AmSurg BMC, LLC DoN # 19102312-TO
Filing Date: October 31, 2019
DPH Questions: November 20, 2019
Applicant Responses

Overall Questions

1. Provide the APM contract percentage for the BMC patients, BMC GI, ENT and Hand surgery patients, and the PVSC patients using the table provided below.

Please refer to the tables below for the Baystate Medical Center ("BMC"); BMC gastroenterology ("GI"), ear, nose and throat ("ENT") and hand surgery; and Pioneer Valley Surgicenter ("PVSC") patient panel data.

BMC Patients							
APM Contract Percentages (for any system-affiliated Primary Care Physicians)				**Payer Mix-List Percentages (Must = 100%)**			
	FY16	FY17	FY18		FY16	FY17	FY18
ACO and APM Contracts	14.5%	15.2%	17.6%	Commercial	37.21%	37.13%	36.59%
				PPO/Indemnity	*22.37%*	*21.57%*	*18.29%*
				HMO/POS	*14.84%*	*15.56%*	*18.30%*
				MassHealth	13.49%	13.63%	15.95%
Non-ACO and Non-APM Contracts	85.6%	84.9%	82.4%	Managed Medicaid	20.33%	18.88%	15.93%
				Commercial Medicare	6.08%	6.74%	7.51%
				Medicare FFS	18.17%	18.79%	18.74%
				All Other	4.72%	4.83%	5.28%

BMC GI, ENT and Hand Surgery Patients							
APM Contract Percentages (for any system-affiliated Primary Care Physicians)				**Payer Mix-List Percentages (Must = 100%)**			
	CY16	CY17	CY18		CY16	CY17	CY18
ACO and APM Contracts	22.8%	23.4%	28.9%	Commercial	45.9%	44.9%	46.2%
				PPO/Indemnity	*28.0%*	*28.2%*	*29.5%*
				HMO/POS	*17.9%*	*16.7%*	*16.8%*
				MassHealth	9.0%	8.9%	5.8%
Non-ACO and Non-APM Contracts	77.2%	76.6%	71.1%	Managed Medicaid	11.5%	10.2%	12.0%
				Commercial Medicare	9.7%	11.2%	11.9%
				Medicare FFS	21.4%	21.9%	21.0%
				All Other	2.5%	3.0%	3.2%

PVSC Patients							
APM Contract Percentages (for any system-affiliated Primary Care Physicians)				**Payer Mix-List Percentages (Must = 100%)**			
	CY16	CY17	CY18		CY16	CY17	CY18
ACO and APM Contracts	3.4%	6.7%	6.6%	Commercial	65.36%	61.19%	58.29%
				MassHealth	3.55%	4.15%	6.57%
				Managed Medicaid	3.42%	6.66%	4.30%
Non-ACO and Non-APM Contracts	96.6%	93.3%	93.4%	Commercial Medicare	0.75%	0.68%	2.78%
				Medicare FFS	24.81%	24.16%	24.74%
				All Other	2.11%	3.16%	3.32%

2. Complete missing data in the Patient Panel chart (attached below).

The missing data in the Patient Panel chart is manually collected in each patient's file. Because this information is not centrally collected, it would be time and resource intensive to respond accurately to the Department of Public Health's ("DPH") request. However, effective immediately, PVSC will begin to track the data electronically in order to comply with future reporting requirements.

3. Factor 1 requires an Applicant demonstrate how a Proposed Project will provide reasonable assurances of health equity.

a. With respect to health equity we understand that PVSC provides language access. Describe what else PVSC is doing around CLAS. Refer to the guide on CLAS ://www.mass.gov/lists/making-clas-happen-six-areas-for- if needed.

PVSC is committed to the Culturally and Linguistically Appropriate Services ("CLAS") standards as well as cultural, linguistic, and health equity. Accordingly, PVSC has supported the adoption of the CLAS standards in the following ways, as divided into the six categories provided in DPH's guide to CLAS, "*Making CLAS Happen: Six Areas for Action"*:

1. Foster Cultural Competence

PVSC requires staff to complete code of Conduct and Corporate Compliance training. The training deals with appropriate staff interactions and diversity training. PVSC also offers additional diversity training courses if deemed necessary.

Furthermore, PVSC is dedicated to offering understandable, respectful care with an understanding of patients' cultural health beliefs and practices and preferred languages. As discussed in the DoN narrative, PVSC offers access to interpreter and translation services to ensure that all patients who need language access services obtain such services in a timely and competent manner. Through Language Services Associates, PVSC assists patients that are

limited-English speaking or hearing-impaired in order to eliminate barriers, promote health equity, and ensure equal access to services. Additionally, PVSC offers documents in both English and Spanish and employs several bilingual staff members.

2. Build Community Partnerships

Given PVSC's narrow focus on outpatient GI, ENT and hand surgery services, many of the activities related to continuity and coordination of care and community partnerships occur outside of PVSC, at the offices of the surgeons who perform procedures at PVSC. However, PVSC's process includes each patient being called at home by a nurse the day after surgery. Translators are utilized if needed for this post-op phone call. Inquiries are made about pain, mobility, medication, diet, nausea and vomiting, and problems with ambulation or dressing, and patient questions and concerns are addressed. All patients have access to follow-up calls with the physician on an as-needed basis.

Moreover, if approved, the Proposed Project will promote increased partnership among PVSC and the community. Specifically, BMC's acquisition of ownership in PVSC will bring the ASC within the Baystate Health, Inc. system. This will allow PVSC to serve as a setting for BMC to manage accountable care organization ("ACO") patients and will provide such patients with the benefits of physician/hospital cooperation, clinical integration and medical management services. Further, specialists on both BMC and PVSC's staff will have access to BMC's electronic health record ("EHR") clinic information system ("CIS") on a read-only basis in their offices and at PVSC, which will allow access to any social determinant of health ("SDoH") screening results in the system on a pre-op basis and promote management of any SDoH issues. As the Applicant also continues to investigate the possibility of further interoperability, such as PVSC's participation in the Pioneer Valley Information Exchange ("PVIX"), such management may be further improved. Finally, as part of the Baystate Health system, PVSC and its BMC-affiliated surgeons will be able to leverage the community resources that BMC currently partners with, as described in BMC's 2019 Community Health Needs Assessment (e.g., Caring Health Center, whose team of community health workers, health navigators, and interpreters ensure that patients receive comprehensive care that addresses their cultural, economic and language needs).

3. Collect and Share Diversity Data

PVSC collects patient demographic data, including but not limited to gender, age, race/ethnicity, and patient origin. While some of the data is already centrally collected in the EHR, other data, such as race/ethnicity, historically has been manually collected in each patient's file. Effective immediately, PVSC will begin to track this data electronically in order to comply with future reporting requirements.

While certain data has not historically been centrally collected in the EHR to-date, it nonetheless is still used to inform service offerings, such as translation and interpretation services, to meet patient needs and address health disparities. For instance, Springfield, where PVSC is located and where nearly 20% of PVSC's patients originate, is home to a high percentage of Hispanic/Latino individuals. Specifically, 43.8% of the city's population is Hispanic or Latino according to data from the United States Census Bureau. Moreover, 38.1% of the city's

individuals report speaking a language other than English, with individuals who are Spanish-speaking accounting for 32.8% of the 38.1% total. Based on this data, PVSC has not only implemented interpreter and translation services to ensure that all patients who need language access services obtain such services in a timely and competent manner, but also offers documents in both English and Spanish and employs several bilingual staff members.

4. Benchmark: Plan and Evaluate

PVSC's Quality Improvement Committee meets quarterly to discuss, amongst other things, any issues or complaints from patients. This includes any concerns/complaints regarding language access services. Moreover, contracts for language access services are evaluated on an annual basis for renewal with recommendation to the Board to continue or terminate the agreement should quality be sub-par. These quality improvement and assurance activities help PVSC ensure that its language access services are meeting the needs of its patient population.

5. Reflect and Respect Diversity

PVSC has the following policies in place related to diversity:

- Anti-Harassment and Anti-Discrimination – PVSC does not tolerate unlawful discrimination or harassment based on race, color, creed, ancestry, religion, age, gender, sexual orientation, ethnicity, genetic information, veteran status (past, present or future service in the Uniformed Services of the United States), pregnancy or related medical condition, national origin, disability, marital or other protected characteristics as required by local, state and federal law.
- Disability Accommodation – PVSC does not discriminate against a qualified individual with a disability in regard to application procedures, hiring, advancement, discharge, compensation, training, or other terms, conditions, and privileges of employment.
- Hiring and Pre-employment – PVSC is committed to providing equal employment opportunity to qualified persons without regard to race, age, sex, sexual orientation, gender identity, marital status, genetic information, national origin, religious beliefs, color, physical disability, mental disability, veteran status, or any other basis protected by federal, state, or local law.

6. Ensure Language Access

As discussed in the DoN narrative and noted above, PVSC is dedicated to offering understandable, respectful care with an understanding of patients' cultural health beliefs and practices and preferred languages. To this end, PVSC maintains language access services tailored and scaled to the needs of the patient populations it serves. Specifically, PVSC offers access to interpreter and translation services via Language Services Associates. Language Services Associates' services are available during all hours of operation both in person and over the phone, and offer patients access to qualified interpreters skilled in 200+ languages including American Sign Language. These services are provided at no cost to limited-English speaking and hearing-impaired patients. Moreover, PVSC offers documents in both English and Spanish and also employs several bilingual staff members. Following the change in ownership, PVSC will continue to provide these language access services with an understanding of patients'

cultural and linguistic beliefs, practices and preferences.

b. We understand BMC PCPs (as risk holders) hold responsibility for SDOH screening and referral. However, we still require additional information on this:

i. How will staff at PVSC review the EHR for evidence of positive screenings and referrals made? Here are two examples that help illustrate our need to understand continuity of care around addressing SDoH needs:

As discussed above, specialists on both BMC and PVSC's staff will not only have access to BMC's EHR CIS when performing surgery at BMC but will also have access to BMC's EHR CIS on a read-only basis in their offices and at PVSC. As the Applicant also continues to investigate the possibility of further interoperability, such as PVSC's participation in PVIX, such management may be further improved. Additionally, the Applicant will plan to augment PVSC's pre-op process to align with BMC's (that includes the SDoH screening).

- **A covered lives patient who has not been screened by his PCP for SDoH needs ends up seeking surgery services at PVSC, when it appears he is hungry.**

As noted above, the Applicant will plan to augment PVSC's pre-op process to align with BMC's (that includes the SDoH screening). If, however, the patient has not been screened for SDoH prior to appointment and the patient appears hungry on the day of the appointment, staff will speak with the patient and confirm if a request for assistance is needed. If a request for assistance is confirmed by the patient, staff will assist the patient by reaching out to the admitting physician to notify him/her of a potential SDoH situation. The admitting physician will then reach out and refer the patient back to his/her primary care physician ("PCP") or to the appropriate state agency or community-based organization for further assistance/follow-up.

- **A covered lives patient has been screened by a PCP for SDoH needs but clearly has ongoing needs, when she explains that she has no way to get home from the surgery.**

Prior to the surgery, the admitting physician will review the patient's medical records in BMC's EHR CIS in his/her office. This review will include any SDoH screening results. Moreover, as noted above, the Applicant plans to augment PVSC's pre-op process to align with BMC's (that includes the SDoH screening). Therefore, the admitting physician will be made aware of any SDoH needs and will follow-up with the patient prior to the surgery accordingly. In this example, if the admitting physician is made aware of a transportation issue prior to the day of the surgery, he/she will work with PVSC staff to arrange for post-op transportation for the patient provided that the patient has someone to accompany him/her home on, per the standard of care.

If, on the day of the surgery, PVSC staff learn for the first time that the patient has no way to get home from surgery, staff will inquire as to whether the patient has someone to accompany him/her home. If staff is able to confirm that the patient has someone to accompany him/her home, staff will arrange for post-op transportation for the patient and his/her support person. If, however, the patient does not have someone to accompany him/her home, the patient's surgery

will need to be re-scheduled, as it is a standard of care requirement that the patient has someone to accompany him/her home post-op. In this instance, staff will work with the admitting physician to explain this to the patient, re-schedule the surgery, and ensure that the patient has someone to accompany him/her home following the re-scheduled surgery.

ii. Explain how any of these processes differ for patients in particular ACOs.

Processes would not be different for an ACO patient vs. a non-ACO patient as the provider would not be aware of who were part of these plans.

4. Factor 1 requires us to consider "evidence of sounds community engagement and consultation throughout the development of the Proposed Project, including documentation of the Applicant's efforts to ensure engagement of community coalitions statistically representative of the Applicant's Patient Panel."[1] We require additional information on this issue:

a. Describe how members of the Patient and Family Advisory Council (PFAC) are selected and how you determined the degree to which they are reflective of the Patient Panel.

BMC's Patient and Family Advisory Council ("PFAC") meets the requirements set forth in DPH's Hospital Licensure regulations at 105 CMR 130.1800 and 130.1801. These regulations require: "At least 50% of the Council members shall be current or former patients and/or family members and should be representative of the community served by the hospital." BMC's PFAC consists of 2 staff members and 11 patient or family member advisors.

BMC strives to attract members that reflect the diversity of the community. Members are solicited through regular communications to BMC patients, families and the community, with preferential treatment given to individuals that have had an experience at/with BMC within the last 3 years. Specifically, in 2019, PFAC members were recruited in the following ways: community-based organizations; Facebook, Twitter, and other social media; BMC publications; promotional efforts within BMC to patients, families, providers and staff; recruitment brochures; and word of mouth/through existing members. While BMC has had some success in attracting diverse members in recent years, it is often a challenge to find individuals that are diverse/representative of the community, have a recent history of experience with BMC, are able to commit to the responsibilities of being a patient or family advisor, and are willing and able to advocate on behalf of other patients and families. Nonetheless, BMC will continue its efforts to recruit members that are reflective of the Patient Panel and the community.

b. List how many PFAC members of the total attended the September 18 meeting and any other attending (other than staff or clinicians employed by or working at BMC or PVSC).

In total, 10 individuals attended the September 18 PFAC meeting. Of the 10 individuals, 9 were PFAC members and 1 was a visitor (i.e. a non-BMC/non-PVSC employee).

[1] https://www.mass.gov/files/documents/2018/12/31/jud-lib-105cmr100.pdf

c. You state that it was important to engage PVSC patients because they will benefit from the project, but no one attended the October forum (pg. 21). How else will PVSC patients be engaged and consulted?

The Applicant emphasizes that the Proposed Project relates to an ambulatory surgical center ("ASC") and not a primary care practice. To this point, most ASC patients are one-time patients that come to the ASC for a specific purpose (e.g., for hand surgery) and do not come back again once they leave. Accordingly, while the Applicant thought it was important to engage PVSC patients around the Proposed Project and, therefore, undertook best efforts to host the October open forum at the ASC and publicize the forum at PVSC's individual physicians' practices, it is not altogether surprising that no one attended the forum.

The Applicant is willing to undertake further engagement and consultation efforts at DPH's direction. However, the Applicant reiterates that other community engagement efforts, such as the BMC PFAC meeting and publicization of the Proposed Project on BMC's and PVSC's websites, were taken to bring awareness of the Proposed Project to all patients, families, local residents and resident groups and provide an opportunity for comment on the Proposed Project.

Information About the Patient Panel

5. The DoN regulation states that Patient Panel in the case of a Transfer of Ownership also includes the Patient Panel of the Entity to be acquired. Throughout the Application you state that the need for the Proposed Project is based on the need of the Applicant, and more specifically BMC.

a. Explain how the integration will also benefit PVSC patients, including a description of the current situation and what is likely to improve as a result of the Proposed Project. (pg.12, pg.16, pg.23).

PVSC is an ASC location where surgeries are performed both by Baystate Health system-affiliated specialists and independent specialists. Specifically, Western Mass. Gastroenterology Associates; Ear, Nose and Throat Surgeons of Western New England; Western New England Hand Surgeons; and Baystate Medical Practices physicians currently maintain block schedules at BMC and PVSC (and other locations in some instances), and schedule patients for surgical services accordingly. The integration that will be achieved through the Proposed Project will benefit future patients of Western Mass. Gastroenterology Associates; Ear, Nose and Throat Surgeons of Western New England; Western New England Hand Surgeons; and Baystate Medical Practices/BMC through better alignment of a physician's block scheduling at each location – PVSC and BMC. Alignment of the block schedules will afford greater flexibility for the specialists and their patients and, therefore, a greater ability to perform services as appropriate at PVSC. For instance, alignment of BMC's Vice President of Surgical Services and her team with the specialists will allow for better planning and scheduling of patients at PVSC when appropriate and when the patient is amenable. To this point, if the Vice President of Surgical Services and her scheduling team is aware of the block time for a specific physician at PVSC then all parties can work to site the procedure based on knowing when the first available appointment at each site is. Overall, this will allow physicians to schedule patients sooner.

The Applicant also notes that the Proposed Project will improve information-sharing and coordination of care, which will benefit PVSC patients. Specifically, the Applicant plans, in the short-term, to set PVSC up with access as appropriate to BMC's EHR CIS. Specifically, specialists on both BMC and PVSC staff will not only have access to BMC's EHR CIS when performing surgery at BMC, but will also have access to BMC's EHR CIS on a read-only basis in their offices. This will allow the specialists to access pertinent patient medical history information during their pre-op appointments and evaluations. Moreover, staff and surgeons will also have read-only access to BMC's EHR CIS at PVSC, which will ensure access to necessary medical history and pre-op information during surgery. As the Applicant continues to investigate the possibility of further long-term interoperability, such as PVSC's participation in PVIX, such information-sharing and coordination may be even further improved.

b. Explain how BMC is promoting value-based cost-effective care through its participation in Baycare Health Partners (BHP) (pg.11).

Baycare Health Partners ("BHP") is a Health Policy Commission ("HPC")-certified ACO that is jointly owned by the Greater Springfield Independent Practice Association and Baystate Health, Inc., of which BMC is a member. The Applicant notes that the purpose of the HPC ACO certification program is to complement existing local and national care transformation and payment reform efforts, encourage value-based care delivery, and promote investments by all payers in high-quality and cost-effective care across the continuum. As an HPC-certified ACO, BHP exhibits the following core attributes: its provider participants and patients have a meaningful role in the governance of the ACO; its governing body monitors quality performance and sets performance improvement goals; it routinely stratifies its patient population and develops population health management programs to address identified needs; and it coordinates with other providers to deliver cross-continuum care. Moreover, in line with its mission to foster physician/hospital cooperation in order to improve the quality, safety, efficiency, sustainability, and cost-effectiveness of health care in the community, some of BHP's major roles include, but are not limited to: contracting with managed care organizations; providing clinical integration, medical management services and practice information systems/infrastructure support; serving as a forum for collaboration and education; and developing physician leaders in the business of medicine. Through BMC's participation in the Baystate Health system and BHP, it is involved in all of these activities with a goal of promoting coordinated, high-quality care to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services, preventing medical errors, enhancing efficiency and cost-effectiveness, and improving the overall patient experience.

i. Explain the benefits (physician/hospital cooperation, clinical integration, and medical management services) of acquisition of PVSC for the entire Patient Panel including how the Proposed Project will improve the current state (pg.12).

As noted throughout the DoN narrative, BMC's ownership in PVSC will enable access to a lower-cost setting for GI, ENT and hand surgery services within the Baystate Health system. In addition to this benefit, the Proposed Project offers further benefits related to physician/hospital cooperation, clinical integration, and medical management services. These benefits are discussed below.

First, as discussed above, the Proposed Project will allow better alignment of block schedules at both BMC and PVSC. This alignment of resources to schedule services will afford greater flexibility for the specialists and their patients and, therefore, a greater ability to perform services as appropriate at PVSC. In turn, this will allow physicians to schedule patients sooner. Moreover, by allowing for increased performance of cases at PVSC overtime, the Proposed Project will create more capacity and greater access to scheduling at BMC for other physicians. This will benefit both BMC and PVSC patients.

Additionally, the Proposed Project will improve information-sharing and coordination of care. In the short-term, the Applicant plans to set PVSC up with access as appropriate to BMC's EHR CIS (i.e., specialists on both BMC and PVSC staff will have access to BMC's EHR CIS when performing surgery at BMC, PVSC specialists will have access to BMC's EHR CIS on a read-only basis in their offices, and PVSC specialists and staff will also have read-only access to BMC's EHR CIS at the PVSC site itself). This will allow physicians performing surgery at PVSC to have access to necessary medical history and SDoH screening results in the system during pre-op appointments and will also allow surgeons and staff to have access to medical history, SDoH and pre-op information at the time of surgery at PVSC. The Applicant anticipates that this will help promote coordinated management of health and SDoH issues. Being that studies show that having access to integrated health information technology systems has a direct impact on health outcomes and leads to enhanced care coordination, the Applicant plans to continue to investigate the possibility of further long-term interoperability, such as PVSC's participation in PVIX. Through such efforts, coordination may be even further improved which will promote improved outcomes and better quality of life.

Finally, BMC will have a role in ensuring patients receive quality care and best practices are shared among PVSC and BMC. Specifically, following approval of the Proposed Project, BMC's Vice President of Surgical Services will sit on the board of the Applicant and PVSC. Being that PVSC's Quality Assurance Committee reports to the PVSC board, BMC's Vice President of Surgical Services will have an opportunity to review and participate in the Quality Assurance Committee processes and reports and effect changes when needed.

6. We understand current referrals to PVSC include certain BMC surgical patients. Explain the referring origin of current (and anticipated) PVSC surgical patients.

As discussed above, PVSC is an ASC location where surgeries are performed both by Baystate Health system-affiliated specialists and independent specialists. Currently, Western Mass. Gastroenterology Associates; Ear, Nose and Throat Surgeons of Western New England; Western New England Hand Surgeons; and Baystate Medical Practices physicians maintain schedules at BMC and PVSC (and other locations in some instances), and schedule patients for surgical services accordingly. Typically, referrals are made through the patient's PCP to the specialist. In some instances, patients self-refer (e.g., patients research and directly contact the specialist based on their respective health concern). From a referring perspective, the Applicant expects that nothing is likely to change from the current state.

7. In order to understand how the Proposed Project will improve continuity and coordination of care for the Patient Panel, describe the post-discharge follow-up protocols for surgical patients:

a. How you will ensure integration with primary care and other providers to achieve optimal post-surgical outcomes?

In the short-term, it is expected that a copy of the operating note will continue to be faxed to the patient's PCP or other appropriate physician. This includes information related to the procedure performed and lab results to ensure that the PCP or other referring provider has the pertinent information to care for their patient post-surgery. As the Applicant continues to investigate the possibility of further long-term interoperability, such as PVSC's participation in PVIX, such integration may be further improved.

b. Follow-up care (such as PT/OT) and other post-surgical care coordination for patients and how it is tracked.

Given PVSC's narrow focus on outpatient GI, ENT and hand surgery services, many of the activities related to continuity and coordination of care (such as referrals for PT/OT) occur outside of PVSC, at the offices of the surgeons who perform procedures at PVSC. Patients' post-op visits are scheduled through the surgeon's medical practice. To help facilitate post-surgical care, however, PVSC coordinates with the patient's PCP or other appropriate physician. As discussed above, currently and in the future short-term, the Applicant expects that a copy of the operating note will continue to be faxed to the patient's PCP or other appropriate physician. This note will include information related to the procedure performed and lab results to ensure that the PCP or other provider has the pertinent information to care for their patient post-surgery. The Applicant will continue to investigate the possibility of further long-term interoperability, such as PVSC's participation in PVIX, so as to further improve post-surgical integration.

In addition, patients are given verbal and written post-op care instructions based on the procedure performed and the physician's orders. To ensure compliance with such instructions and to check-in on post-surgical patients, PVSC's process includes a nurse calling a patient at home the day after surgery to assess pain, mobility, medication, diet, nausea and vomiting, and problems with ambulation or dressing, and to address patient questions and concerns. Translators are utilized if needed for this post-op phone call. All patients have access to the surgeon as needed by calling the physician's office.

c. A recent study suggests that preoperative education programs in ASCs are not always prescribed and its quality can be variable. Describe your preoperative education programming.

PVSC provides a brochure to patients that provides patient pre-op instructions including NPO requirements (e.g., fasting), arrival time, what to do regarding taking current medications, any special instructions (e.g., preps), the need to have someone accompany/drive them, and the need to have someone to stay with them after the surgery/procedure. Additionally, patients are contacted by PVSC prior to the date of surgery to review health history, arrival time, date of surgery instructions, and a reminder regarding the need to have a driver and someone to stay with them at home after surgery. In the event that the patient has a complex health history, the patient will be further screened, by phone or in person, by the anesthesiologist to ensure that the patient is an appropriate candidate for the ASC setting.

Being that PVSC is accredited by the Accreditation Association for Ambulatory Health Care and additionally is a member of the Massachusetts Association of Ambulatory Surgery Centers and the national Ambulatory Surgery Center Association, the Applicant is confident that PVSC maintains the highest standards of quality care, including high-quality preoperative education programming. Moreover, PVSC currently utilizes and will continue post-transaction to utilize the Outpatient and Ambulatory Surgery Community Assessment of Healthcare Providers and Systems ("OAS-CAHPS") Survey. The OAS-CAHPS Survey is a patient experience survey administered to patients of ambulatory and outpatient facilities that includes questions related to six key areas: (1) Before a patient's procedure; (2) Facility and staff; (3) Communications about the procedure; (4) Recovery; (5) Overall experience; and (6) Patient demographics. PVSC currently scores high on these surveys and the Applicant has established a benchmark of 88% for top-box scores for "Overall Experience" at PVSC post-transaction, which is the top decile for reporting providers. Accordingly, the OAS-CAHPS Survey will be a way to measure quality preoperative education programming at PVSC into the future.

8. You mention the Pioneer Valley Information Exchange (PVIX) (Pgs 19-20). Pending PVSC's participation in PVIX, how will you promote integration and coordination?

The Applicant notes that it continues to review the possibility of further long-term interoperability, such as PVSC's participation in PVIX. In the short-term, however, the Applicant plans to set PVSC up with access as appropriate to BMC's EHR CIS. Specifically, specialists on both BMC and PVSC staff will have access to BMC's EHR CIS when performing surgery at BMC, PVSC specialists will have access to BMC's EHR CIS on a read-only basis in their offices, and PVSC specialists and staff will also have read-only access to BMC's EHR CIS when performing surgery at PVSC. This will allow staff and physicians performing surgery at PVSC to have access to necessary medical history, SDoH and pre-op information throughout the pre-op assessment and surgical encounter, which the Applicant anticipates will help to promote coordinated management of health and SDoH issues. Moreover, in the short-term, PVSC will continue its current practice of communicating results of any procedure with the referring physician and/or PCP or other appropriate physician (e.g., via fax). This includes information related to the procedure performed and lab results to ensure that the PCP or other provider has the pertinent information to care for their patient post-surgery.

9. You state in CY18 12,420 patients received GI, ENT and/or hand surgery services at BMC (pg.4). You also state that this is the number of patients that may have been eligible to have their surgical procedure at an outpatient facility, such as PVSC (pg. 9).

a. Provide the percentage of GI, ENT and hand of these 12,420.

Of the total 12,420 patients who received GI, ENT and/or hand surgery services at BMC in CY2018: 78% were GI surgical patients (9,680 patients); 8% were ENT surgical patients (953 patients); and 14% were hand surgical patients (1,787 patients).

b. You state that the Proposed Project would allow appropriate patients to receive high-quality GI, ENT and hand surgery services in a cost-effective, operationally-efficient, community-based and convenient setting (pgs.9, 11).

i. What percentage of all patients receiving GI, ENT and/or hand surgery do you anticipate shifting to PVSC for surgery?

It is estimated that a very high percentage (in excess of 90%) of the historical GI surgical activity at BMC could be performed in a freestanding ASC setting, and that greater than 50% of the historical ENT and hand surgery cases at BMC could be performed in a freestanding ASC setting. Based on this historical data and on available capacity at PVSC by specialty, it is estimated that 4,000 patients could be shifted and scheduled to receive their care at PVSC per year. The greater majority of these patients will be GI patients (approximately 3,400-3,600 cases per year), with an estimated 200-300 ENT and hand surgery cases each shifted to PVSC for surgery per year.

c. You also state that the Proposed Project will allow patients to select the ASC for their surgery needs (pg. 15).

i. How are you educating patients about this choice?

Currently, the specialist's office informs the patient of their options in the area. For example, Western Mass. Gastroenterology Associates provides patients with three options as to where the procedure can be performed (BMC, PVSC or Mercy Medical Center). This overall process will not change, although better alignment of the physicians' block schedules at both BMC and PVSC will create a greater ability to present both options to their patients in terms of offering more timely appointments.

10. You state that over the last few years, some ENT procedures have already been moved from BMC to PVSC.

a. What percentage of ENT patients receiving these procedures were transferred over the last 3 years?

The Applicant emphasizes, as a clarifying point, that PVSC is an ASC location where surgeries are performed both by Baystate Health system-affiliated specialists and independent specialists. Specifically, Western Mass. Gastroenterology Associates; Ear, Nose and Throat Surgeons of Western New England; Western New England Hand Surgeons; and Baystate Medical Practices physicians currently maintain block schedules at both BMC and PVSC (and other locations in some instances). To this point, BMC does not "transfer" patients to PVSC. Rather, the physicians that maintain block schedules at both BMC and PVSC schedule patients for surgical services accordingly. Therefore, there is no specific "transfer" rate of ENT patients from BMC to PVSC over the last 3 years. However, to respond to DPH's request, the Applicant offers the following information: the increase in ENT cases performed by the group at PVSC was 16.1% from 2016 to 2018 while over the same period cases declined at BMC by 14.9%.

b. How do you anticipate that percentage increasing over time through this Project?

As noted above, it is estimated that an additional 200-300 patients receiving ENT surgery will be scheduled at PVSC rather than BMC per year.

11. Explain why acquiring PVSC will address Patient Panel need for access to ambulatory surgery more effectively than the current system for transferring select patients to PVSC?

Please note, as discussed above, that BMC does not "transfer" patients to PVSC; rather, the physicians that perform their cases at both locations determine scheduling between the two locations based on the block schedules that they maintain. Nonetheless, BMC's acquisition of ownership in PVSC will address Patient Panel need for access to ambulatory surgery more effectively than the current system, as such acquisition will enable collaboration in aligning block schedules. This will afford greater flexibility for the specialists and their patients (i.e., the integration of the scheduling would allow for offering the patient the first available appointment at each setting) and, therefore, a greater ability to perform services as appropriate at PVSC.

12. In order to understand how the Proposed Project will improve health outcomes and quality of life:

a. Describe patient outcomes and quality of life measures that will be improved as a result of the Proposed Project.

Patient outcomes and quality of life measures for patients are very high at both BMC and PVSC. By transferring appropriate patients to PVSC, the Applicant anticipates that patients will continue to receive high, if not improved, patient outcomes and quality. To ensure that patients receive high-quality care and outcomes, the Applicant has proposed several clinical quality indicators that it will track and report on for PVSC following the transaction (i.e., patient satisfaction, hospital transfers and patient falls). The Applicant is willing to track and report on further measures at DPH's direction.

b. Explain how additional oversight from BMC will improve the quality of care (pg.14).

As discussed in Question #5, BMC will have a role in ensuring patients receive quality care and best practices are shared among PVSC and BMC. Specifically, following approval of the Proposed Project, BMC's Vice President of Surgical Services will sit on the board of the Applicant and PVSC. Being that PVSC's Quality Assurance Committee reports to the PVSC board, BMC's Vice President of Surgical Services will have an opportunity to review and participate in the Quality Assurance Committee processes and reports and effect changes when needed. Although PVSC is already a high-quality ASC (e.g., it is accredited by the Accreditation Association for Ambulatory Health Care and additionally is a member of the Massachusetts Association of Ambulatory Surgery Centers and the national Ambulatory Surgery Center Association), this additional oversight from BMC's Vice President of Surgical Services is anticipated to further improve quality of care.

c. You state that the Proposed Project will operate more efficiently and result in shorter wait times (pg.15).

i. What are the current wait times for BMC surgery patients and for PVSC patients for the surgeries in question?

Currently, wait times at PVSC range from 1-3 weeks depending on the surgeon. At BMC, wait times are as follows: for GI surgery, 30 days; for ENT surgery, 2-3 weeks, and for hand surgery, 2 weeks.

ii. How will the Proposed Project impact wait times?

It is anticipated the that the Proposed Project will result in an overall decrease in wait times at BMC, as lower acuity patients are shifted to the more appropriate ASC setting, thereby opening up slots and effecting more timely access to surgical care at BMC. While this will result in additional patients being seen at PVSC, the Applicant is confident that this shift will not result in poor wait times at PVSC. As discussed in the DoN narrative, due to operating efficiencies, ASCs – like PVSC – are substantially faster than hospitals at performing outpatient procedures. According to the data, procedures performed in ASCs take, on average, 31.8 fewer minutes than those performed in hospitals – a 25% difference relative to the mean procedure time. Consequently, for an ASC and a hospital outpatient department that have the same number of staff and of operating and recovery rooms, the ASC can perform more procedures per day than the hospital.[2]

[2] Elizabeth L. Munnich & Stephen T. Parente, *Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up*, 33 HEALTH AFFAIRS 764 (2014), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1281.

Table 1: Overview of BMC Patient Panel, BMC GI, ENT, and Hand Surgery Patients, and PVSC Patients[3]

	BMC patients	BMC Surgery Patients	PVSC patients
Total Unique Patients (FY18)	201,718	12,420	7,046
Gender (FY18)			
Male	41%	47%	50%
Female	59%	53%	50%
Age (FY18)			
0-18	22%	5%	10%
19-64	56%	68%	53%
65+	22%	27%	37%
Race (FY18)[4]			
White	58%	68.6%	
Black/African American	9%	6.9%	
Asian	1.5%	1.3%	
Hispanic/Latino	27%	20.6%	
American Indian/Alaska Native	0.1%	0.1%	
Other/Unknown	4.3%	2.6%	
Patient Origin (FY18)[5]			
• 85% of BMC's patients are from 20 communities • 86% of BMC's GI, ENT, and hand surgery patients are from 20 communities • 87% of PVSC's patients are from 20 communities	Springfield 34.9% Chicopee 9% West Springfield 5.2% Westfield 4.4% Holyoke 4.2% Ludlow 3.5% Agawam 2.7% East Longmeadow 2.6% Longmeadow 2.4% Wilbraham 2.2%	Springfield 29.6% Chicopee 9.3% West Springfield 5.2% Westfield 4.8% Ludlow 4.1% Holyoke 3.9% East Longmeadow 3.5% Longmeadow 3.4% Wilbraham 3.1% Agawam 3.1%	Springfield 19.8% Chicopee 7.8% West Springfield 6.2% Ludlow 6.5% Longmeadow 6.3% Westfield 5.9% East Longmeadow 5.4% Wilbraham 4.7% Agawam 4.3% Feeding Hills 4.0%

[3] The Applicant is a newly formed joint venture between BMC and AmSurg, so the Applicant does not have a patient panel. The Applicant instead relied upon patient panel data from BMC (patient population and surgery patients) and the ASC (PVSC) to establish need for the Proposed Project.
[4] Based on self-reporting
[5] Represents top ten communities from which patients originate.

AmSurg BMC, LLC DoN # 19102312-TO
Filing Date: October 31, 2019
DPH Questions: January 14, 2020
Applicant Responses

In your response to DoN follow-up questions, you state the following:

a. **Of the total 12,420 patients who received GI, ENT and/or hand surgery services at BMC in CY2018, 78% (9,680 patients) were GI surgical patients; 8% (953 patients) were ENT surgical patients, and 14% (1,787 patients) were hand surgical patients.**
b. **90% of the historical GI surgical activity at BMC and 50% of the historical ENT and hand surgery cases at BMC could be performed in a freestanding ASC setting.**
c. **Based on historical data and available capacity at PVSC, 4,000 patients (3,400-3,600 GI cases, 200-300 ENT and hand surgery cases) could be shifted and scheduled to receive their care at PVSC per year.**

1. **In order to understand how the Proposed Project will address Patient Panel need for outpatient surgery in the ASC setting, we need to understand more about the volume of these procedures now and how that will change in the future when more procedures are moved/shifted to PVSC by surgeon/patient choice.**

CY2018	Patients	Number of Procedures
BMC[1]		
GI	9,680	13,739
ENT	953	1,513
Hand Surgery	1,787	4,220
PVSC		
GI	5,783	6,784
ENT	1,050	1,694
Hand Surgery	377	591

	For BMC - Code	Definition	2018 Volume
Five Highest Volume CPT Code #s--GI	1) 45385	Colonoscopy, flexible w/ removal of tumor, polyp, or other lesion by snare TQ	2,773
	2) 43239	EGD transoral w/ biopsy, single or multiple	2,381
	3) 45380	Colonoscopy w/ biopsy, single or multiple	2,023
	4) 45378	Colonoscopy, flexible; dx w/ collection of specimens when performed	1,931
	5) 43235	EGD transoral diagnostic	1,178
Five Highest Volume CPT Code #s--ENT	1) 69436	Tympanostomy general anesthesia	172
	2) 42820	Tonsillectomy and adenoidectomy < age 12	107
	3) 69930	Cochlear device implantation w / wo mastoidectomy	107
	4) 30520	Septoplasty or submucous resection w / wo cartilage graft	76
	5) 42830	Adenoidectomy < age 12	74

[1] Data for procedures is CPT codes billed. Some of the codes are used more than once per surgical encounter in particular in hand surgery where multiple fingers/joints in the hands are repaired in the same surgical encounter.

Five Highest Volume CPT Code #s--Hand Surgery	1) 25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints	328
	2) 25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	273
	3) 26440	Tenolysis, flexor tendon; palm or finger, each tendon	239
	4) 26055	Tendon sheath incision	184
	5) 64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	157

	For PVSC - Code	**Definition**	**2018 Volume**
Five Highest Volume CPT Code #s--GI	1) 45385	Colonoscopy, flexible w/ removal of tumor, polyp, or other lesion by snare TQ	1,705
	2) 45378	Colonoscopy, flexible; dx w/ collection of specimens when performed	1,488
	3) 45380	Colonoscopy w/ biopsy, single or multiple	1,130
	4) 43239	EGD transoral w/ biopsy, single or multiple	1,122
	5) G0105	Colorectal cancer screening; high risk individual	507
Five Highest Volume CPT Code #s--ENT	1) 69436	Tympanostomy general anesthesia	530
	2) 42830	Adenoidectomy < age 12	130
	3) 42826	Removal of tonsils	124
	4) 30520	Septoplasty or submucous resection w / wo cartilage graft	117
	5) 42820	Tonsillectomy and adenoidectomy < age 12	111
Five Highest Volume CPT Code #s--Hand Surgery	1) 26442	Release palm and finger tendon	124
	2) 64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	124
	3) 20926	Removal of tissue for graft	61
	4) 29848	Wrist endoscopy / surgery	61
	5) 26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (e.g., intrasmusc)	22

In answering the questions above, what is the current PVSC capacity to accommodate additional surgical procedures? We understand that PVSC has capacity to accommodate 15,000 surgical procedures yearly.[2]

It is estimated that Pioneer Valley Surgicenter ("PVSC") has the capacity to add approximately 4,000 more patients. It is estimated that will result in approximately 5,000 procedures.

[2] CPA report page 3.

2. In your response to DoN follow-up questions, you state that PVSC is an ASC location where surgeries are performed by *Baystate Health System-affiliated specialists and independent specialists*.[3] You say these physicians currently maintain block schedules at BMC and PVSC and schedule patients for surgical services accordingly. Explain how many surgeons are part of these practices, and the percentage that participate as MassHealth providers.

The Applicant wishes to amend its original response. Currently, physicians from Western Mass. Gastroenterology Associates ("Western MA GI Associates"), Ear, Nose and Throat Surgeons of Western New England ("ENT Surgeons of WNE"), and Western New England Hand Surgeons ("WNE Hand Surgeons"), as well as certain independent physicians, maintain block schedules at Baystate Medical Center ("BMC") and PVSC (and other locations in some instances), and schedule patients for surgical services accordingly. These providers, who are listed below, are on the medical staff at both BMC and PVSC. 100% of these providers participate in MassHealth.

	Provider	**Practice Group**
Gastroenterology	Paul Farkas, MD	Western MA GI Associates
	Marc Goldman, MD	Unaffiliated
	Kenneth Koenigs, MD	Western MA GI Associates
	Joanna Sampson, MD	Western MA GI Associates
	Barry Slitzky, MD	Western MA GI Associates
	Peter Weinstein, MD	Western MA GI Associates
Otolaryngology	Lauren Busekroos, MD	ENT Surgeons of WNE
	Robert Eppsteiner, MD	ENT Surgeons of WNE
	Barry Jacobs, MD	ENT Surgeons of WNE
	Theodore Mason, MD	ENT Surgeons of WNE
	Daniel Plosky, MD	ENT Surgeons of WNE
	Jacquelyn Reilly, MD	ENT Surgeons of WNE
	Jerry Schreibstein, MD	ENT Surgeons of WNE
Orthopedics	Jeffrey Wint, MD	WNE Hand Surgeons
	Bruce Wintman, MD	WNE Hand Surgeons

In the future, the Applicant has plans for Baystate Medical Practices ("BMP") physicians to be credentialed to perform surgery at PVSC. However, these physicians are not currently on the medical staff at PVSC and therefore do not currently perform surgeries at PVSC. The panel of patients for those specialties at BMC that was provided with the DoN application (i.e., GI, ENT, and hand surgery) includes both the physicians listed above that are currently on the medical staff at PVSC as well as existing BMP physicians. Therefore, it is anticipated – while recognizing that the decision ultimately rests with the individual physician and patient – that the Proposed Project will result in an increase in utilization at PVSC and a decrease in utilization at BMC for appropriate surgeries.

[3] Western Mass. Gastroenterology Associates; Ear Nose and Throat Surgeons of Western New England; Western New England Hand Surgeons; and Baystate Medical Practices.

3. How will PVSC accommodate the ~30% of (appropriate) surgical patients who are being managed under APM/ACO contracts? We note that of the total of PVSCs current patients, a low percentage comes from those managed under APM/ACO contracts?

Of the 28.9% of BMC's GI, ENT and hand surgery patients who were managed under APM/ACO contracts in CY2018, the breakdown is as follows:

- BC AQC = 2.8%
- Medicare Next Generation ACO = 12.9%
- Health New England Medicare Risk = 1.8%
- Health New England Fully Funded HMO Baycare = 5.0%
- Health New England Medicaid ACO = 6.4%

From a Health New England perspective, PVSC previously entered into a contract with Health New England's Medicaid ACO, as discussed in the DoN narrative. This activity is captured in the APM/ACO percentage submitted for PVSC. Additionally, PVSC has recently entered into a new contract with Health New England to also accept Medicare and Commercial. Therefore, all of the patients that are part of these contractual arrangements now have access to PVSC. This represents 13.2% of the total 28.9% of BMC's GI, ENT and hand surgery patients who were managed under APM/ACO contracts in CY2018.

For BC AQC and Medicare Next Generation ACO (which together comprise the remaining 15.7% of the total 28.9%), BMC is able to track this information based on knowing a patient's primary care physician ("PCP"). However, PVSC historically would not know this information. Therefore, PVSC likely has already been seeing patients managed under these APM/ACO contracts without being able to track such participation.

4. In your response to DoN follow-up questions, you state that you will augment PVSC's pre-op process to align with BMC's, including social determinants of health (SDoH) screening. In order to understand how the Proposed Project contributes to health equity as required in Factor 1:

a. Explain how BMC's SDoH screening works, as well as the referral and tracking for positive screening.

<u>Overall SDoH Screening</u>

The Applicant notes that variation exists within the Baystate Health system hospitals as to the populations that are screened for Social Determinants of Health ("SDoH") and the logistics for screening. However, at a minimum, the Baystate Health system primary care practices and health centers that are participating in the BeHealthy ACO Program are screening patients for SDoH needs. Specifically, a 6-item health-related social needs screening tool is used to screen all BeHealthy ACO members for SDoH. The screening is built into the electronic health record (which allows for tracking) and the majority of screenings are completed within the member's appointment at their respective PCP and/or health center. If an SDoH concern is identified, the member is connected with a Community Health Worker ("CHW"). The CHW makes appropriate referrals to social service agencies in the community that can help address the member's concerns. Depending on the level of concern identified, a CHW can work with a member for as

little as a day or up to a few months. CHWs address the SDoH concerns by making referrals, educating member's on local resources, conducting home visits to follow-up on SDoH applications, navigating the health system with the member, and even attending appointments together.

Surgical Patients

For surgical patients specifically, BMC uses what is referred to as the "Green Sheet" for SDoH screening. Staff initially prepares a Pre-Op Assessment Evaluation ("PAE") via phone call using the "Green Sheet." The PAE questions relate to SDoH issues that are relevant to a surgical appointment. For example, the PAE covers any health issues, and also addresses concerns such as safety at home, transportation, flights of stairs, mental health, substance abuse, etc. This assessment is then reviewed again with the patient at an in-person appointment which includes the medical clearance phase of the pre-op assessment. If, during the PAE process or at any time during a patient's pre-op or surgical appointment, staff become concerned that a SDoH issue exists, a social worker is brought in to assist. The social worker will assist the patient directly by addressing the identified risks and/or will refer the patient back to his/her PCP for additional follow-up and linkage to community-based support.

a. Outline any differences in the process for patients in ACOs/managed risk plans vs non-ACO patients/managed risk plans.

The 6-item health-related social needs screening tool is used to screen all BeHealthy ACO members for SDoH; variation exists among patients in other ACOs and non-ACO patients. However, there is no difference in the "Green Sheet"/PAE process outlined above for BMC surgical patients in ACOs/managed risk plans vs. non-ACO patients/managed risk plans.

b. How will PVSC's pre-operative process align with BMC's SDoH screening process?

The Applicant plans to augment PVSC's pre-operative process to parallel BMC's "Green Sheet"/PAE process as described above for surgical patients. In PVSC's case, if, during the PAE process or at any time during a patient's pre-op or surgical appointment, staff become concerned that a SDoH issue exists, staff will assist the patient by reaching out to the admitting physician to notify him/her of a potential SDoH situation. The admitting physician will then reach out and refer the patient back to his/her PCP or to the appropriate state agency or community-based organization for further assistance/follow-up.