Massachusetts Department of Public Health
Determination of Need
Application Form

Version: 11-8-17

Application Type: Ambulatory Surgery

Application Date: 8/30/2024

Applicant Name: West Bridgewater MA Endoscopy ASC, LLC

Mailing Address: 120 West Center Street

City: West Bridgewater State: Massachusetts Zip Code: 02379

Contact Person: Christopher Fenore Title: Director, Operations

Mailing Address: 120 West Center Street

City: West Bridgewater State: Massachusetts Zip Code: 02379

Phone: 7818954901 Ext: E-mail: Chris.Fenore@amsurg.com

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name: Commonwealth Endoscopy Center

Facility Address: 120 West Center Street

City: West Bridgewater State: Massachusetts Zip Code: 02379

Facility type: Freestanding Ambulatory Surgery Facility CMS Number: 22C0001025

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? CEC

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

1.6 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

1.8 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

7.3 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

8.2 Current location of Site

Facility Name:	Commonwealth Endoscopy Center
Physical Address:	120 West Center Street

City:	West Bridgewater	State:	Massachusetts	Zip Code:	02379
Facility type:	Freestanding Ambulatory Surgery capacity				

8.3 Location of Proposed Site

Facility Name:	Commonwealth Endoscopy Center				
Physical Address:	3 Washington Place				
City:	Easton	State:	Massachusetts	Zip Code:	02356
Facility type:	Freestanding Ambulatory Surgery capacity				

8.4 Compare the scope of the project for each element below:

	Current Site	Proposed Site
Gross Square Feet	3320	7500
Primary Service Area Towns served	See attached narrative.	See attached narrative.
Patient Population (Demographics)	See attached narrative.	See attached narrative.
Patient Access	See attached narrative.	See attached narrative.
Impact on Price	See attached narrative.	See attached narrative.
Total Medical Expenditure	See attached narrative.	See attached narrative.
Provider Costs	See attached narrative.	See attached narrative.
Description	See attached narrative.	See attached narrative.

8.5 Detail all Anticipated Capital Expenditures to be incurred as a result of the proposed Transfer of Site.

Add Del Row	Anticipated Capital Expenditure	Cost
+ -	Total Construction Costs	$6,800,000.00
+ -	Fair Market Value of Leased Property	$3,571,384.00
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
+ -		
	Total Cost	$10,371,384.00

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:	$10,371,384.00
12.2 Total CHI commitment expressed in dollars: (calculated)	$518,569.20
12.3 Filing Fee: (calculated)	$20,742.77
12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:	$3,304,293.00
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.

		Present Square Footage		Square Footage Involved in Project				Resulting Square Footage		Total Cost		Cost/Square Footage	
				New Construction		Renovation							
Add/Del Rows	Functional Areas	Net	Gross	Net	Gross	Net	Gross	Net	Gross	New Construction	Renovation	New Construction	Renovation
+ -	Ambulatory Surgery Center	3,320	3,320	7,500	7,500					$10,371,384.00		$1,382.85	
+ -													
+ -													
+ -													
+ -													
+ -													
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	Total: (calculated)	3,320	3,320	7,500	7,500					$10,371,384.00		$1,382.85	

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	$0	$0	$0
	Site Survey and Soil Investigation	$0	$0	$0
	Other Non-Depreciable Land Development	$0		
	Total Land Costs	$0	$0	$0
	Construction Contract (including bonding cost)			
	Depreciable Land Development Cost	$0	$0	$0
	Building Acquisition Cost	$0	$0	$0
	Construction Contract (including bonding cost)	$4875000	$0	$4875000
	Fixed Equipment Not in Contract	$1675000	$0	$1675000
	Architectural Cost (Including fee, Printing, supervision etc.) and Engineering Cost	$250000	$0	$250000
	Pre-filing Planning and Development Costs	$0	$0	$0
	Post-filing Planning and Development Costs	$0	$0	$0
Add/Del Rows	Other (specify)			
+ -		$0	$0	$0
	Net Interest Expensed During Construction	$0	$0	$0
	Major Movable Equipment	$0	$0	$0
	Total Construction Costs	$6800000	$0	$6800000
	Financing Costs:			
	Cost of Securing Financing (legal, administrative, feasibility studies, mortgage insurance, printing, etc	$0	$0	$0
	Bond Discount	$0	$0	$0
Add/Del Rows	Other (specify			
+ -	Fair Market Value of Leased Property	$3571384	$0	$3571384
	Total Financing Costs	$3571384	$0	$3571384
	Estimated Total Capital Expenditure	$10371384	$0	$10371384

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

- [x] Affidavit of Truthfulness Form
- [x] Scanned copy of Application Fee Check
- [x] Affiliated Parties Table Question 1.9
- [x] Change in Service Tables Questions 2.2 and 2.3
- [ ] 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: CEC-24082115-AS

Use this number on all communications regarding this application.

☐ Community Engagement-Self Assessment form