

NEW ENGLAND BAPTIST SURGERY CENTER, LLC

**APPLICATION FOR DETERMINATION OF NEED; APPLICATION # XXX FOR AMBULATORY SURGERY
CENTER**

August 31, 2022

BY

NEW ENGLAND BAPTIST SURGERY CENTER, LLC

40 ALLIED DRIVE, DEDHAM, MA 02026

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Massachusetts Department of Public Health

Determination of Need

Application Form

Version: 11-8-17

Application Type:	Ambulatory Surgery	Application Date:	
Applicant Name:	New England Baptist Surgery Center, LLC		
Mailing Address:	40 Allied Drive, Suite #200		
City:	Dedham	State:	Massachusetts
		Zip Code:	02026
Contact Person:	Alan H. Einhorn	Title:	Of Counsel
Mailing Address:	111 Huntington Avenue		
City:	Boston	State:	Massachusetts
		Zip Code:	02199
Phone:	6173424094	Ext:	
E-mail:	AEinhorn@foley.com		

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name:			
Facility Address:	40 Allied Drive, Suite #200		
City:	Dedham	State:	Massachusetts
		Zip Code:	02026
Facility type:	Freestanding Ambulatory Surgery Facility	CMS Number:	
Add additional Facility		Delete this Facility	

1. About the Applicant

1.1 Type of organization (of the Applicant):	for profit
1.2 Applicant's Business Type:	☐ Corporation ☐ Limited Partnership ☐ Partnership ☐ Trust ☒ LLC ☐ Other
1.3 What is the acronym used by the Applicant's Organization?	NEBSC
1.4 Is Applicant a registered provider organization as the term is used in the HPC/CHIA RPO program?	☐ Yes ☒ No
1.5 Is Applicant or any affiliated entity an HPC-certified ACO?	☒ Yes ☐ No
1.5.a If yes, what is the legal name of that entity?	Beth Israel Lahey Health Performance Network, LLC
1.6 Is Applicant or any affiliate thereof subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00 (filing of Notice of Material Change to the Health Policy Commission)?	☒ Yes ☐ No
1.7 Does the Proposed Project also require the filing of a MCN with the HPC?	☒ Yes ☐ No

1.7.a If Yes, has Material Change Notice been filed?

☒ Yes ☐ No

1.7.b If yes, provide the date of filing.

01/18/2022

1.8 Has the Applicant or any subsidiary thereof been notified pursuant to M.G.L. c. 12C, § 16 that it is exceeding the health care cost growth benchmark established under M.G.L. c. 6D, § 9 and is thus, pursuant to M.G.L. c. 6D, §10 required to file a performance improvement plan with CHIA?

☐ Yes ☒ No

1.9 Complete the Affiliated Parties Form

2. Project Description

2.1 Provide a brief description of the scope of the project.

See attached Narrative.

2.2 and 2.3 Complete the Change in Service Form

3. Delegated Review

3.1 Do you assert that this Application is eligible for Delegated Review?

☐ Yes ☒ No

4. Conservation Project

4.1 Are you submitting this Application as a Conservation Project?

☐ Yes ☒ No

5. DoN-Required Services and DoN-Required Equipment

5.1 Is this an application filed pursuant to 105 CMR 100.725: DoN-Required Equipment and DoN-Required Service?

☐ Yes ☒ No

6. Transfer of Ownership

6.1 Is this an application filed pursuant to 105 CMR 100.735?

☐ Yes ☒ No

7. Ambulatory Surgery

7.1 Is this an application filed pursuant to 105 CMR 100.740(A) for Ambulatory Surgery?

☒ Yes ☐ No

7.2 If yes, is Applicant or any affiliate thereof a HPC-certified ACO OR in the process of becoming a Certified ACO?

☒ Yes ☐ No

7.2.a If yes, Please provide the date of approval and attach the approval letter:

04/12/2022

7.3 Does the Proposed Project constitute: (Check all that apply)

- ☐ Ambulatory Surgery capacity located on the main campus of an existing Hospital **105 CMR 100.740(A)(1)(a)(i);**
- ☒ An Expansion, Conversion, Transfer of Ownership, transfer of Site, or change of designated Location for Ambulatory Surgery capacity located on a satellite campus of an existing Hospital **105 CMR 100.740(A)(1)(a)(ii);**
- ☐ A Freestanding Ambulatory Surgery Center within the Primary Service Area of an independent community hospital (Refer to a list that we update regularly with support from HPC) **105 CMR 100.740(A)(1)(a)(iii);** or
- ☐ An Expansion, Conversion, Transfer of Ownership, transfer of Site, or change of designated Location for a Freestanding Ambulatory Surgery Center that received an Original License as a Clinic on or before January 1, 2017 **105 CMR 100.740(A)(1)(a)(iv).**

7.4 See section on Ambulatory Surgery in the Application Instructions

8. Transfer of Site

8.1 Is this an application filed pursuant to 105 CMR 100.745?

☐ Yes ☒ No

9. Research Exemption

9.1 Is this an application for a Research Exemption?

☐ Yes ☒ No

10. Amendment

10.1 Is this an application for a Amendment?

☐ Yes ☒ No

11. Emergency Application

11.1 Is this an application filed pursuant to 105 CMR 100.740(B)?

☐ Yes ☒ No

12. Total Value and Filing Fee

Enter all currency in numbers only. No dollar signs or commas. Grayed fields will auto calculate depending upon answers above.

Your project application is for: Ambulatory Surgery

12.1 Total Value of this project:

\$26,273,899.00

12.2 Total CHI commitment expressed in dollars: (calculated)

\$1,313,694.95

12.3 Filing Fee: (calculated)

\$52,547.80

12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:

12.5 Total proposed Construction costs, specifically related to the Proposed Project, If any, which will be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated total dollars.

13. Factors

Required Information and supporting documentation consistent with 105 CMR 100.210

Some Factors will not appear depending upon the type of license you are applying for.

Text fields will expand to fit your response.

Factor 1: Applicant Patient Panel Need, Public Health Values and Operational Objectives

F1.a.i Patient Panel:

Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant's existing patient panel and payer mix.

See attached Narrative.

F1.a.ii Need by Patient Panel:

Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.

See attached Narrative.

F1.a.iii Competition:

Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.

See attached Narrative.

F1.b.i Public Health Value /Evidence-Based:

Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

See attached Narrative.

F1.b.ii Public Health Value /Outcome-Oriented:

Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

See attached Narrative.

F1.b.iii Public Health Value /Health Equity-Focused:

For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's need-base, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g. culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.

See attached Narrative.

F1.b.iv Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

See attached Narrative.

F1.c Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.

See attached Narrative.

F1.d Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project.

See attached Narrative.

F1.e.i Process for Determining Need/Evidence of Community Engagement: For assistance in responding to this portion of the Application, Applicant is encouraged to review *Community Engagement Standards for Community Health Planning Guideline*. With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.

See attached Narrative.

F1.e.ii Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".

See attached Narrative.

Factor 2: Health Priorities

Addresses the impact of the Proposed Project on health more broadly (that is, beyond the Patient Panel) requiring that the Applicant demonstrate that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.

F2.a **Cost Containment:**

Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

See attached Narrative.

F2.b **Public Health Outcomes:**

Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

See attached Narrative.

F2.c **Delivery System Transformation:**

Because the integration of social services and community-based expertise is central to goal of delivery system transformation, discuss how the needs of their patient panel have been assessed and linkages to social services organizations have been created and how the social determinants of health have been incorporated into care planning.

See attached Narrative.

Factor 3: Compliance

Applicant certifies, by virtue of submitting this Application that it is in compliance and good standing with federal, state, and local laws and regulations, including, but not limited to M.G.L. c. 30, §§ 61 through 62H and the applicable regulations thereunder, and in compliance with all previously issued notices of Determination of Need and the terms and conditions attached therein .

F3.a Please list all previously issued Notices of Determination of Need

Add/Del Rows	Project Number	Date Approved	Type of Notification	Facility Name
 				

Factor 4: Financial Feasibility and Reasonableness of Expenditures and Costs

Applicant has provided (as an attachment) a certification, by an independent certified public accountant (CPA) as to the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel.

F4.a.i **Capital Costs Chart:**

For each Functional Area document the square footage and costs for New Construction and/or Renovations.

[illegible]

F4.a.ii For each Category of Expenditure document New Construction and/or Renovation Costs.

	Category of Expenditure	New Construction	Renovation	Total (calculated)
	Land Costs			
	Land Acquisition Cost			
	Site Survey and Soil Investigation			
	Other Non-Depreciable Land Development			
	Total Land Costs			
	Construction Contract (including bonding cost)			
	Depreciable Land Development Cost			
	Building Acquisition Cost	\$21272000.		\$21272000.
	Construction Contract (including bonding cost)	\$617441.		\$617441.
	Fixed Equipment Not in Contract			
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost			
	Pre-filing Planning and Development Costs			
	Post-filing Planning and Development Costs			
Add/Del Rows	Other (specify)			
+ -				
	Net Interest Expensed During Construction			
	Major Movable Equipment	\$3934458.		\$3934458.
	Total Construction Costs	\$25823899.		\$25823899.
	Financing Costs:			
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc	\$450000.		\$450000.
	Bond Discount			
Add/Del Rows	Other (specify)			
+ -				
	Total Financing Costs	\$450000.		\$450000.
	Estimated Total Capital Expenditure	\$26273899.		\$26273899.

Factor 5: Relative Merit

F5.a.i Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

Proposal:

See attached Narrative.

Quality:

See attached Narrative.

Efficiency:

See attached Narrative.

Capital Expense:

See attached Narrative.

Operating Costs:

See attached Narrative.

List alternative options for the Proposed Project:

Alternative Proposal:

See attached Narrative.

Alternative Quality:

See attached Narrative.

Alternative Efficiency:

See attached Narrative.

Alternative Capital Expense:

See attached Narrative.

Alternative Operating Costs:

See attached Narrative.

Add additional Alternative Project

Delete this Alternative Project

F5.a.ii Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

See attached Narrative.

Factor 6: Community Based Health Initiatives

F6 Does your existing CHNA/CHIP meet the minimum standards outlined in the Community Engagement Standards for Community health Planning Guideline?

☒ Yes ☐ No

Documentation Check List

The Check List below will assist you in keeping track of additional documentation needed for your application. Once you have completed this Application Form the additional documents needed for your application will be on this list. E-mail the documents as an attachment to: DPH.DON@state.ma.us

- ☐ Copy of Notice of Intent
- ☐ Affidavit of Truthfulness Form
- ☐ Scanned copy of Application Fee Check
- ☐ Affiliated Parties Table Question 1.9
- ☐ Change in Service Tables Questions 2.2 and 2.3
- ☐ Certification from an independent Certified Public Accountant
- ☐ Articles of Organization / Trust Agreement
- ☐ Limited Liability Company agreement
- ☐ Partnership agreement
- ☐ Trust agreement
- ☐ Current IRS Form, 990 Schedule H CHNA/CHIP and/or Current CHNA/CHIP submitted to Massachusetts AGO's Office
- ☐ Community Engagement Stakeholder Assessment form
- ☐ Community Engagement-Self Assessment form

Document Ready for Filing

When document is complete click on "document is ready to file". This will lock in the responses and date and time stamp the form.

To make changes to the document un-check the "document is ready to file" box. Edit document then lock file and submit

Keep a copy for your records. Click on the "Save" button at the bottom of the page.

To submit the application electronically, click on the "E-mail submission to Determination of Need" button.

This document is ready to file:

☐

Date/time Stamp:

E-mail submission to
Determination of Need

Application Number: NEBSC-22051121-TO

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form

APPENDIX 2

APPLICATION NARRATIVE

2. Project Description

New England Baptist Surgery Center, LLC (the “Applicant” or “NEBSC”) is filing a Notice of Determination of Need (“Application”) with the Massachusetts Department of Public Health (“Department”) for the establishment of a freestanding ambulatory surgery facility. Currently, New England Baptist Hospital (“NEBH”) operates a Hospital Outpatient Surgical Department (“HOPD”) at 40 Allied Drive, Suite #200, Dedham, MA. Upon approval of the Application, the NEBH facility will be converted to a free-standing ambulatory surgery clinic (“ASC”) owned by the Applicant and operated at the facility’s current location (“Proposed Project”). The Proposed Project will not add new operating rooms. The Applicant, NEBSC, is owned by NEBSC Hospital Holdings, LLC (“Hospital HoldCo”) and NEBSC Surgeon Holdings, LLC (“Surgeon HoldCo”). Hospital HoldCo is a limited liability company formed for the purpose of participating in a joint venture with Surgeon HoldCo to own and operate the licensed ASC. Hospital HoldCo will hold a 51% interest in the joint venture and Surgeon HoldCo will hold a 49% interest. Constitution Surgery Alliance (“CSA”) will manage the ASC. The transition of the current HOPD site in Dedham to an ASC is responsive to the shift of orthopedic procedures from the inpatient setting to outpatient settings, as well as patient demand for these procedures in the ASC setting. Cases that are now performed on an inpatient basis or in the HOPD can be performed at the ASC in a more clinically efficient and cost-effective manner.

NEBH is the premier regional provider for orthopedic surgery and the treatment of musculoskeletal diseases and disorders. It has received national recognition for high patient satisfaction and for its leadership in quality and clinical outcomes, and it is consistently ranked as one of America’s top hospitals for orthopedics by *U.S. News and World Report*. NEBH is an affiliate of Tufts University School of Medicine, conducts teaching programs in collaboration with Harvard Medical School, and has been the official hospital of the Boston Celtics for over 30 years. NEBH is part of Beth Israel Lahey Health, Inc. (“BILH”), a health care system that brings together academic medical centers and teaching hospitals, community and specialty hospitals, more than 4,000 physicians, and 35,000 employees in a shared mission to expand access to high quality care and advance the science and practice of medicine through groundbreaking research and education.

With 17 managed centers, 9 of which are hospital / physician joint ventures, CSA is one of the largest independent operators of outpatient surgery centers in the US. Since 1997, CSA has developed and managed surgical facilities that provide patients with the highest level of surgical care, while fostering operational efficiency. CSA also manages and operates joint ventures for its physician and hospital partners. CSA currently manages 15 Ambulatory Surgery Centers and 2 Hospital Outpatient Departments, including 10 locations in Connecticut, 4 in Massachusetts and 1 each in Rhode Island, Virginia and Pennsylvania. In total, CSA manages 71 Operating Rooms, performing about 100,000 surgical cases per year. Over half of CSA’s case volume is musculoskeletal (orthopedics, podiatry, pain management, etc.) and its managed ASCs performed almost 1,500 joint replacement operations in 2021.

The building that houses the HOPD contains approximately 66,000 square feet on two floors. The first floor consists of private physician offices, the NEBH Sports Performance Center, a

NEBH Radiology suite, and a patient lobby and waiting area. The second floor of the building, where the HOPD is located, consists of 8 operating suites, pre-operative and post-op/recovery areas, 2 procedure rooms located within the pre-op PACU suite (that are used for non-invasive pain management procedures), administrative offices, and a patient lobby and waiting area. The Proposed Project, as operated by the Applicant as a free-standing ASC, will specialize in orthopedics and total joint replacement. There will be no change in the number of operating suites or procedure rooms.

The Proposed Project is responsive to patient demand, developments in surgical technique and a changing reimbursement landscape. In particular, total joint replacements (“TJR”) cases are forecasted to move from the inpatient to the outpatient and ASC settings nationwide.¹ Advancements in anesthesia and less invasive surgical techniques mean that patients are increasingly able to go home the same day after TJR procedures. Given these advancements, patients prefer to receive these procedures in the outpatient and ASC settings, especially since the advent of the COVID-19 pandemic – when crowding and the potential for cross-infection triggered and heightened concerns about cross-infection in the hospital setting. Additionally, financial incentives play a role in patient preference. Blue Cross Blue Shield’s Health Report of America estimates that when members elect to have a knee or hip replacement performed in an outpatient facility, costs can be 30-40% lower than if these replacements were performed in the inpatient setting.² Not only is the ASC setting more convenient and cost-effective for patients, data from the National Survey of Ambulatory Surgery demonstrates that procedures performed in ASCs are more clinically efficient, taking 25% less time than procedures performed in inpatient settings.³ Furthermore, this clinical efficiency is accompanied by improvements in quality of care and outcomes. Notably, surgeries performed in ASC settings can have faster recovery times and lower rates of infections.⁴

In addition to maintaining or exceeding the quality of care available at HOPD or inpatient settings, the Proposed Project will also promote and further Massachusetts’ cost containment goals. Due also in large part to advancements in surgical techniques, commercial and government payer reimbursement is now available to ASCs for many procedures, including joint replacement procedures—and Medicare, as an example, reimburses ASCs at 58% of the rate for

¹Madeleine McDowell, MD, FAAP. *Sg2 2021 Impact of Change® Forecast: Post-Pandemic Recovery, Rising Acuity and Ambulatory Shifts*. (June 2021). Available at: <https://www.sg2.com/health-care-intelligence-blog/2021/06/sg2-2021-impact-of-change-forecast/>

² Pooja Kumar and Ramya Parthasarathy. *Walking out of the hospital: The continued rise of ambulatory care and how to take advantage of it*. (September 2020). Available at: <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/walking-out-of-the-hospital-the-continued-rise-of-ambulatory-care-and-how-to-take-advantage-of-it>

³ *Study: Commercial Insurance Cost Savings in Ambulatory Surgery Centers*. (June 2016). Available at: <https://www.ascassociation.org/advancingsurgicalcare/reducinghealthcarecosts/privatepayerdata/healthcarebluebookstudy>

⁴ Louis Levitt. *The Benefits of Outpatient Surgical Centers*. (June 2017). Available at: <https://www.cfaortho.com/media/news/2017/06/the-benefits-of-outpatient-surgical-centers>

HOPDs, on average.⁵ The Proposed Project will help the state restrain total medical expense growth by moving procedures to a lower-cost setting, while maintaining quality of care.

In summary, the Proposed Project will better serve existing and new patients in the service area efficiently, cost effectively and with high quality, while responding to market forces. The Proposed Project, through its partnership with some of the nation's leading orthopedic surgeons at the current Dedham HOPD site, will expand options for patients. NEBSC's surgeon partners represent a variety of sub-specialties, including: TJR (arthroplasty), hip preservation, and the Sports Medicine subspecialties of foot and ankle, hand, and general sports surgery; in short, a wide range of outpatient orthopedic surgical care options. The transition of an existing HOPD to an ASC meets the applicable factors required for Determination of Need approval – the ASC will reduce costs for patients, commercial and government payers, and for the Commonwealth, while maintaining access and delivering high quality and positive outcomes.

Factor 1: Applicant Patient Panel Need, Public Health Values and Operational Objectives

F1.a.i Patient Panel:

Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant's existing patient panel and payer mix.

As discussed in the "Project Description" section, the Applicant is a newly formed joint venture company owned by Hospital HoldCo and Surgeon Holdco, with CSA managing the ASC. Since the Applicant is a new joint venture company, it does not have its own patient panel. As such, the patient panel data in this application is based on historical data from NEBH's current HOPD in Dedham. The Applicant will update the Department should the expected patient panel evolve over time.

A. Current NEBH Outpatient Orthopedic Surgical Volume at Dedham

For contextual purposes, there were 9,649 total outpatient orthopedic surgical patients undergoing outpatient orthopedic surgeries at NEBH's HOPD site in Dedham between FY 2019 and FY 2021 as shown in Table 1. The number of patients increased by 18.5% between FY 2019 and FY 2021 at the Dedham site, even given the COVID-19 pandemic environment. The increase in patients at NEBH's HOPD site is consistent with regional and national trends in outpatient

⁵ Ambulatory Surgery Center Association. *Medicare Cost Savings Tied to Ambulatory Surgery Centers*. (2013). Available at: <https://www.ascaconnect.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=7b33b916-f3f1-42e5-a646-35cc2f38fe4d&forceDialog=0>

orthopedic surgeries and is indicative of overall increasing patient demand for these procedures.

As shown in Table 1, most of the procedures currently performed at the Dedham HOPD site are endoscopies or arthroscopies.

Table 1: Total Orthopedic Surgical Volume by Service Line at NEBH HOPD Dedham Site, FY 2019 – FY 2021

Orthopedic Surgical Volume by Service Line FY 2019 - FY 2021			
Service Line	FY 2019	FY 2020	FY 2021
Endoscopy/Arthroscopy Procedures on the Musculoskeletal System	1,499	1,150	1,680
Foot and Toes	492	405	563
Forearm and Wrist	283	239	356
Hand and Fingers	283	219	299
Leg (Tibia and Fibula) and Ankle Joint	143	158	242
General	205	175	174
Humerus (Upper Arm) and Elbow	100	87	146
Femur (Thigh Region) and Knee Joint	93	84	125
Shoulder	85	99	101
Other (including Pelvis and Hip Joint)	20	33	111
Total	3,203	2,649	3,797

B. Patient Panel

As noted above, the Patient Panel data in this section is limited to the historical data for NEBH's current HOPD in Dedham. As shown in Table 2, the gender breakdown of the Patient Panel consists of approximately 53.5% females and 46.5% males based on FY 2021 data. The proportion of patients aged 65 and older has slightly decreased between FY 2019 (19.6%) and FY 2021 (19.0%), while the proportion of patients under the age of 18 has slightly increased from 1.7% to 1.8% in the same time period. Approximately 79.2% of patients are aged 18-64, based on data from FY 2021.

Based on self-reported data, in FY 2021, 84.6% of the Patient Panel identified as white, 8.0% identified as Black or African American, 2.3% identified as Asian, and 1.5% identified as Hispanic/Latino. Between FY 2019 and FY 2021, there was an increase in patients who identified as Black or African American, from 7.0% to 8.0%.

Table 2: Patient Panel Demographics

Patient Panel Summary								
October 1, 2018 - December 1, 2022								
	FY 19		FY 20		FY 21		Q1 - FY 22	
Demographic Measure	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Gender								
Male	1,538	47.9%	1,231	46.3%	1,766	46.5%	472	50.8%
Female	1,675	52.1%	1,428	53.7%	2,031	53.5%	458	49.2%
Other	1	0.0%	-	0.0%	-	0.0%	-	0.0%
Total	3,214	100.0%	2,659	100.0%	3,797	100.0%	930	100.0%
Age								
0 to 17	54	1.7%	43	1.6%	67	1.8%	14	1.5%
18 to 64	2,522	78.5%	2,092	78.7%	3,007	79.2%	735	79.0%
65+	638	19.9%	524	19.7%	723	19.0%	181	19.5%
Total	3,214	100.0%	2,659	100.0%	3,797	100.0%	930	100.0%
Race								
White	2,668	83.3%	2,301	86.9%	3,211	84.6%	798	85.8%
Black or African American	225	7.0%	165	6.2%	304	8.0%	52	5.6%
Asian	102	3.2%	61	2.3%	86	2.3%	29	3.1%
Other	151	4.7%	85	3.2%	127	3.3%	29	3.1%
Unknown	57	1.8%	37	1.4%	69	1.8%	22	2.4%
Total	3,203	100.0%	2,649	100.0%	3,797	100.0%	930	100.0%
Ethnicity								
Hispanic/Latino	84	2.6%	45	1.7%	57	1.5%	7	0.8%
Not Hispanic/Latino	3,117	97.3%	2,600	98.2%	3,736	98.4%	923	99.2%
Unknown	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Other	2	0.1%	4	0.2%	4	0.1%	-	0.0%
Total	3,203	100.0%	2,649	100.0%	3,797	100.0%	930	100.0%
Zip Codes Summary								
MA	3,013	94.1%	2,477	93.5%	3,581	94.3%	844	90.8%
NH	74	2.3%	63	2.4%	96	2.5%	23	2.5%
RI	57	1.8%	56	2.1%	47	1.2%	26	2.8%
ME	13	0.4%	13	0.5%	21	0.6%	6	0.6%
Other	46	1.4%	40	1.5%	52	1.4%	31	3.3%
Total	3,203	100.0%	2,649	100.0%	3,797	100.0%	930	100.0%

Notes: BILH includes Addison Gilbert Hospital, AJH, BayRidge Hospital, Beverly Hospital, BIDMC, BID-Milton, BID-Needham, BID-Plymouth, LHMC-Burlington, LHMC-Peabody, MAH, NEBH, and Winchester Hospital.

- Counts represent the number of unique patients that visited a facility on a BILH hospital license for inpatient or outpatient services, including patients who were admitted through the emergency department. Unique patients are identified at the hospital level, with the exception of Addison Gilbert Hospital, BayRidge Hospital, and Beverly Hospital, which are jointly identified, and LHMC-Burlington and LHMC-Peabody, which are also jointly identified. Patients visiting multiple BILH hospitals in a given year are not uniquely identified.

- Patients for whom a gender is not specified or whose gender varies across visits over the time period are included in "Other."

- Patients who fall into multiple age categories in a given year are included in the younger category.

- Race information is self-reported. Patients for whom a race is not specified are included in "Patient Declined," "Unknown," or "Other," per the local facility's data collection methodology. Patients for whom race varies across visits over the time period are included in "Other." Under Race, "Other" includes American Indian or Alaska Native, Native Hawaiian, Hawaiian or Other Pacific Islander, and Patient Declined.

- Ethnicity information is self-reported. Patients for whom ethnicity is not specified are included in "Patient Declined," "Unknown," or "Other," per the local facility's data collection methodology. Patients for whom ethnicity varies across visits over the time period are included in "Other." Under Ethnicity, "Other" includes "Patient Declined."

- Patients whose primary payor is missing in the data are included in "Unknown." Patients whose primary payors within a given fiscal year fall into more than one payor category are included in "Multiple Payors." "Other" includes the following payor categories: self pay, worker's compensation, other government payment, free care, health safety net, auto insurance, Commonwealth Care/ConnectorCare plans, and dental plans.

- Under ZIP Code Summary, "Other" includes CT, FL, and NY, which account for most of the cases among states not listed individually.

- Source: Internal inpatient and outpatient visit data submitted by the Party hospitals.

Table 3 shows the top 15 zip codes for NEBSC's Patient Panel, including many cities and towns surrounding the Proposed Project Site. The top 15 zip codes reflect 19.2% of the total Patient Panel. Dedham, Braintree, Quincy, Milton, and Norwood represent the zip codes with the highest number of patients.

Table 3: Patient Panel Geography

Top 15 Zip Codes					
FY 19		FY 20		FY 21	
Zip Code	Encounters	Zip Code	Encounters	Zip Code	Encounters
Braintree	70	Braintree	50	Dedham	72
Quincy	55	Quincy	47	Braintree	67
Dedham	53	Dedham	40	Quincy	60
Milton	52	Milton	36	Milton	54
Norwood	49	Hyde Park	35	Norwood	51
Randolph	47	Randolph	35	Jamaica Plain	49
West Roxbury	45	Norwood	34	West Roxbury	49
Westwood	44	Natick	32	Hyde Park	47
Dorchester	44	Plymouth	32	Plymouth	45
Roslindale	42	West Roxbury	30	Randolph	44
Needham	38	Roslindale	30	Canton	42
Canton	37	Dorchester	28	Sharon	40
Jamaica Plain	36	Brookline	28	Needham	39
Hyde Park	34	Canton	27	Medford	36
Plymouth	33	Needham	26	Natick	35

C. Patient Panel Payer Mix

Table 4 shows the payer mix based on the historical data for NEBH's current HOPD in Dedham. The majority of the Patient Panel is commercially insured – 61.9% in FY 2021, with Medicare FFS as the second largest insurer at 13.2%. The proportion of the patient panel that was covered by MassHealth and Managed Medicaid increased from 1.6% in FY 2019 to 5.1% in FY 2021.

Table 4: Patient Panel Payer Mix

Patient Panel									
Payer Mix - List Percentages (must = 100%)									
APM Contract Percentages					Non-ACO and Non- APM Contracts				
	FY 19	FY 20	FY 21	Q1-FY 22		FY 19	FY 20	FY 21	Q1-FY 22
ACO and APM Contracts	5.2%	3.7%	3.6%	4.9%					
					Commercial PPO/Indemnity	9.8%	9.2%	8.0%	10.2%
					Commercial HMO/POS	60.6%	61.8%	61.9%	61.5%
					MassHealth	0.9%	1.1%	1.7%	0.9%
Non-ACO and Non-APM Contracts	94.8%	96.3%	96.4%	95.1%	Managed Medicaid	0.7%	1.5%	3.4%	2.0%
					Commercial Medicare	5.0%	4.2%	4.5%	4.1%
					Medicare FFS	13.7%	13.9%	13.2%	13.4%
					All Other	9.2%	8.4%	7.2%	7.9%

TOTAL	100.0%	100.0%	100.0%	100.0%	TOTAL	100.0%	100.0%	100.0%	100.0%
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F1.a.ii Need by Patient Panel:

Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.

The conversion of the NEBH’s existing HOPD into a free-standing ASC will enhance current patient access to orthopedic and TJR procedures at a lower cost while maintaining the excellent standard of care offered by NEBH. In addition, the free-standing ASC will meet future patient needs and demands for these procedures.

Nationally, TJRs are expected to grow significantly – with most of this growth occurring in the outpatient setting.⁶ A similar trend exists at the local level in Massachusetts, although total (inpatient and outpatient) volume growth is slower than anticipated due to the impact of COVID-19 and the suspension of elective surgeries. Massachusetts also lags behind the rest of the U.S. in the adoption of outpatient TJRs. Locally, inpatient total hip and knee replacements are expected to decline significantly over the next decade while outpatient total hip and knee replacements are expected to see significant growth. Sg2, a healthcare intelligence and analytic consultancy, has projected that there will be 152% growth by 2024 and 255% growth by 2029 for total knee replacements and total hip replacements in the outpatient setting.⁷ There is a similar anticipated shift from inpatient to outpatient settings for total shoulder replacements, although this shift is not as significant as the shift for the shoulder replacement procedure. Overall, outpatient shoulder replacements are projected to increase from 7% in 2019 to 22% in 2024, and to 35% in 2029.⁸

In addition to national and Massachusetts data on increasing demand for these outpatient procedures, patients are reluctant to stay or receive care in inpatient settings unless absolutely necessary – due to concerns that were amplified and reinforced during the COVID-19

⁶ Madeleine McDowell, MD, FAAP. *Sg2 2021 Impact of Change® Forecast: Post-Pandemic Recovery, Rising Acuity and Ambulatory Shifts*. (June 2021). Available at: <https://www.sg2.com/health-care-intelligence-blog/2021/06/sg2-2021-impact-of-change-forecast/>

⁷ Sg2 projections are based on all hospital discharges for patients residing in the combined NEBH primary and secondary service areas.

⁸ Sg2 projections are based on all hospital discharges for patients residing in the combined NEBH primary and secondary service areas.

pandemic. Since ASCs are designed to only perform a certain subset of procedures that require a shorter stay, they are also less likely to create widespread exposures for patients and staff. Furthermore, the movement of appropriate orthopedic procedures from NEBH's inpatient campus to the outpatient ASC will allow providers at NEBH to enhance throughput for more complex cases at the hospital's main campus (e.g., spine cases) – resulting in greater efficiency and shorter wait times for those complex cases as well. Currently, NEBH has approximately 90% use of the sixteen operating rooms on the main campus of the hospital, which represents a highly utilized block schedule. NEBH has wait times for surgery that are up to six months for some surgeons, with an average wait time of about six weeks. NEBH has requests from spine surgeons who wish to perform surgery at NEBH, but are unable to be accommodated due to space constraints. As more outpatient total knee and total hip replacement procedures move to the ASC to be operated by NEBSC, NEBH will be able to provide more operating room time to legacy NEBH surgeons and to surgeons who are waiting to join the NEBH community. Ultimately, the ASC will increase access for patients as wait times for certain procedures on NEBH's main campus decrease.

Patient demand in orthopedic procedures is driven by several factors, including growth in older populations, disease prevalence, and advances in technology that make surgical intervention more attractive to younger patients with sports-related injuries. In Massachusetts, residents aged 65 and older are projected to grow from 13.8% of the population in 2010 to 21.2% in 2030.⁹ As the baby boomer population ages and medical technology advances, there will be an exponential growth in demand for all orthopedic procedures.¹⁰ Demand for TJRs in younger patients, aged 45-64, is also increasing – 188% for knee replacements and 123% for hip replacements between 2000 and 2009.¹¹¹²

As shown in Table 1, the volume of outpatient orthopedic surgical services increased by 18.5% at the current HOPD site between FY 2019 and FY 2021. Historically, the most common procedures performed at the current HOPD site in Dedham have been knee arthroscopy, hip

⁹ Tufts Health Plan Foundation. (2014). *Highlights from the Massachusetts Health Aging Data Report: Community Profiles 2014*. Available at: <https://www.mass.gov/doc/mass-healthy-aging-data-report-community-profiles-commissioned-by-tufts-health-plan-0/download#:~:text=the%20percentage%20of%20the%20state,remarkable%2021%20percent%20in%202030.>

¹⁰ Yang, Relin et al. "Unique Aspects of the Elderly Surgical Population: An Anesthesiologist's Perspective." *Geriatric orthopaedic surgery & rehabilitation* vol. 2,2 (2011): 56-64. doi:10.1177/2151458510394606

¹¹ Drew, Jacob M. et al. *Trends in Total Knee Arthroplasty in the U.S.: Understanding the Shift to a Younger Demographic*. (March 2014). Available at: <https://www.abstractsonline.com/Plan/ViewAbstract.aspx?mID=3358&sKey=2ad4cafd-9e8b-42f3-8af1-c591b71fd9e6&cKey=bd1c947a-e921-467a-b89b-1047fdb059c5&mKey=4393d428-d755-4a34-8a63-26b1b7a349a1>

¹² Drew, Jacob M. et al. *Trends in Total Hip Arthroplasty in the United States: The Shift to a Younger Demographic*. (March 2014). Available at: <https://www.abstractsonline.com/Plan/ViewAbstract.aspx?mID=3358&sKey=d07c3db3-cf5f-4768-8384-2da45a32be4a&cKey=c1b27dc5-0efd-49a8-ad3c-19d6e9b6dd6f&mKey=4393d428-d755-4a34-8a63-26b1b7a349a1>

arthroscopy, and wrist endoscopy. Going forward, we expect to see an increase in TJRs at the ASC, given the national and local trends.

The Applicant has projected volume at the ASC based on the following assumptions:

1. The existing orthopedic case volume at the HOPD stays at the ASC. Year 1 uses an adjusted case count for 2020 to present a conservative projection.
2. For participating total joint arthroplasty surgeons, an estimated 1/3 of their eligible cases will be performed at the ASC by Year 2.
3. For participating orthopedic surgeons who already perform more than 1/3 of their cases at the Dedham location, the Applicant assumes that volume will remain at the location, augmented by a fraction of their cases (if any) assumed to be performed at other locations and perhaps increased, if HoldCo Physicians choose to do more of their cases at the ASC.
4. Year 1 includes a ramp up of additional orthopedics and joint arthroplasty cases.
5. The Applicant conservatively assumes that there is a 2% growth for orthopedics and 4% growth for arthroplasty cases.

Table 5: Projected ASC Volume for NEBSC

NEBSC Projected ASC Volume					
	Year 1	Year 2	Year 3	Year 4	Year 5
Existing Cases	2,930	2,988	3,048	3,109	3,171
Additional Cases:					
Orthopedics	183	188	192	195	199
Joint Arthroplasty	961	1,921	1,998	2,078	2,161
Total Additional Cases	1,143	2,109	2,189	2,273	2,360
Total Cases	4,073	5,097	5,237	5,382	5,531

The Proposed Project is expected to meet increasing patient need that is driven by growing demand at the current site, anticipated population growth, and an overall shift from inpatient to outpatient settings. In fact, the Proposed Project will increase the services available to patients in the ASC's service area – the ASC will accommodate a growth in existing outpatient orthopedic procedures, thus decreasing wait times for procedures that require an inpatient setting at NEBH's main campus.

F1.a.iii Competition:

Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.

The Proposed Project meets Massachusetts' cost containment goals by competing on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. The Proposed Project will convert an existing HOPD to a free-standing ASC (a lower cost setting). Procedures performed in an ASC setting are reimbursed by payers at lower rates in comparison to inpatient or HOPD settings. As noted previously, Medicare, on average, reimburses ASCs at 58% of the rate for HOPDs.¹³ This translates into more than \$2 billion in savings for Medicare and its beneficiaries annually. Similarly, ASCs significantly reduce healthcare costs in the commercial insurance market – including through lower deductible and coinsurance payments for insured patients.¹⁴

Due in large part to medical advancements in orthopedic surgery equipment and techniques, commercial insurance carriers are increasingly requiring procedures, like TJRs, that used to be performed only in hospital settings, to be performed in lower cost outpatient and ASC settings, unless the patient is expected to experience severe problems during or following surgery. The Centers for Medicare & Medicaid Services ("CMS") have followed this trend, first by allowing reimbursement for additional orthopedic procedures in hospital outpatient settings, and then, recently, in ambulatory surgery centers (see Table 6).

Table 6: CMS Reimbursement Setting by Procedure

CPT Code	Procedure	Settings CMS will Reimburse:				
		2017	2018	2019	2020	2021
27447	Total Knee	IPO	HOPD	HOPD	ASC	ASC
27130	Total Hip	IPO	IPO	IPO	HOPD	ASC
23472	Total Shoulder	IPO	IPO	IPO	IPO	HOPD
		IPO = Inpatient Only				
		HOPD = Hospital outpatient & Inpatient				
		ASC = ASCs, Hospital Outpatient, Inpatient				

¹³ Ambulatory Surgery Center Association. *Medicare Cost Savings Tied to Ambulatory Surgery Centers*. (2013). Available at: <https://www.ascacconnect.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=7b33b916-f3f1-42e5-a646-35cc2f38fe4d&forceDialog=0>

¹⁴ *Commercial Insurance Cost Savings in Ambulatory Surgery Centers*. Available at: <https://www.ascassociation.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=829b1dd6-0b5d-9686-e57c-3e2ed4ab42ca&forceDialog=0>

Both commercial and government payers are expected to continue to shift care reimbursement standards to incentivize the use of outpatient and ASC settings, where appropriate. Additionally, in the next few years, it is anticipated that ASCs will perform over 60% of orthopedic surgeries – creating further savings for patients, private and public payers, and providers and driving down total medical expense.¹⁵ From an integrated health system perspective, the option to perform these orthopedic surgeries in an ASC setting will allow ACOs to better manage total medical expense, in a clinically effective and efficient manner.

F1.b.i Public Health Value / Evidence-Based:

Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

The Proposed Project meets the patient need by providing high quality care in a more cost-efficient setting and is grounded in the following evidence-based rationale:

1. Cost-effective care settings will increase access to care for patients. In a recent survey, one in eleven adults reported forgoing or delaying care due to financial cost.¹⁶ The Proposed Project is an alternative care setting that is generally associated with lower out-of-pocket costs for patients.¹⁷
2. In general, ASCs provide the same, or better care at a lower cost in comparison to HOPDs – partially due to lower reimbursement, as noted in the previous section. In one analysis, Medicare savings from the migration of outpatient total knee arthroplasty to ASCs could reach almost \$3 billion from 2020 to 2028.¹⁸ Furthermore, the savings to Medicare does not result in a reduction in care quality. ASCs generally experience no differences in complication rates in comparison to HOPDs and can often result in higher patient satisfaction.¹⁹ In the case of this particular application, the surgeons who will operate at the ASC are anticipated to continue their medical staff membership at NEBH

¹⁵ 2021 Ambulatory Surgery Center Market Report. (October 2021). Available at: https://www.researchandmarkets.com/reports/5178168/2021-ambulatory-surgery-center-market-report?utm_source=GNOM&utm_medium=PressRelease&utm_code=km7gmp&utm_campaign=1454975+-+2020+Ambulatory+Surgery+Center+Market+Report&utm_exec=jamu273prd

¹⁶ Ortaliza, Jared et al. *How does cost affect access to care?* (January 2022). Available at: <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/>

¹⁷ Waddill, Kelsey. *How Ambulatory Surgery Centers Lower Payer Outpatient Spending.* (September 2021). Available at: <https://healthpayerintelligence.com/news/how-ambulatory-surgery-centers-lower-payer-outpatient-spending>

¹⁸ Ambulatory Surgery Center Association. *Reducing Medicare Costs by Migrating Volume from Hospital Outpatient Departments to Ambulatory Surgery Centers.* (October 2020). Available at: <https://www.advancingsurgicalcare.com/advancingsurgicalcare/reducinghealthcarecosts/costsavings/reducing-medicare-costs>

¹⁹ Tanaka, Miho J. *Ambulatory Surgery Centers Versus Hospital-based Outpatient Departments: What's the Difference?* (September 2019). Available at: <https://www.aaos.org/aaosnow/2019/sep/managing/managing02/#:~:text=ASCs%20have%20been%20shown%20to,smaller%20and%20more%20personalized%20teams.>

and as such, the Applicant is committed to maintaining NEBH's high-quality care outcomes for which NEBH is renowned.

3. As discussed in *F1.a.ii Need by Patient Panel*, population growth and aging, in combination with advancements in surgical technique, is driving an increase in TJRs. As the population ages, the prevalence of certain diseases requiring surgical intervention may also increase. For example, doctor-diagnosed arthritis is projected to affect 25.9% of all adults in the U.S. by 2040.²⁰ Other chronic conditions that have an impact on joints, such as obesity, will also increase the need for TJRs and other orthopedic procedures.²¹

F1.b.ii Public Health Value / Outcome-Oriented:

Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

The Applicant assumes that the Proposed Project will positively impact health outcomes and quality of life by increasing access to orthopedic surgical procedures, especially TJRs, in a more cost-effective setting. In order to assess the impact of the Proposed Project, the Applicant will track the following clinical quality indicators:

1. Patient Fall Prevention: This measure is the incidence of patient falls that occur within the ASC either before or after surgery. Fall prevention is critical to an interdisciplinary approach to care.
 - a. Measure: The number of patient falls. A fall is defined as a sudden, unintentional descent, with or without injury to the patient that results in the patient coming to rest on the floor, on or against another surface, on another person, or an object.
 - b. Projections: Since the Proposed Project is a new ASC and the Applicant is a newly created entity, the Applicant will provide baseline data and projections following the first full fiscal year once implementation of the Proposed Project is complete.
 - c. Monitoring: Monthly
2. Surgical Site Infection: Surgical Site Infections can be a significant setback to the patient's recovery. Effective surgical infection prevention encompasses systems and processes to reduce risk factors and optimize evidence-based processes of care.

²⁰ Hootman, Jennifer M. et al. *Updated Projected Prevalence of Self-Reported Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation Among US Adults, 2015-2040*. (July 2016). Available at: <https://pubmed.ncbi.nlm.nih.gov/27015600/>

²¹ American Academy of Orthopedic Surgeons. *The Impact of Obesity on Bone and Joint Health*. (March 2015). Available at: <https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1184-the-impact-of-obesity-on-bone-%20and-joint-health1.pdf>

- a. Measure: The number of infections that were not present or incubating at the time of admission to the facility that occur within 90 days of surgery for hip replacement, knee replacement, laminectomy, and spinal fusions.
 - b. Projections: Since the Proposed Project is a new ASC and the Applicant is a newly created entity, the Applicant will provide baseline data and projections following the first full fiscal year once implementation of the Proposed Project is complete.
 - c. Monitoring: Monthly and quarterly
- 3. Patient Satisfaction: This self-reported metric measures the extent to which a patient is content with the care that they received from their health care provider. The results will drive performance improvement to enhance patient satisfaction.
 - a. Measure: CAHPS Patient Satisfaction Survey – Overall Rating 9/10 on Scale of 1-10.
 - b. Projections: Since the Proposed Project is a new ASC and the Applicant is a newly created entity, the Applicant will provide baseline data and projections following the first full fiscal year once implementation of the Proposed Project is complete.
 - c. Monitoring: Monthly

F1.b.iii Public Health Value / Health Equity-Focused:

For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's need-base, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g. culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.

The Applicant is committed to promoting health equity and ensuring equal access to high quality care in several ways. The Applicant will not engage in discrimination based on a patient's ability to pay for services or a patient's insurer and, furthermore, the Applicant will implement a financial assistance policy, modeled after NEBH's existing policy, at the Proposed Project. This policy will offer patients assistance with applying for public assistance programs or other financial assistance programs that may cover some or all of their medical bills. Secondly, the Applicant shares the same commitment to diversity, equity, and inclusion as NEBH and BILH. To this end, the Proposed Project will not discriminate based on gender, race, religion, sexual orientation, disability status, financial situation, or any other status protected by law. Third, the Proposed Project will provide language access through the same language line and interpreter services that are currently being used at NEBH. These services are accessible through a remote, telephonic, and electronic-supported system. Cross Cultural Communication Systems currently provides NEBH with 24/7 access for language interpreter services – with the most commonly requested languages being Spanish, Russian, Portuguese, Italian and Greek. Fourth, social determinant of health (SDoH) assessments will be performed by surgeon offices,

prior to the patient's arrival at NEBSC and then be verified by NEBSC. These SDoH screenings include an assessment of the patient's transportation needs, ability to pay for medications, utilities or other home services, and their caregiver needs. Patients will be asked about their plans for safe transportation to and from their surgery, and will be referred to community resources should they need assistance with transportation. The Proposed Project is also located near the handicap-accessible MBTA commuter rail (Franklin/Foxboro line), making public transportation a viable option for patients from a variety of communities. Finally, practitioners operating at the ASC will undergo the same annual cultural competency training as at NEBH. Every employee and licensed independent practitioner at NEBH is required to complete this learning management system training, which focuses on cultural and religious sensitivity, diversity, equity, and inclusion.

F1.b.iv Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

The Proposed Project will result in improved health outcomes and quality of life for both existing and future patients by serving as a high quality, lower cost alternative care setting for patients seeking orthopedic surgeries. As discussed elsewhere in this narrative, improved surgical technology has allowed more procedures, especially lower acuity procedures, to be safely performed in an ASC setting. The Proposed Project will not only increase patient access to these orthopedic surgeries, but it will also allow more complex cases to be performed at the main campus of NEBH, thereby reducing current wait times. Increasing access to care, including through the reduction of wait times, can result in improved health outcomes and higher quality of life.

F1.c Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.

To ensure coordination, continuity of care, and effective communication, NEBSC nursing staff aim to create a secure pathway to send the patient's operative report to the patient's PCP. Each patient will be called the day after surgery by a NEBSC RN to inquire about the patient's condition. This evaluation reviews pain control, movement, ambulation, patient education deficits, general sense of well-being and any questions regarding prescriptions. In addition to these care coordination efforts, NEBSC will look to implement an extensive Patient Reported Outcomes ("PRO") Program which could include the following elements, to further improve care coordination and continuity.

- Electronic patient follow-up at appropriate intervals. For example, TJA would be pre-operative and 30-, 90-, 180- and 365-days following surgery. Automated electronic patient follow-up encourages early intervention, if necessary.

- Patient reported complications (e.g., infection, hospitalization) to be reported back to the surgeon's office.
- Provision of tools for physician-patient shared decision-making, which will empower patients to make informed decisions about their care. These tools include Patient IQ and Force Therapeutics. Patient IQ is a patient engagement platform which allows for automated patient communication. Force Therapeutics is a platform which provides digital rehabilitation, virtual physical therapy, and virtual perioperative care.
- Opportunities for patient education and digital care modules for all phases of surgical care.
- Collection, organization, and benchmarking of clinical and cost data to understand and achieve better healthcare value and improve clinical processes and quality for patients. For example, data would be collected and merged into the CSA clinical quality registry. These data would then be shared with national and international affiliates, such as the American Joint Replacement Registry and the International Consortium of Health Outcome Measures. All data collection and data sharing will be compliant with HIPAA and similar laws. Examples of data elements would include:
 - Patient Demographics
 - Surgical & Implant Information
 - Comorbidities
 - Adverse Events
 - Patient-Reported Outcome Measurements
- Integration of NEBSC data into shared risk stratification modeling to improve patient risk assessment for appropriateness of surgery and risk-based contract negotiations.
- Presentation of physician and facility level, risk-adjusted, benchmark dashboards for quality and outcomes analyses.

F1.d Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project

The Applicant consulted with the following Government Agencies regarding the Proposed Project:

- Department of Public Health
 - Lynn Conover, DON Program Analyst, Department of Public Health
 - Rebecca Rodman, General Counsel, Department of Public Health
 - Daniel Gent, Plan Review Manager, Department of Public Health
 - Jennica Allen, Manager of Community Engagement Practices, Department of Public Health
- Health Policy Commission
 - Sasha Hayes-Rusnov, Associate Director for Market Oversight and Monitoring, Health Policy Commission

- Lois Johnson, General Counsel, Health Policy Commission
- Tom Hajj, Manager, Health Policy Commission
- Gina Dello Russo, Policy Associate, Health Policy Commission

F1.e.i. Process for Determining Need/Evidence of Community Engagement: For assistance in responding to this portion of the Application, Applicant is encouraged to review Community Engagement Standards for Community Health Planning Guideline. With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.

As noted throughout the Narrative, the Applicant determined the need for this Proposed Project based on an examination of national and local trends in orthopedic surgical procedures (especially TJRs), review of its current patient panel, and projection of future patient need based on advancements in surgical technology and payer reimbursement. In its discussion with local officials, NEBH reviewed the current HOPD site, its future state as a free-standing ASC, and how the conversion will address patient needs.

Please see the response to F1.e.ii. for more detail.

F1.e.ii. Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the “Public Health Value” of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to “Patient Panel” need; and Linking the Proposed Project to “Public Health Value”.

NEBH has a 10-year history of interaction with HOPD’s host communities of Dedham and Westwood, Massachusetts. The town line between these two communities runs right through the middle of the Proposed Project site. To ensure sound community engagement and consultation throughout the development of the Proposed Project, the President of NEBH has had briefings with several elected officials in the service area, including:

- State Senator Michael Rush (Suffolk and Norfolk District) on January 11, 2022
- State Representative Paul McMurtry (Eleventh Norfolk District) on January 13, 2022
- Sarah MacDonald, Vice Chair, Dedham Board of Selectmen on January 13, 2022

A briefing of the Proposed Project for members of NEBH’s Patient and Family Advisory Council (“PFAC”) was held on June 21, 2022 from 12:00pm – 1:00pm via Zoom. All PFAC members were in attendance at this meeting – there were 3 attendees representing NEBH and 5 patient representatives. David Passafaro, President of NEBH, presented on the Proposed Project and its impact. After the presentation, the floor was opened to PFAC members to ask questions,

including questions pertaining to anticipated volume, joint venture structure, and marketing / advertising.

On July 12, 2022, David Passafaro, President of NEBH, wrote to the municipal leadership of both Dedham and Westwood detailing the proposed conversion of the NEBH surgery center to a newly licensed freestanding ambulatory surgery clinic using the existing Dedham facility, but to be owned by a new joint venture company in which NEBH will remain a participant. Included in the communication were a brief description of the Proposed Project, an explanation of the regulatory process, and an attachment of the appropriate sections of the DON application. This communication was sent to:

- For Dedham: L. Goodwin, Town Manager, N. Baker, Asst. Town Manager, K. Cimeno, Building Inspector, and W. Spillane, Fire Chief
- For Westwood: Members of the Select Board, Fire Chief, and C. Coleman, Building Inspector

For detailed information on these activities, please see Appendix 3: Factor 1 Exhibit: *New England Baptist Outpatient Care Center – Community Engagement*. This Exhibit is an informational presentation used for the aforementioned briefings, explaining the need and rationale for the Proposed Project.

Factor 2: Health Priorities

F2.a Cost Containment:

Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

The Proposed Project will meaningfully contribute to The Commonwealth's goals for cost containment by providing efficient and high-quality care in a lower cost setting. As previously discussed in F1.a.iii, procedures performed in an ASC setting are reimbursed by payers at lower rates in comparison to inpatient or HOPD settings. Reimbursement rates for procedures performed in ASCs are, on average, reimbursed at 58% of the rate at HOPDs. The Proposed Project, as a free-standing ASC, will allow procedures that were once performed in a HOPD or inpatient setting to be performed in the outpatient setting – thereby reducing overall healthcare expenditures for the Commonwealth.

F2.b Public Health Outcomes:

Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

The Proposed Project will improve public health outcomes by serving as a high quality, lower cost alternative care setting for patients seeking orthopedic surgeries. As previously discussed

in F1.b.iv, the Proposed Project will increase patient access and reduce current wait times for orthopedic procedures without increasing the number of operating and procedure rooms. Increased access to care, including through lower out-of-pocket costs (due to the procedure being performed at an ASC), has been shown to lead to improved health outcomes and higher quality of life for patients.²²

F2.c Delivery System Transformation:

Because the integration of social services and community-based expertise is central to goal of delivery system transformation, discuss how the needs of their patient panel have been assessed and linkages to social services organizations have been created and how the social determinants of health have been incorporated into care planning.

The Applicant is committed to providing patients with appropriate care planning resources, including linkages to social service organizations as necessary. If patients have identified social determinations of health needs, staff at the ASC will follow-up with the patient's primary care provider to notify them of the patient's needs. As an affiliate of BILH, JV patients will have access to the full complement of social services support through NEBH or other BILH affiliates when these needs are identified.

Factor 5: Relative Merit

F5.a.i. Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

Proposal: The Proposed Project seeks to convert the existing HOPD to a freestanding ASC, without adding new operating rooms. It is superior to alternative and substitute methods for meeting the existing Patient Panel needs identified in this Application because it will better serve patients in the service area by providing more cost-effective care, while maintaining quality. As noted earlier in the Application, procedures performed in an ASC setting are reimbursed by payers at lower rates in comparison to inpatient or HOPD settings which translates into savings for both the Commonwealth and patients.

²² Office of Disease Prevention and Health Promotion. *Healthy People 2020: Access to Health Services*. Available at: <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services>

Quality: As cited throughout this Application, orthopedic surgical procedures and care provided at ASCs demonstrate the same or better quality and health outcomes in comparison to HOPDs for the same procedures.

Efficiency: The specialization of services in orthopedics and total joint replacement at the ASC will allow the Proposed Project to achieve clinical and operational efficiencies. Clinical efficiencies will be achieved through the use of highly trained staff and operational efficiencies will be achieved through the use of a highly experienced management company (CSA).

Capital Expense: \$26,273,899

Operating Costs: Operating costs for the first Fiscal Year of implementation of the Proposed Project are projected at \$23,932,000.

Alternative Proposal: An alternative to the Proposed Project would be for NEBH to continue to operate the 40 Allied Drive site as a HOPD.

Alternative Quality: Quality of care would not decrease under this alternative proposal. However, as noted earlier in this application, procedures performed at ASCs can demonstrate the same or better quality outcomes in comparison to HOPDs.

Alternative Efficiency: The alternative does not allow for the clinical and operational efficiencies that can be achieved through the Proposed Project.

Alternative Capital Expenses: Current capital expenses would not change under this alternative.

Alternative Operating Costs: Under this alternative proposal, operating costs are projected to exceed those projected under the Proposed Project.