Hospital is authorized to provide the same services as the Applicant in the same planning region used for the purposes of determining need under the State Health Plan for Facilities and Services (“SHP”). Frederick Hospital provides operating rooms for both inpatient and outpatient procedures on behalf of the Frederick County community. The building, development, or establishment of a hospital or an ambulatory surgical facility is regulated under the same General Surgical Services chapter of the SHP. COMAR 10.24.11. The majority of Frederick Hospital’s surgery time in its operating rooms is used for general surgery and orthopedic surgery. The Applicant identifies its primary surgical areas as general, ophthalmology, orthopedics, and plastics/reconstructive. (App. Ex. A).

The Applicant identifies its service area as Maryland, Pennsylvania, and West Virginia, with Frederick County, Maryland as its “primary county”. (App. at p. 28.) Frederick Hospital is located within the heart of Frederick County and provides medical services to patients across western Maryland and lower Pennsylvania. Specifically, Frederick Hospital is located at 400 West 7<sup>th</sup> Street in Frederick, Maryland (Frederick County), which is 2.6 miles away from the Applicant’s location. The Applicant and Frederick Hospital are both physically located in the same planning region – the Western Maryland planning region.

In addition, as explained in more detail herein, Frederick Hospital stands to suffer a detrimental impact, (*see herein*, Interested Party Comments, §9, COMAR 10.24.01G(3)(f) *Impact on Existing Providers and the Health Care Delivery System.*) Accordingly, Frederick Hospital satisfies the requirements as an Interested Party.

## Interested Party Comments

The Applicant must satisfy its burden in documenting and supporting its compliance with each of the regulatory standards in a Certificate of Need analysis. Interested party comments assist the Commission in understanding the real impact of the proposal on other health care providers. Frederick Hospital's comments below track the specific CON requirements in the natural order of the Application, and where necessary, provide more global context on the Project's potential impact on the Frederick County community and Frederick Hospital.

### 1. [Standard 05\(a\)\(2\) - Information Regarding Procedure Volume.](#)

Standard 05(A)(2) requires that an applicant provide certain information on surgical procedures. Applicant is missing Attachment F from its submission, (App. p. 20), which purports to provide a list of procedures for the prior 12 months, referred to as "Report CT 6003".

### 2. [Standard 05\(A\)\(3\) – Charity Care Policy.](#)

Standard 05(A)(3)(c) requires an applicant to commit to providing charitable surgical services to indigent patients and that the applicant demonstrate that it has established a track record to support that commitment. The Applicant lacks sufficient justification for its charity care threshold.

Specifically, the Applicant states that its charity care goals are .68% of its operating expenses, (App. p. 23), yet based on its own data, the Applicant's charity care goals have never been met and will not be met for several more years. (App. p. 24.) Upon a failure to meet the expected level of charity care, the Applicant must demonstrate why its lower level of charity care is appropriate to the needs of the service population. *See* Standard 05(A)(3)(c)(iii). With the exception of 2020, which was impacted by the pandemic in all aspects of service, Applicant does not explain why its charity care historically has not satisfied expectations or that it was appropriate to the needs of the community. Moreover, it

is important that the Commission acknowledge that any for-profit ambulatory surgical facility's failure to meet the base standards for charity care will impact Frederick Hospital and other surgery facilities that provide a greater proportion of charity care services. As the Applicant's proposal intends to pull hundreds of reimbursable orthopedic surgeries provided to self-pay or insured patients from Frederick Hospital and other surgery facilities, the Hospital's surgical services will shoulder an ever-increasing proportion of the community's non-reimbursable procedures for all patients, regardless of their ability to pay. In other words, adding surgical capacity that will provide care only for reimbursable services, without shouldering a meaningful amount of medically indigent care, disproportionately removes those reimbursable services from the health care facility that needs it the most to provide the same care to the medically indigent. The Application requires more than a verbal commitment to "provide charity care" and repeating a previously unfulfilled charity care policy does not have sufficient specificity to achieve the charity care goal required by the SHP. The Applicant should be required to show with specificity an expansion of its former charity care policy to satisfy the SHP requirement. The Applicant further should explain specifically why failing to meet its charity goals for 2018 and 2019, (the two most recently reported years reported to the Commission<sup>2</sup>), before the Commission approves their Application.

### 3. Standard .05B(3) Need –Expansion of an Existing Facility.

Standard .05B(3) requires various capacity assumptions for each proposed additional operation room utilizing the capacity assumptions metrics included at Regulation .07. There are several concerns with the Applicant's need calculations.

In response to Standard .05B(3)(a) there is minimal discussion of the Applicant's existing dedicated outpatient general purpose operating room, and no discussion of the other existing

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<sup>2</sup> See App. at Att. S, which represents the Commission's most recent reported data is for years 2017, 2018, and 2019.

operating room. (App. p. 29.) While the Applicant states that its “projections” indicate that each new operating room could support up to 1143 cases per year, the Applicant does not provide any documentation to support these “projections.”

Standard 05B(3)(b) requires a demonstration that the Applicant’s existing operating rooms were utilized at “optimal capacity” in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission (HSCRC) and the Maryland Health Care Commission (MHCC). In response, Applicant provides the total number of cases for each operating room, and nothing more. This baseline of data fails to explain fully how the utilization was at “optimal capacity.” For example, in response to this Standard, there is no explanation of utilization hours or the nature of the case mix, which would aid in interpreting the true case utilization. (App. 29.)

Applicant does provide utilization information<sup>3</sup> in Applicant’s Table 1-2 in response to subsequent Standards. (App. p. 31.) Table 1-2, however, does not indicate that current utilization is at optimal capacity, which is 2.0. Rather, it indicates that current utilization for the past two years has been less than 2.0 (2019 at 1.89 and 2020 at 1.63). The Applicant provides a caseload number per surgeon from 2020 to 2025, but does not indicate specifically how the existing operating rooms, or the two proposed operating rooms, have been, and will be, utilized.

Standard .05B(3)(b) also requires that the Applicant provide a needs assessment that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the Project. This needs assessment must include **historic and projected trends** in the demand for **specific types of surgery among the population in the proposed service area**. The Applicant inadequately addresses this

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<sup>3</sup> Applicant does not cite any sources for its utilization numbers or for its projected trends.

standard. There is no specific data or discussion of historic or projected trends for specific types of surgery in Frederick County. Instead, Applicant merely discusses **its own anticipated utilization**, without any allocation of specific types of surgery, and without sufficient discussion of the population in the proposed service area, leaving the Commission in a position to speculate that sufficient utilization will occur in accordance with this standard. (App. p. 30.)

Standard .05B(3)(c)(ii) requires that this needs assessment also address operating room time required for surgical cases historically provided at the facility **by surgical specialty or operating room category**. Again, Applicant fails to allocate its data by surgical specialty or operating room category. (App. p. 30, Table 1-2.) Not only is it impossible to determine how the Applicant has been utilizing its existing two operating rooms, it is impossible to know how the Applicant plans on utilizing the two additional operating rooms it requests because there is insufficient data in the Application regarding the quantity of types of procedures in their projections.

Finally, Standard .05B(3)(c)(iii) requires that the Applicant provide data on projected cases to be performed in each proposed additional operating room. Neither Applicant's Table 1-2, nor its vague accompanying description, adequately address this Standard. There is insufficient data on the types of projected cases to be performed in each of the additional operating rooms requested, and virtually nothing to substantiate the projections.

#### [4. Standard .05B\(8\) Financial Feasibility.](#)

There is no specific response by Applicant to demonstrate that the Project will be financially feasible. (App. p. 36.) Applicant does provide financial projections in Tables 3 and 4, (App. p. 46-48), but fails to specify that it meets the required elements outlined in Standards .05B(8)(a)(i) through (iv), or to provide a statement concerning the assumptions used to develop the Applicant's projections.

5. [Standard .05B\(9\) Impact.](#)

Standard .05B(9)(a)(i) requires that the Applicant present the number of surgical cases projected for each provider. (App. p. 36.) There are multiple concerns associated with the volume projections provided by the Applicant.

First, as demonstrated in Table A below, the Applicant assumes a 39% increase in growth. The Applicant must be able to justify such a significant volume expansion with clear data.

**Table A** - Anticipated growth rate per year as indicated in the PSCF application.<sup>4</sup>

	2020	2021	2022	2023	2024	2024
Total Volume	2060	2865	3275	3700	4175	4575
Incremental Cases		805	410	425	475	400
% Change		39%	14%	13%	13%	10%

In support of this rapid growth in volume, Applicant first relies upon the anticipated high productivity of James Steinberg, D.O. well into 2025. Dr. Steinberg is an orthopedic surgeon who specializes in joint replacement and repair surgeries. Dr. Steinberg is a surgeon who has practiced in the Frederick area for close to 25 years, and his active practice represents 229 of the 2060 procedures performed in 2020, or 11.1% of its volume. (App. p. 30.) Dr. Steinburg, however, recently made public his intention to leave Maryland in mid-2022. In fact, Frederick Hospital received a letter from Dr. Steinberg confirming the termination of his Medical Directorship, and he has shared verbally that he will be relocating to Georgia in 2022.

Dr. Steinberg's practice – one that is highly specialized after decades of practice – is not easily replicated. It would be next to impossible to replace Dr. Steinberg's lifelong practice and reputation with a newly recruited surgeon. As a result, the projection of caseloads by Dr.

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<sup>4</sup> The data in this Table A is extrapolated from the Applicant's tables provided on page 37 of its Application.

Steinberg into 2025 is not a reliable measure of potential cases in the Application. Table B below demonstrates how the loss of Dr. Steinberg will have a significant impact to PSCF’s volume projections. It is difficult to envision a scenario where a new surgical facility would be able to reach its financial pro forma projections if over 10% of its projected procedures disappear.

**Table B – The Loss of Dr. Steinberg on PSCF’s Volume Projections**

Year	Footnote	2020	2021	2022	2023	2024	2024
Projected Volume	A	2,060	2,865	3,275	3,700	4,175	4,575
Dr. Steinberg Leaving	B	229	290	350	365	380	400
Surgical Minutes	C	(20,610)	(26,100)	(31,500)	(32,850)	(34,200)	(36,000)
Turn-around	D	(5,725)	(7,250)	(8,750)	(9,125)	(9,500)	(10,000)
Total Minutes	E	(26,335)	(33,350)	(40,250)	(41,975)	(43,700)	(46,000)
Total Hours	F	(439)	(556)	(671)	(700)	(728)	(767)
OR Room Equivelant	G	(0.27)	(0.34)	(0.41)	(0.43)	(0.45)	(0.47)
% of Total Volume	H	11.1%	10.1%	10.7%	9.9%	9.1%	8.7%

**Footnotes**

- A 3. Standard 0.05B, Minimum Utilization, Volume Table, page 30.
- B 3. Standard 0.05B, Minimum Utilization, Volume Table, page 30.
- C Consistent Dr. Steinberg Actual Average 90 minutes per 9. Standard 0.05B (Impact), page 36.
- D Average 25 minute per case.
- E Surgical minutes + turn-around-time minutes
- F Total minutes divided by 60 minutes to determine hours.
- G Total hours divided by 1,632, which is the minimum number of hours per OR per regulation.
- H Dr. Steinberg's volumes as a percent of total volume for the proposed center.

In further support of its volume projections, the Applicant also relies upon procedures it assumed the Centers for Medicare and Medicaid Services (“CMS”) would permit in an outpatient setting, despite CMS’s long-standing so-called “Inpatient Only” restriction on those procedures. CMS places procedures on the Inpatient Only list because of their medical complexity and because these procedures require additional safety and resources that are only available in an inpatient setting.<sup>5</sup> At the time of the Application, PSCF assumed that

<sup>5</sup> The American Academy of Orthopaedic Surgeons agreed with CMS’s approach regarding patient safety concerns regarding moving procedures to an outpatient setting. See CMS’ Proposed Payment Policy Changes for 2022 Are Significant, <https://www.aaos.org/aaosnow/2021/sep/advocacy/advocacy01/> (last accessed Dec. 30, 2021).

certain surgeries, including reconstruction shoulder joint (AMA CPT 23472) and reconstructed ankle (AMA CPT 27702), (see App. p. 52), would be permitted in an ambulatory surgery center. CMS, however, recently reversed its position with regard to roughly 228 procedures, due, in part, to what it cites as safety concerns.<sup>6</sup> As a result, many of the surgeries PSCF anticipated as part of its expected volume are no longer subject to reimbursement by Medicare in an ambulatory surgical facility setting.<sup>7</sup> As indicated in Table C, this also materially decreases PSCF’s volume projections.

**Table C – Impact on Volume Projections**

Rooms Affected						
-5%	(0.19)	(0.26)	(0.30)	(0.34)	(0.39)	(0.42)
-10%	(0.38)	(0.53)	(0.61)	(0.68)	(0.77)	(0.85)
-20%	(0.76)	(1.06)	(1.21)	(1.37)	(1.54)	(1.69)

Footnote: Assumptions consistent with Table B.

Table C assumes that Applicant’s projected volume from Inpatient Only procedures constitutes either 5%, 10%, or 20% of its total projected volume. As explained above, however, Applicant did not provide sufficient specificity as to the numbers and specialty types of procedures in their projections (see *herein*, Interested Party Comments, §3).

CMS’s reversal on the Inpatient Only List cannot be overstated, and it significantly compromised the viability of the Applicant’s ability to achieve its projected volume assumptions. As indicated in Table D (below), 232 cases or 28.8% of the total projected incremental volumes for PSCF are based on existing surgeons in the center increasing their number of outpatient cases. Although it is reasonable to expect some incremental growth

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<sup>6</sup> <https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0> (accessed 12.13.2021); 86 Fed. Reg. 63548, 63671 (Nov. 16, 2021).

<sup>7</sup> It is also widely accepted that commercial third party payors follow CMS’s reimbursement and coding guidelines, which means that none of the commercial carriers are likely to reimburse the Applicant for these procedures in an outpatient ambulatory surgical facility.

based on the population’s increasing demands, a 28% growth among existing orthopedic surgeons seems unlikely. In response to Section 10.24.01.08G(3)(f), Impact on Existing Providers and the Healthcare Delivery System, the Applicant states, “PSCF projects to experience an increase in the number of joint replacements from [Frederick Health Hospital] FHH by 2025 around 200 per year and other cases are negligible....” (App. p. 53.) Therefore, the CMS decision to release the Inpatient Only List and to not add several hundred musculoskeletal procedures to the APC-CPL (Covered Procedure List)<sup>8</sup> should result in a reduction of Applicant’s estimated projected growth in orthopedic surgeries by approximately 20%.

**Table D – Source of Incremental Projected Volumes 2020 and 2021**

Volumes	2020	2021	Projected Change	Incremental Cases	Projected Change #	% of Total Incremental Cases
<b>CON Total</b>	2,060	2,865	805	Non-Orthopedic	230	28.6%
<b>Rate of Growth</b>		39%				
<b>Non-Orthopedic</b>				<u>Orthopedic Cases</u>		
Andochick	69	95		Hand Surgeries		
Mecinski	333	375		Nesbitt (Hand)	32	
Thadani	<u>513</u>	<u>675</u>		Horton (Hand)	226	
<b>Sub-total</b>	<b>915</b>	<b>1,145</b>	230	Total Hand	258	32.0%
<b>Rate of Growth</b>		25.1%				
<b>Mid-Muscularskeletal Institute (MMI)</b>				<u>Current Surgeons</u>		
Nesbitt (Hand)	643	675		Steinberg	61	
Steinberg	229	290		Levine	49	
Levine	166	215		Walsh	120	
Horton (Hand)	59	285		Henry	7	
Walsh	20	140		<u>Gupta</u>	(5)	
Henry	8	15		Total Existing Surgeons	232	28.8%
<u>Gupta</u>	<u>5</u>	<u>0</u>				
<b>Sub-total</b>	<b>1,130</b>	<b>1,620</b>	490	<u>New Surgeons</u>	<u>85</u>	<u>10.6%</u>
<b>Rate of Growth</b>		43.4%		Total Incremental Cases	805	100.0%
<b>Montgomery County</b>						
TBD						
TBD						
TBD						
<b>Sub-total</b>	<b>15</b>	<b>100</b>	85			
<b>Rate of Growth</b>		566.7%				

<sup>8</sup> See fn. 5.

A third built-in assumption relevant to the Applicant’s volume projections is its unreasonable turn-around-time (TAT) for all cases, which inflates the number of minutes that its proposed operating rooms will be utilized. Applicant used a TAT of 25 minutes for 100% of the projected volume of the ASC. (App. p. 31.) TAT, however, is best viewed as the amount of time required to clean and organize *between* cases. There can be zero surgical minutes available before the first procedure of the day because there is no procedure before the first procedure. Likewise, there can be no surgical minutes *after* the last procedure of the day because there are no procedures after the physician has left the operating room for the day. Therefore, the first and last cases do not have TAT. The number of cases performed in 2020 was 2060, which is a daily average of 8.2 assuming 251 operational days of the ASC. Assuming the first and last cases are removed from the average (two cases), then on average 6.2 cases would have a TAT or 76%. Table E below reflects the impact of this TAT error on the Applicant’s volume assumptions.

**Table E:** Number of OR Rooms affected by the technical calculation error.

	2020	2021	2022	2023	2024	2024
Total Volume	2060	2865	3275	3700	4175	4575
Stated TAT	51,500	71,625	81,875	92,500	104,375	114,375
	8.2					
1st & 2nd Case	2.0					
% of Total	24%					
Cases with TAT	76%					
Corrected TAT min.	38,950	54,171	61,923	69,959	78,940	86,503
Stated vs. Corrected	(12,550)	(17,454)	(19,952)	(22,541)	(25,435)	(27,872)
Converted to Hours	(209)	(291)	(333)	(376)	(424)	(465)
Portion of ASC Room	(0.13)	(0.18)	(0.20)	(0.23)	(0.26)	(0.28)

Each of these disproven assumptions (Dr. Steinberg’s continued practice, the procedures that are not Inpatient Only and not available for outpatient surgery per CMS, and the TAT

calculations) materially inflates the actual projected volume that the Applicant can anticipate. Table F below compiles all of those erroneous assumptions and shows, accurately, the overall impact on the Applicant’s volume projections.

**Table F – Impact of PSCF Assumptions on Overall Volume Projections**

<b>PSCF Assumptions</b>	<b>Note</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>
Surgical Cases	A	2,060	2,865	3,275	37,800	4,175	4,575
Surgical Minutes	B	108,883	151,845	196,500	222,000	250,500	274,500
Turn-Around-Times	C	<u>1,566</u>	<u>2,177</u>	<u>2,489</u>	<u>28,728</u>	<u>3,173</u>	<u>3,477</u>
Total Minutes	D	110,449	154,022	198,989	250,728	253,673	277,977
Hours	E	1,841	2,567	3,316	4,179	4,228	4,633
State Minimum	F	1,632	1,632	1,632	1,632	1,632	1,632
<b>Number of OR(s) Needed</b>	G	<b>1.13</b>	<b>1.57</b>	<b>2.03</b>	<b>2.56</b>	<b>2.59</b>	<b>2.84</b>
<b>Technically Incorrect Assumptions</b>							
Steinberg Leaving	H		(0.34)	(0.41)	(0.43)	(0.45)	(0.47)
CMS IPO List (5%)	I		(0.12)	(0.17)	(0.19)	(0.22)	(0.25)
<u>Reconciled TAT</u>	J		<u>(0.13)</u>	<u>(0.18)</u>	<u>(0.20)</u>	<u>(0.23)</u>	<u>(0.26)</u>
<b>Adjusted Number of OR</b>	K		<b>(0.59)</b>	<b>(0.76)</b>	<b>(0.83)</b>	<b>(0.89)</b>	<b>(0.97)</b>
<b>Actual Number of OR(s)</b>							
<b>PSC Needs</b>	L		<b>0.98</b>	<b>1.27</b>	<b>1.74</b>	<b>1.70</b>	<b>1.86</b>

<sup>1</sup> Table Notes and Assumptions:

- A - The number of projected surgical cases for the facility, Standard 0.05B(9) Impact, page 36.
- B - Surgical minutes abstracted from Table 2: Statistical Projections, page 41.
- C - Turn-around-time at 25 minutes per case, does not include first and last case or 24% of cases.
- D - Surgical minutes + Turn-around-times.
- E - Total surgical minutes divided by 60 to establish hours.
- F - State minimum is per operating room.
- G - Total projected surgical hours divided by the State minimum.
- H - Projected surgical cases by provider, Standard 0.05(9)(i) Impact, page 36, multiplied by 90 minutes average procedure (ii) time for Dr. Steinburg.
- I - Total cases projected reduced by 5%, multiplied by 90 minutes and accounting for turn-around-time that would not be required. This assumes conservatively that only 5% of Applicant’s projected volume was from now IPO precede.
- J - An average number of cases per day (251 days) is equal to 8 - first and last cases (2) = 6 cases with Turn-around-Time. 6/8 = 76%.

K - Sum of Adjustments based on technical errors.

L - Projected number of OR(s) need plus adjustments due to technical assumption errors equals actual OR(s) needed.

As demonstrated above, and correcting several of the assumptions in Applicant's own data, Applicant's need projections reveal a need for only 1.86 operating rooms well into 2025, which is its current operating room capacity. This establishes that no additional operating room capacity is warranted at all.

Even if the Commission relies on the flawed calculations provided by the Applicant without corrections, the Applicant's own data indicates a need into 2025 for only 2.84 operating rooms – which is less than the four requested.

#### [6. COMAR 10.24.01.08G\(3\)\(b\) - Need](#)

For all of the reasons expressed in detail above (*see herein*, §5, Standard .05B(9) Impact), Frederick Hospital again questions the volume projections which, in turn, are dependent on surgical minutes and volume calculated based upon the incorrect assumptions. The need simply is not justified due to the inherently incorrect assumptions relied upon by the Applicant.

#### [7. COMAR 10.24.01.08G\(3\)\(c\) - Availability of More Cost Effective Alternatives.](#)

COMAR 10.24.01.08G(3)(c) requires an applicant to discuss with specificity cost effective alternatives to the proposed project. The Commission recognizes that the utilization of surgical capacity in an ambulatory surgical center project compared to a hospital is very relevant to the analysis of cost effective alternatives. Specifically,

[t]he growth that has occurred throughout the nation in non-hospital settings for outpatient surgery and the shift in volume of outpatient surgery from hospitals to non-hospital settings, especially classes of surgery for which higher levels of reimbursement can be obtained, has raised concerns about the ultimate financial impact on hospitals.

COMAR 10.24.11.03B (citing Kehayes, K. and Hartzell, S. “Increasing surgery migration puts pressure on hospitals to develop an ASC plan.” *Becker’s ASC Review*, August 18, 2020).

The Commission has further acknowledged that:

[while t]he State’s all-payer hospital rate regulation reduces the risk that the loss of lucrative surgical lines of business will threaten a hospital’s financial viability, [...] the potential underutilization of hospital surgical capacity or a reduction in efficiency for hospitals as a result of a shift in outpatient surgical cases will be monitored by the MHCC and HSCRC.

COMAR 10.24.11.03B.

Applicant does not meet its burden of proof in addressing the most cost effective solution-utilizing existing operating room capacity. The same chapter of the SHP regulates both the provision of general surgical services by hospitals and ambulatory surgical facilities. The Applicant did not contact Frederick Hospital to identify or assess if the existing capacity existed to support the need for its projected needs.

There are multiple benefits to hospital operating rooms, however, that extend beyond economics, especially since the standard of “cost effective” does not specifically mean “cheapest provider.” Hospitals provide higher caliber staff and are available to provide more intensive resources for longer periods of time. Better healthcare outcomes are usually more cost effective to both the patient and the health care delivery system over the life of the patient. A hospital also can manage a higher complexity of cases and have more dynamic interactions with other providers in emergencies. Pre-surgical and post-surgical work is more effectively aligned by a hospital because the pre-surgical intake and post-surgery discharge planning is provided by specialized care coordination planners for more consistent surgical and post-acute care outcomes. Indeed, such post-discharge planning is required by law.<sup>9</sup> Hospitals have service integration, better information flow, more resources, and the

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<sup>9</sup> 42 C.F.R. §482.43.

implementation of best practices. In failing to address fully this very viable alternative, the Applicant did not satisfy its burden of proof with regard to addressing more cost-effective alternatives.

The Applicant also fails to address a hospital-planned expansion as a potentially more cost effective alternative. A hospital-owned ambulatory surgical facility could be part of an integrated care delivery model, managing care across the care continuum to ensure the most appropriate care setting. A hospital-guided physician alignment strategy would be to shift lower intensity surgical procedures to the hospital-owned facility while providing the physicians access to the hospital for inpatient and more complex outpatient procedures which need to be performed in a hospital based setting. Frederick Hospital would have incentives under the Maryland Total Cost of Care model to manage health care spending appropriately across the entire Frederick Health system, the parent organization to Frederick Hospital.

#### 8. COMAR 10.24.01.08G(3)(d) Viability of the Proposal.

COMAR 10.24.01.08G(3)(d) requires that an applicant demonstrate that its project is financially viable. In support of this standard, applicants are encouraged to document relevant community support. The Applicant states that community support is “evident” but there is no documentation (for example, no letters of support) provided to support that position, and Applicant sought no such support from Frederick Hospital<sup>10</sup>, a key stakeholder contributing to the community’s healthcare safety net, prior to making its Application.

This standard also requires that the anticipated revenue be supported by reliable data. Unfortunately, as mentioned herein, the anticipated revenue is largely dependent upon misguided volume projections and a significant increase in outpatient surgeries removed

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<sup>10</sup> As a result of the docketing of the Application, Frederick Hospital initiated contact with the Applicant to begin discussions about the Project.

from Frederick Hospital. As a result, the revenue figures in the Application are inaccurate and should not be relied upon to determine the viability of the Application.

#### 9. [COMAR 10.24.01G\(3\)\(f\) Impact on Existing Providers and the Health Care Delivery System](#)

The Commission must consider the impact of any proposed project on existing providers and the healthcare delivery system in general. COMAR 10.24.01.08G(3)(f). There are multiple reasons why the Project, if approved, will impact both Frederick Hospital and Maryland's healthcare delivery system. Some of those impacts are discussed above, but Frederick Hospital urges the Commission to consider the following additional detrimental effects as it weighs any benefits of the Project.

a. Patient Shift. The Applicant must address the proportion of volume expected to shift from other providers. *See also* Standard .05B(9)(a)(iii). In response to this requirement, the Applicant inconsistently concludes that its projected volume of procedures removed from the Hospital operating rooms “will not account for a large number of patients”. It is difficult to determine, however, what the impact would be on Frederick Hospital (even if the Inpatient Only list remained unchanged for CY2022), because Applicant does not clearly indicate the source of any anticipated volume for certain surgical procedures. PSCF only provides total volume projections. Moreover, the Applicant does not specify which surgeries it anticipates will be shifted from the Hospital to account for the expected cases identified in its response to .05B(9)(a)(ii), or how those surgeries will impact the Hospital's revenue. And, as has been noted with regard to many of the Applicant's responses, the case counts are not supported by any documentation. As a result, it is impossible for the Commission to determine, from the Application, the actual volume expected to shift from existing facilities to this newly proposed ambulatory surgical facility.

b. Case Mix - The Project will have a negative impact on case mix. The Applicant's six identified surgeons have a payer mix that is 61% commercial, with virtually no (less than 1%) charity care. The proposed expansion will remove less complex, more reimbursable procedures from Frederick Hospital (in a number that the Applicant declined to estimate accurately), and leave more complex, less reimbursable procedures to be performed at Frederick Hospital, which the Hospital will serve consistent with its expansive medically indigent care policy.

c. Staffing – The Project will have a negative impact on staffing, which may, in turn, impact patient safety. PSCF provides its anticipated workforce information in Table L. (*See App. immediately following p. 50.*) Based upon its representations, PSCF intends to hire incrementally 21 full time employees (FTEs) to support its proposed project.<sup>11</sup> PSCF does not discuss how it intends to develop or hire staff for its major expansion.

Furthermore, due in large part to the pandemic, the healthcare industry is experiencing a significant staffing shortage. The food service, retail, and health care industries have been among the hardest hit. In particular, 534,000 U.S. workers in health care or social assistance positions resigned or quit their jobs in August of 2021.<sup>12</sup> To date, 3.6% more healthcare workers quit already have their jobs in 2021 than in the prior year.<sup>13</sup> To exacerbate the problem, 20% of surgical nurses nationally are expected to reach retirement age within the next five years.<sup>14</sup> If surgeons are the eyes and hands of a surgical facility, surgical nurses are its backbone. Frederick Hospital has not been immune from the present staffing crisis.

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<sup>11</sup> 40.1 FTEs versus 19.1 on Table L workforce information.

<sup>12</sup> *See* Advisory Board, 2021, "The 'Great Resignation' is coming for health care. How can you respond?" <https://www.advisory.com/daily-briefing/2021/10/18/employees-quitting> (accessed 12/13/2021).

<sup>13</sup> *See* Harvard Business Review, Who is Driving the Great Resignation? <https://hbr.org/2021/09/who-is-driving-the-great-resignation> (accessed 12/13/2021).

<sup>14</sup> *See* Association of periOperative Registered Nurses (AORN), <https://www.aorn.org/outpatient-surgery/articles/news-archive/2021/august/chamberlain> (accessed 12/13/2021).

In fact, it recently sought assistance from Governor Hogan to address the ongoing shortages in support of its mission to provide care to the Frederick County community. (See, letter to Governor Hogan, attached hereto as Exhibit A.)

A healthcare staffing shortage has significant consequences to the delivery of high quality health care. Experts predict that the current staffing shortages could lead to higher infection rates, as well as other patient safety and care quality issues.<sup>15</sup> It remains crucial that Frederick Hospital retain its staff – the same staff that Frederick Hospital dedicated significant time and expense to nurture and train.

Given the staffing shortages, and no apparent plan outlined by Applicant to recruit elsewhere, any expansion in the midst of this staffing crisis, especially one that requires hiring highly specialized and highly trained surgical specialty registered nurses, will result in the Applicant turning to Frederick Hospital’s work force to fill its needs. Hospitals are the primary training grounds for medical staff. It is likely that the skilled surgical nurses who work in the hospital will be recruited to the proposed surgical center. With the Hospital left to recruit and train new surgical nurses, those surgical cases at the Hospital requiring the greatest care from complex co-morbidities will be supported by less experienced nurses, which will negatively impact the sickest of the surgical patients.

### **Conclusion**

Frederick Hospital respectfully requests that the Commission take these Comments into consideration and either deny PSCF’s Application or require the Applicant to meet its burden of proof by amending its Application before staff considers it for a final determination. As an interested party, Frederick Hospital also requests to receive copies of all relevant

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<sup>15</sup> See Becker’s Hospital Review, “The less-discussed consequence of healthcare’s labor shortage”, <https://www.beckershospitalreview.com/patient-safety-outcomes/the-less-discussed-consequence-of-healthcare-s-labor-shortage.html> (accessed 12/13/2021).

notices concerning the application for Docket No. 21-10-2451. Lastly, Frederick Hospital requests oral argument before a recommended decision is prepared.

Respectfully submitted,



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*Frederick Health Hospital, Inc.*

Affirmation

I hereby declare and affirm under the penalties of perjury that the facts stated in these Interested Party Comments 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

## Exhibit A



Thomas A. Kleinhanzl MHA, FACHE  
President & CEO

Frederick Health  
400 West 7<sup>th</sup> Street  
Frederick, MD 21701

240-566-3390

The Honorable Lawrence J. Hogan, Jr.  
Governor, State of Maryland  
100 State Circle  
Annapolis, MD 21401-1925

Dear Governor Hogan,

On behalf of Frederick Health (FH) and our more than 3,350 employees, I write to urge you to support the Maryland Hospital Association's request for the state to create a one-time \$100 million fund to support critical workforce needs in all hospitals in 2022. We supported our communities and your constituents throughout the pandemic at every juncture. We expanded access to care, ran testing sites in the community while partnering with the state on its sites, vaccinated the most vulnerable, and during it all, we saved more than 51,000 lives. And we were glad to do it.

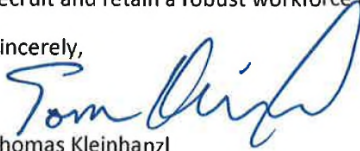
Now, your help is needed. We are facing an unprecedented workforce crisis. While demand for clinical staff is increasing due to the pandemic and aging of our communities, the availability of staff has decreased. The FH vacancy rate is currently 16% compared to 10% in 2019. Positions most challenging to hire are registered nurses (RN), nursing assistants, respiratory therapists (RT), and medical assistants. Agency costs have doubled, assuming staffing companies have clinicians available to contract. In 2020, an agency RN had an average hourly wage of \$90, as of today, the cost is \$200. For RT, agency rates increased by \$70 per hour to \$145 during the same time. These dynamics are fueling the nationally recognized burnout among healthcare staff as well as increasing labor costs. We are facing an incredibly steep increase in total salary dollars. Over the last 18 months, **FH has implemented \$16.8 million** in salary increases, bonuses, and incentives to ensure adequate staffing.

Due to these issues, we are facing increased Emergency (ED) Department wait times, increased ED patients leaving without being seen (LWBS), decreased Intensive Care Unit (ICU) capacity due to fewer ICU RNs and RRTs, and reduction in surgical capacity due to fewer operating room RNs. The sharp uptick in labor costs along with shortages may force us to reduce overall bed capacity, which is important for responding to the pandemic and expected healthcare needs of our community. In addition, the existing delays in timely ED and surgical care will be exacerbated that will have an impact on the health of our community. Moreover, our heroic staff will be burdened to sustain their health while attempting to meet patient needs as nurse-to-patient ratios will be affected. Unique programs that are consistent with the goals of reducing the total cost of care will be at risk as the staff is triaged to meet immediate patient care needs.

Hospitals are essential to the health of the state. And we are a massive economic engine for our local communities and Maryland as a whole. Given the tremendous strain on Maryland's acute and specialty

hospitals, a \$100 million one-time investment would provide a vital lifeline to ensure that hospitals can recruit and retain a robust workforce ready to tackle the challenges we face today and into the future.

Sincerely,

A handwritten signature in blue ink, appearing to read "Tom Kleinhanzl". The signature is fluid and cursive, with a large loop at the end.

Thomas Kleinhanzl  
President & CEO

CC:

The Honorable David R. Brinkley, Secretary, Maryland Department of Budget & Management

The Honorable Dennis Schrader, Secretary, Maryland Department of Health

Keiffer Mitchell, Chief Legislative Officer, Office of Governor Larry Hogan

Senator, Michael Hough

Senator, Ronald Young

Delegate, Barrie Ciliberti

Delegate, Daniel Cox

Delegate, Ken Kerr

Delegate Carol Krimm

Delegae Jesse Pippy

Delegate Karen Lewis-Young