

BAYSTATE WING HOSPITAL

**APPLICATION FOR DETERMINATION OF NEED
BH-23061217-TS – TRANSFER OF SITE**

July 19, 2023

BY

**BAYSTATE HEALTH, INC.
759 CHESTNUT STREET
SPRINGFIELD, MA 01199**

BAYSTATE HEALTH, INC.
APPLICATION FOR TRANSFER OF SITE
BH-23061217-TS

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APPLICATION FORM



Massachusetts Department of Public Health

Determination of Need

Application Form

Version: 11-8-17

Application Type: Application Date: 07/19/2023 12:05 pm

Applicant Name:

Mailing Address:

City: State: Zip Code:

Contact Person: Title:

Mailing Address:

City: State: Zip Code:

Phone: Ext: E-mail:

Facility Information

List each facility affected and or included in Proposed Project

1 Facility Name:

Facility Address:

City: State: Zip Code:

Facility type: CMS Number:

2 Facility Name:

Facility Address:

City: State: Zip Code:

Facility type: CMS Number:

1. About the Applicant

1.1 Type of organization (of the Applicant):

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?

- 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?
- 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.

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

3.1.a If yes, under what section?

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

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:

Physical Address:

City: Ware State: Massachusetts Zip Code: 01082

Facility type: Hospital

8.3 Location of Proposed Site

Facility Name: Baystate Wing Hospital

Physical Address: 40 Wright Street

City: Palmer State: Massachusetts Zip Code: 01069

Facility type: Hospital

8.4 Compare the scope of the project for each element below:		
	Current Site	Proposed Site
Gross Square Feet	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Primary Service Area Towns served	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Patient Population (Demographics)	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Patient Access	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Impact on Price	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Total Medical Expenditure	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Provider Costs	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)
Description	See attached Narrative (Appendix 2)	See attached Narrative (Appendix 2)

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
<input type="checkbox"/> + <input type="checkbox"/> -		\$0.00
<input type="checkbox"/> + <input type="checkbox"/> -		
<input type="checkbox"/> + <input type="checkbox"/> -		
<input type="checkbox"/> + <input type="checkbox"/> -		
<input type="checkbox"/> + <input type="checkbox"/> -		
<input type="checkbox"/> + <input type="checkbox"/> -		
	Total Cost	\$0.00

9. Research Exemption

9.1 Is this an application for a Research Exemption? Yes No

10. Amendment

10.1 Is this an application for an 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: Transfer of Site/Change in Designated Location

12.1 Total Value of this project:	<input type="text" value="\$0.00"/>
12.2 Total CHI commitment expressed in dollars: (calculated)	<input type="text" value="\$0.00"/>
12.3 Filing Fee: (calculated)	<input type="text" value="\$0.00"/>
12.4 Maximum Incremental Operating Expense resulting from the Proposed Project:	<input type="text" value="\$0.00"/>
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.	<input type="text"/>

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.

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

- Affidavit of Truthfulness Form
- Articles of Organization / Trust Agreement

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: 07/19/2023 12:05 pm

E-mail submission to
Determination of Need

Application Number: BH-23061217-TS

Use this number on all communications regarding this application.

Community Engagement-Self Assessment form

APPENDIX 2

NARRATIVE

2. Project Description

Baystate Health, Inc. (“Baystate Health” or “Applicant”), with a principal place of business at 759 Chestnut Street, Springfield, MA 01199, is filing a Notice of Transfer of Site (“Notice”) with the Massachusetts Department of Public Health (“Department”) for Baystate Wing Hospital Corporation (“BWH”) to transfer its existing CT unit from its satellite, Baystate Mary Lane Outpatient Center (“BML”) located at 85 South Street, Ware, Massachusetts 01082, to its main campus located at 40 Wright Street, Palmer, Massachusetts 01069 (“Proposed Project”). The Proposed Project is needed to maintain access to CT services for the Applicant’s Patient Panel when the service closes at BML effective in or about December 2023. Consequently, the Applicant respectfully requests that the Department find that the proposed transfer of site does not require a Determination of Need (“DoN”) as a Substantial Capital Expenditure or Substantial Change in Service, specifically DoN-Required Equipment, pursuant to 105 CMR 715(B)(2).

8. Transfer of Site

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

In compliance with the requirements set forth at 105 C.M.R. 100.745(D) and the DoN form, the following information is provided relative to the Transfer of Site request:

1. **Gross Square Feet (“GSF”)**. Currently, the CT unit at BML occupies 474 GSF. Following the transfer of site, the CT unit will occupy 462 GSF at the main campus.
2. **Primary Service Area Towns Served**. The Primary Service Area of BML for CT services includes the cities and towns of Ware, Belchertown, Palmer, Monson, West Brookfield, Warren, Ludlow, Brimfield, and Wilbraham. The Primary Service Area for CT services at the main campus overlaps with BML’s and includes the cities and towns of Springfield and Chicopee.
3. **Patient Population Demographics**. The following table captures unique patients who received CT services at BML and BWH in FY22.

Demographic Measure	Baystate Mary Lane	Percent	Baystate Wing Hospital	Percent
Age – 0 - 18	<11 ¹	0.4%	211	2.3%
Age – 19 - 30	17	2.4%	784	8.6%
Age – 31 - 40	25	3.5%	936	10.3%
Age – 41 - 50	52	7.3%	1,042	11.5%
Age – 51 - 65	250	35.0%	2,331	25.6%
Age – 65+	371	51.9%	3,786	41.7%
Total	715	100.00%	9,090	100.00%
Gender - Female	383	53.6%	5,074	55.8%
Gender - Male	332	46.4%	4,016	44.2%
Total	715	100.00%	9,090	100.00%
Race - American Indian or Alaska Native	0	0%	<11	0.1%
Race - Asian	<11	0.4%	65	0.7%

¹ To ensure patient privacy, we have used the notation “<11” in any instance where the patient count for a demographic category included less than 11 individuals.

Race - Black or African American	<11	0.4%	387	4.3%
Race - Hispanic	<11	0.1%	198	2.2%
Race - Native Hawaiian or Other Pacific Islander	<11	1.4%	571	6.3%
Race - Refuse to Answer	<11	0.1%	<11	0.1%
Race – Unknown/Other ²	21	0.4%	90	0.9%
Race - White	694	97.1%	7,779	85.6%
Total	715	100.00%	9,090	100.00%

4. **Patient Access.** The Proposed Project is necessary to ensure BML’s patient population has continued, timely access to CT imaging. By relocating the right to operate the second CT unit to the main campus, BWH will continue to meet the needs of patients without adversely affecting BWH patients’ access to CT services. Without the relocation of the right to operate the second CT unit at BWH, BWH will not be able to meet demand following the closure of BML, adversely affecting access for patients of the main campus and patients who formerly received CT services at BML through increased wait times and limited ability to provide urgent same-day studies. Also, the second unit at BWH will ensure that there is continued access should either unit require downtime due to maintenance. Finally, the Applicant expects that patients who reside closer to Palmer than to Ware will experience more convenient access to CT imaging at BWH.
5. **Impact on Price.** The Proposed Project will not impact price. There will be no change in contracts or in payor reimbursement.
6. **Total Medical Expenditure.** The Proposed Project is not expected to materially impact total medical expenditure for the Commonwealth. BWH has an existing closed CT unit that will be relicensed, resulting in an efficient use of existing resources without a new expenditure to acquire a CT unit. The relocation of the right to operate will ensure timely access to CT imaging, allowing for diagnosis and treatment before a patient’s condition becomes more costly to treat.
7. **Provider Costs.** The Proposed Project is not expected to increase operating costs as the costs are currently incurred at BML, a satellite of BWH. As outlined in the Application Form, the maximum capital expenditure for the Proposed Project is \$0.

Description. BWH is a 74-bed community hospital in Palmer, Massachusetts, approximately ten (10) miles away from BML. BML is a licensed satellite location of BWH. BWH provides comprehensive services that include, among others, 24-hour emergency care, behavioral health and addiction recovery reservices, stroke care, heart and vascular disease care, orthopedics, pulmonary medicine, and surgery. BWH currently has one CT unit and a second unit that has been out of service. Through the Proposed Project, BWH will transfer the right to operate the BML unit to the out-of-service unit at BWH. This will provide patients with continued access to imaging. On January 26, 2021, BWH filed the required notices with the Department of its intent to close BML within two years and relocate a majority of its services to BWH.

As mentioned above, the cost associated with the Proposed Project is \$0. The Applicant plans to place an out-of-service CT unit back online at BWH by transferring the right to operate the CT unit from BML to BWH. As the project does not involve a capital

² Includes multiple race/ethnicity categories for confidentiality.

expenditure and does not increase CT capacity for BWH, the Proposed Project is not considered a Substantial Capital Expenditure or a Substantial Change in Service requiring a DoN.

APPENDIX 3

ARTICLES OF INCORPORATION

https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2003/1224/000071371/0001/200358622110_1.pdf

https://corp.sec.state.ma.us/CorpWeb/CorpSearch/CorpSearchRedirector.aspx?Action=PDF&Path=CORP_DRIVE1/2005/0725/000143793/0001/200520540770_1.pdf

APPENDIX 4

AFFIDAVIT



Massachusetts Department of Public Health

Determination of Need

Affidavit of Truthfulness and Compliance with Law and Disclosure Form 100.405(B)

Version: 7-6-17

Instructions: Complete Information below. When complete check the box "This document is ready to print:". This will date stamp and lock the form. Print Form. Each person must sign and date the form. When all signatures have been collected, scan the document and e-mail to: dph.don@state.ma.us Include all attachments as requested.

Application Number: Original Application Date:

Applicant Name:

Application Type:

Applicant's Business Type: Corporation Limited Partnership Partnership Trust LLC Other

Is the Applicant the sole member or sole shareholder of the Health Facility(ies) that are the subject of this Application? Yes No

The undersigned certifies under the pains and penalties of perjury:

1. The Applicant is the sole corporate member or sole shareholder of the Health Facility[ies] that are the subject of this Application;
2. I have ~~read~~^{*} 105 CMR 100.000, the Massachusetts Determination of Need Regulation;
3. I understand and agree to the expected and appropriate conduct of the Applicant pursuant to 105 CMR 100.800;
4. I have ~~read~~^{*} this application for Determination of Need including all exhibits and attachments, and ~~certify that~~^{**} all of the information contained herein is accurate and true;
5. I have submitted the correct Filing Fee and understand it is nonrefundable pursuant to 105 CMR 100.405(B);
6. I have submitted the required copies of this application to the Determination of Need Program, and, as applicable, to all Parties of Record and other parties as required pursuant to 105 CMR 100.405(B);
7. I have caused, as required, notices of intent to be published and duplicate copies to be submitted to all Parties of Record, and all carriers or third-party administrators, public and commercial, for the payment of health care services with which the Applicant contracts, and with Medicare and Medicaid, as required by 105 CMR 100.405(C), et seq.;
8. I ~~have caused~~^{**} proper notification and submissions to the Secretary of Environmental Affairs pursuant to 105 CMR 100.405(E) and 301 CMR 11.00; will be made if applicable
9. If subject to M.G.L. c. 6D, § 13 and 958 CMR 7.00, I have submitted such Notice of Material Change to the HPC - in accordance with 105 CMR 100.405(G);
10. Pursuant to 105 CMR 100.210(A)(3), I certify that both the Applicant and the Proposed Project are in material and substantial compliance and good standing with relevant federal, state, and local laws and regulations, as well as with all ~~previously issued~~^{**} Notices of Determination of Need ~~and the terms and Conditions attached therein;~~^{**}
11. I have ~~read~~^{*} and understand the limitations on solicitation of funding from the general public prior to receiving a Notice of Determination of Need as established in 105 CMR 100.415;
12. I understand that, if Approved, the Applicant, as Holder of the DoN, shall become obligated to all Standard Conditions pursuant to 105 CMR 100.310, as well as any applicable Other Conditions as outlined within 105 CMR 100.000 or that otherwise become a part of the Final Action pursuant to 105 CMR 100.360;
13. Pursuant to 105 CMR 100.705(A), I certify that the Applicant has Sufficient Interest in the Site or facility; and
14. Pursuant to 105 CMR 100.705(A), I certify that the Proposed Project is authorized under applicable zoning by-laws or ordinances, whether or not a special permit is required; or,
 - a. If the Proposed Project is not authorized under applicable zoning by-laws or ordinances, a variance has been received to permit such Proposed Project; or,
 - b. The Proposed Project is exempt from zoning by-laws or ordinances.

Corporation:
 Attach a copy of Articles of Organization/Incorporation, as amended

<i>Type name here</i>		7-14-2023
CEO for Corporation Name:	Signature:	Date
<i>Type name here</i>		
Board Chair for Corporation Name:	Signature:	Date

*been informed of the contents of
 **have been informed that
 ***issued in compliance with 105 CMR 100.00, the Massachusetts Determination of Need Regulation effective January 27, 2017 and amended December 28, 2018

This document is ready to print:

Date/time Stamp:
