

Project Description

Emerson Endoscopy and Digestive Health Center, LLC (the “Applicant”), located at 310 Baker Avenue, Concord, MA 01742, is filing a Notice of Determination of Need (DON, the “Application”) with the Massachusetts Department of Public Health (DPH) to expand its existing ambulatory surgery center (ASC) by adding one (1) procedure room and three (3) pre/post-op bays for a total of three (3) procedure rooms and nine (9) pre/post-op bays at Emerson Endoscopy and Digestive Health Center (the “Center”) (the “Proposed Project”).

The Applicant received DoN approval in 2021 to construct an ASC with two procedure rooms to provide endoscopy services in Concord, MA. The Center has been licensed by DPH since 2022 and is certified by The Centers for Medicare & Medicaid. It is a participating MassHealth provider and is a member of Mass General Brigham’s Accountable Care Organization. In 2024, the Center provided outpatient endoscopy to over 3,000 patients. To ensure the Center has adequate capacity to provide the Patient Panel with timely access to endoscopy services, the Applicant requests DoN approval to construct a third procedure room at the Center.

First, the recent closure of Nashoba Valley Medical Center (NVMC) in 2024 created the need for additional endoscopy access in the region. Next, current screening guidelines recommend average-risk adults have a colonoscopy every 10 years beginning at age 45. More frequent screening is recommended for adults with a higher risk. However, cancer incidence rates are rising among adults under the age of 50 and there is likely to be a greater need for colonoscopy by adults in their 40s and even 30s. Lastly, the population of the Center’s service area is projected to grow, specifically among the 45-75 age cohort. Individually and collectively, these reasons demonstrate the need for endoscopy care is growing. Therefore, the Applicant’s request for a third procedure room will ensure there is adequate capacity to preventative care in the community.

The Proposed Project is consistent with Massachusetts’ goals for cost containment. With a third procedure room, patients will continue to have timely access to endoscopy in a lower cost setting than procedures performed in hospital outpatient departments (HOPD). The Center can provide endoscopy services at a lower cost compared to HOPDs because it maximizes operational efficiencies by limiting the range of supplies, equipment, and staff needed to provide care. Consequently, the Proposed Project will contribute to the Commonwealth’s goal of containing the rate of growth of total medical expenses (TME) and total healthcare expenditures.

In sum, the Proposed Project will address an identified need of patients in the region to access timely outpatient endoscopy in a convenient location. By increasing the Center’s capacity, the Applicant can provide timely access to outpatient endoscopy and improve patient outcomes through preventative care and early diagnosis. Accordingly, the Proposed Project meets the factors of review for approval.

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;

The Center is a freestanding single-specialty endoscopy ASC that opened in April 2022. It currently operates two (2) outpatient procedure rooms. The following charts provide a breakdown of the Applicant’s patients:

- Table 1: Patient Panel Demographics

- Table 2: Patient Panel Geographic Origin
- Table 3: Patient Panel Payer Mix

Demographics

While the percent of patients aged 50-69 remained relatively consistent from 2022 to 2024, the percent of patients aged 18-49 increased from 27% to 37%, resulting in almost three times as many patients under 50 receiving care at the Center in 2024 compared to 2022. The Applicant's Patient Panel has averaged 60% female patients and 40% male patients; however the percent of male patients has increased from 35% in 2022 to almost 44% in 2024.

Table 1: Demographics¹	2022 Count	2022 Percent	2023 Count	2023 Percent	2024 Count	2024 Percent
Total	1,610	100%	3,210	100%	3,275	100%
Gender: Female	1,042	64.7%	1,883	58.6%	1,843	56.2%
Gender: Male	568	35.2%	1,327	41.3%	1,432	43.7%
Age: 18-49	441	27.3%	1,030	32%	1,226	37.4%
Age: 50-69	861	53.4%	1,723	53.6%	1,690	51.6%
Age: 70+	308	19.1%	457	14.2%	359	10.9%

Geographic Origin.

The Applicant's primary service area is comprised of over 20 cities and towns in northeastern Massachusetts. From 2022 to 2024, the geographic origin of the Center's patients remained relatively consistent. The largest percentage of the ASC's patients are from Acton, Concord and Sudbury, representing one-fifth of the Patient Panel. Additionally, the Center serves a number of towns that were also served by NVMC including Acton, Westford, Littleton, Groton, Harvard, Leominster, Ayer, Lunenburg, and Pepperell.

Table 2: Geographic Origin	2022 Count	2022 Percent	2023 Count	2023 Percent	2024 Count	2024 Percent
Concord	134	8.3%	310	9.6%	264	8%
Acton	123	7.6%	275	8.5%	265	8%
Sudbury	100	6.2%	200	6.2%	188	5.7%
Westford	96	5.9%	184	5.7%	143	4.3%
Bedford	75	4.6%	118	3.6%	106	3.2%
Maynard	66	4%	150	4.6%	140	4.2%
Littleton	58	3.6%	110	3.4%	126	3.8%
Groton	54	3.3%	111	3.4%	142	4.3%
Stow	52	3.2%	102	3.1%	87	2.6%
Hudson	44	2.7%	68	2.1%	73	2.2%
Carlisle	36	2.2%	48	1.4%	71	2.1%
Chelmsford	35	2.1%	63	1.9%	100	3%
Boxborough	34	2.1%	58	1.8%	68	2%
Harvard	34	2.1%	62	1.9%	61	1.8%

¹ The Applicant does not collect information related to patients' race or ethnicity as part of its intake process.

Leominster	33	2%	63	1.9%	66	2%
Ayer	30	1.8%	55	1.7%	62	1.8%
Marlborough	29	1.8%	71	2.2%	52	1.5%
Lexington	27	1.6%	70	2.1%	53	1.6%
Lunenburg	26	1.6%	43	1.3%	45	1.3%
Pepperell	26	1.6%	53	1.6%	51	1.5%
All Other	498	31.6%	996	31%	1,112	33.9%

Payer.Mix.

In 2024, government payers accounted for one-fifth of patients' insurance. Commercial payers represented the largest share of the Center's payer mix.²

Table 3: Patient Panel Payer Mix	2022	2023	2024
Commercial (PPO/Indemnity and HMO/POS)	60%	72.6%	81.1%
Medicare	20%	15%	12.3%
Commercial Medicare (Private Medicare/ Medicare Advantage)	11%	11%	4.8%
Medicaid	4%	0%	1.5%
All Other	1%	1.2%	.3%

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 F7, and 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.

As with the original DoN project, the goal of the Proposed Project is to ensure patients have timely access to outpatient endoscopy in the most appropriate and accessible care setting. The Center has experienced steady volume growth since opening and anticipates it will need a third procedure room for a number of factors. First, the closure of NVMC has resulted in unmet demand for endoscopy in the region. In addition, Emerson Hospital, a joint owner of the Center, has a clinical affiliation with Atrius Health which will continue to result in new cases being referred to the Center. Finally, new volume will continue to be driven by the expansion of colorectal cancer (CRC) screening guidelines, a growing population of adults ages 45-75, and higher incidences of CRC among young adults. Therefore, to plan for the projected demand for outpatient endoscopy without waiting for care delivery to first be negatively impacted through longer wait times, the Applicant requests approval to add one (1) procedure room and three (3) pre/post-op bays at the Center to ensure it can continue to provide timely access to endoscopy services in the community.

² The high percentage of commercial payers reflects the age and socioeconomic demographics of the Applicant's service area. Overall, the towns within the Applicant's service area have higher median household incomes and lower poverty rates compared to the overall Massachusetts figures. For example, the towns of Acton and Concord account for 16% of the Applicant's patient panel and both towns have poverty rates below 3%. Community Health Needs Assessment 2024, EMERSON HOSPITAL, <https://www.emersonhospital.org/getmedia/09a13d4d-947a-41af-a59c-d6f27a9b8bb6/2024-Community-Health-Needs-Assessment.aspx> (last visited December 16, 2024).

A. Historical Utilization

As demonstrated in the table below, case volume at the Center has increased year over year since opening April of 2022. In 2024, the Center provided endoscopy services to 3,275 unique patients and performed 4,873 cases, a 36% increase from 2023. The most common procedures performed at the Center are colonoscopy screenings for high risk and standard risk patients, colonoscopies to conduct biopsies or remove polyps, and esophagogastroduodenoscopies (“EGD”) to perform biopsies. In some cases, these procedures will yield results that require further investigation, leading to approximately 21 recalls per month for further testing at the Center. The most common patient diagnoses are colon cancer, colon polyps, gastrointestinal (“GI”) cancer, epigastric pain, and melena.

Table 4: Historical Volume	CY2022	CY2023	CY2024
Cases at the Center	1,782	3,583	4,873

The Center’s hours of operation are 7am to 5pm Monday through Friday. Each case at the Center is scheduled for a 30-minute slot, allowing for a maximum of 14 cases per room per day, accounting for 10 minutes of turnover time between each case. The Center is closed each year for ten (10) holidays, resulting in a maximum of 3,500 cases per room per year.³

B. Projected Need

The most immediate driver for additional capacity at the Center is the closure of NVMC in August 2024. As noted in Section F1.a.i, NVMC’s service area significantly overlapped with the service area of the Emerson Hospital as well as the Center, including the towns of Acton, Westford, Littleton, Groton, Harvard, Leominster, Ayer, Lunenburg, and Pepperell. Leading up to NVMC’s closure, Emerson Health prepared for the expected increase in patient demand by hiring additional staff, increasing operating hours at some sites, and opening an observation unit at Emerson Hospital. Since the closure of NVMC, all of Emerson Health’s health care services have experienced a steady increase in the number of daily patients. For example, Emerson Hospital’s emergency department has seen an additional six (6) patients per day since the closing of NVMC, an almost 50% increase in visits. Additionally, Emerson Health’s imaging, urgent care, and laboratory services have experienced patient volume increases of 30%, 20%, and 8%, respectively, since NVMC’s closure. As part of its plan to ensure access to NVMC’s former patients, Emerson Health recently hired 14 primary care providers from the NVMC service area. As primary care providers are a significant referral source for endoscopy, the Applicant anticipates cases from the service area shared by the Center and NVMC will shift to the Center. As former NVMC patients make Emerson Health their medical home, additional capacity is needed to ensure access in the community. Accordingly, the Applicant anticipates a significant portion of former NVMC patients will seek endoscopy care at the Center thus requiring an additional procedure to accommodate the shift in care.

The Proposed Project will also ensure capacity for additional cases the Center anticipates will be referred by Atrius Health, a collaborative health care system focused on primary and specialty care, with 27 practice locations in Eastern Massachusetts, including one such location within the same plaza as the Center. Through an affiliation agreement between Emerson Hospital and Atrius Health, the Center provides access to preventative and diagnostic endoscopy for patients of Atrius Health’s primary care providers and gastroenterologists. This affiliation results in approximately 45 cases per month at the Center. For 2025, this rate is expected to grow to approximately 75 cases per month and increase steadily in future years.

The need for the Proposed Project is further driven by projected population growth in the Applicant’s service area and increasing cancer rates in Massachusetts. In 2030, the 45-74 age cohort is expected to

³ ((52 weeks per year x 5 days per week)) – 10 holidays) x 14 slots = 3,500.

surpass 39,000 residents in the towns of Acton, Concord, Groton, Sudbury, and Westford, the top 5 towns in the Applicant's service area.⁴ By 2050, the number residents in this age range will reach almost 50,000 for those same towns, a 23% increase from today.⁵ The projected growth in this age range will lead to increased demand for the Center's services based on the screening guidelines for CRC, which recommend screening every 10 years beginning at age 45 through age 75.⁶ This would result in approximately 3,900 residents from the Center's top 5 towns being screened for CRC every year in compliance with the guidelines, which would lead to increased demand for the Center's services as the number of residents in this age group continues to grow. With screening compliance currently at 70% in Massachusetts, the need for endoscopy will continue to grow as the population not only ages but also increases in size.⁷

Finally, as Massachusetts's cancer rates continue to increase, ASCs will play a pivotal role in early detection and improving patient outcomes. Between 2016 to 2020, there was an annual average of 39,280 new cancer cases, resulting in 196,399 new cases during this 5-year period.⁸ However in 2024, it was projected the number of new cancer cases would grow to 44,040, evidence that the number of cancer diagnoses in Massachusetts continues to increase annually.⁹ Most notably, the cohort of adults under the age of 50 was the only group that underwent an increase in overall cancer incidence between 1995 and 2020.¹⁰ Today, CRC is the leading cause of death for men younger than 50 and is the second leading cause for women in the same age group.¹¹ To that end, access to timely screening is necessary to ensure new cancer cases are diagnosed early, when treatment is most likely to result in positive outcomes.

As a result of each of these factors, the Center anticipates the need for outpatient endoscopy will increase to more than 9,000 cases in 2031. Through the addition of a third procedure room, the Center will be able to maintain a utilization under 90% capacity which will not negatively impact patient wait times.

Table 5: Projected Volume	2027	2028	2029	2030	2031
Total Cases	5,564	6,564	7,564	8,564	9,314

In summary, the Center anticipates many former NVMC patients will seek care through Emerson Health, including the Center, as they shift their care to a new medical home. Next, the Center will continue to see volume grow through Emerson Health's affiliation with Atrius Health. Lastly, as the total number of individuals ages 45-74 increases between 2025 and 2050 in the top 5 towns with the Center's service area, the need to screen for cancer and age-related disease will continue to grow. The combination of NVMC's closure, growing referrals from Atrius Health, an aging population, and the increasing incidence of cancer

⁴ UMDI-V2024 Massachusetts Population Projections, UMASS DONAHUE INSTITUTE, https://donahue.umass.edu/documents/UMDI_V2024_Long-Term_Population_Projections_MCD%2C_County%2C_RPA%2C_State_Age_Sex_detail_2010-2050.xlsx (last visited January 15, 2025).

⁵ UMDI-V2024 Massachusetts Population Projections, supra note 4.

⁶ Guideline for Colorectal Cancer Screening, AMERICAN CANCER SOCIETY, <https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html#:~:text=The%20American%20Cancer%20Society%20recommends,if%20they%20do%20not%20have> (last visited January 13, 2025).

⁷ Colorectal Cancer Facts & Figures 2023-2025, AMERICAN CANCER SOCIETY, <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/colorectal-cancer-facts-and-figures/colorectal-cancer-facts-and-figures-2023.pdf> (last visited January 13, 2025).

⁸ Cancer Incidence and Mortality in MA 2016-2020, MASSACHUSETTS CANCER REGISTRY, [https://www.mass.gov/doc/cancer-incidence-and-mortality-in-massachusetts-2016-2020-statewide-report/download#:~:text=All%20cancers%20combined%20incidence%20\(new%20cases\)&text=Between%202016%20and%202020%2C%20there,average%20of%2039%2C280%20cases%20yearly](https://www.mass.gov/doc/cancer-incidence-and-mortality-in-massachusetts-2016-2020-statewide-report/download#:~:text=All%20cancers%20combined%20incidence%20(new%20cases)&text=Between%202016%20and%202020%2C%20there,average%20of%2039%2C280%20cases%20yearly) (last visited January 13, 2025).

⁹ Estimated Number of New Cases and Deaths by State, AMERICAN CANCER SOCIETY, <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2024/sd3-21-cancers-by-state-2024.pdf> (last visited January 13, 2025).

¹⁰ 2024 – First Year the US Expects More than 2M New Cases of Cancer, AMERICAN CANCER SOCIETY, <https://www.cancer.org/research/acs-research-news/facts-and-figures-2024.html> (last visited February 11, 2025).

¹¹ 2024 – First Year the US Expects More than 2M New Cases of Cancer, supra note 10.

in Massachusetts will drive the need for outpatient endoscopy at the Center in the coming years. To that end, the Proposed Project will ensure the Center has the capacity necessary to meet the needs of the community and can continue to provide timely access to high quality outpatient endoscopy that is essential for detecting disease early and improving health outcomes.

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 0? Financial Feasibility and Reasonableness of Costs?

The Proposed Project will compete on the basis of price, TME, provider costs and health care spending generally because of the cost savings driven by the provision of outpatient endoscopy at the Center. These savings will be the direct result of expanding access to endoscopy care at the Center which can be provided at a lower cost than in an HOPD. The Massachusetts Health Policy Commission (HPC), an independent state agency charged with monitoring health care spending growth in Massachusetts recently found that the Commonwealth has the fourth fewest ASCs per capita in the United States.¹² As a result, there are only 23 ASC operating rooms per one million residents in the Commonwealth compared to the national average of 56 operating rooms per one million residents.¹³ In order to match the national average, Massachusetts would need twice as many procedure rooms per one million residents.¹⁴ With respect to ASCs offering endoscopy services, Massachusetts only has 12 single specialty endoscopy ASCs, and an additional six (6) multi-specialty ASCs that offer endoscopy services.¹⁵ Increasing the number of procedure rooms dedicated to endoscopy will contribute to the Commonwealth's goal of cost containment by reducing widespread reliance upon HOPDs to provide low acuity endoscopy at a considerably higher price than ASCs as illustrated in Table 6 below.

Single specialty endoscopy ASCs are able to compete with HOPDs by providing high quality care at a lower cost. These ASCs are able to keep overhead costs low because they can limit the staff, equipment and supplies needed to operate. Streamlined efforts such as these also promote operational efficiencies. Moreover, Medicare reimbursement rates for ASCs are, on average, just 50% of the amount paid to HOPDs for all eligible procedures, including endoscopies.¹⁶ Annually, this translates into more than \$4.2 billion in savings for the Medicare program and its beneficiaries.¹⁷ Studies demonstrate that ASCs are likely to reduce Medicare costs by \$73.4 billion from 2019 to 2028.¹⁸ Similarly, the Medicaid program, Commercial payers and other payers realize significant savings by shifting clinically appropriate patients and procedures to ASCs.¹⁹ To that end, the lower costs of ASCs translate to lower out-of-pocket costs for patients compared to endoscopy performed in an HOPD.²⁰

The table below illustrates the current cost savings available to Medicare patients who chose, or are able, to have their endoscopy procedure performed in an ASC compared to an HOPD. Potential savings for procedures performed in an ASC range from 38% to 78% compared to an HOPD.

¹² HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, Massachusetts Health Policy Commission, <https://www.mass.gov/doc/datapoints-issue-26-printable-version/download> (last visited February 18, 2025).

¹³ HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, *supra* note 12.

¹⁴ HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, *supra* note 12.

¹⁵ HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, *supra* note 12.

¹⁶ Reducing Medicare Costs, AMBULATORY SURGICAL CENTERS ASS'N, (last visited November 20, 2024).

¹⁷ Medicare Cost Savings, AMBULATORY SURGICAL CENTERS ASS'N, (last visited November 20, 2024).

¹⁸ Medicare Cost Savings, *supra* note 13.

¹⁹ Medicare Cost Savings? *supra* note 13; See also Commercial Insurance Cost Savings in Ambulatory Surgery Centers (2016), AMBULATORY SURGICAL CENTERS ASS'N, (last visited November 21, 2024).

²⁰ Commercial Insurance Cost Savings, *supra* note 15.

Table 6: Procedure Cost in ASC Versus HOPD²¹

Procedure	ASC Cost	HOPD Cost	ASC Savings
Colonoscopy	\$652	\$1,048	38%
Colonoscopy with biopsy	\$805	\$1,317	39%
Endoscopy	\$970	\$1,951	50%
Endoscopy with biopsy	\$984	\$1,965	50%
EGD	\$588	\$981	40%
EGD with biopsy	\$604	\$997	39%
Sigmoidoscopy	\$206	\$925	78%
Sigmoidoscopy with biopsy	\$544	\$940	42%

The growing availability of ASCs as a high-quality care option for routine endoscopy has increased their utilization and led to a reduction of costs for payors and patients. This trend will continue to create savings for payors, patients, and providers, directly impacting TME. Therefore, the Proposed Project will compete on the basis of price, TME and provider costs. By creating more capacity for outpatient endoscopy at the Center, recognized measures of health care spending will be positively impacted.

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?

As described in F1.a.ii, the need for outpatient endoscopy continues to grow in the Applicant's service area. Accordingly, the Proposed Project will provide sufficient capacity to ensure timely access to outpatient endoscopy and is supported by extensive evidence-based research on the use of endoscopy to diagnose and treat digestive health diseases and conditions and promote patient safety and satisfaction.

A. Clinical Applications of Routine Endoscopy

Endoscopy is a non-invasive procedure that examines the digestive tract utilizing a flexible tube with a light and camera called an endoscope.²² This method allows physicians to view and operate on the internal organs while avoiding conventional surgery and large incisions. Routine endoscopy is used for screening, diagnostic and treatment purposes. When used as a screening tool, such as colonoscopy, clinicians are able to routinely monitor patients and identify disease early on so that treatment can be initiated sooner.²³ As opposed to diagnostic tests, screening endoscopy evaluates individuals that have a low pretest probability of a particular disease. These individuals are either asymptomatic or are at preclinical stages of their disease.²⁴ Endoscopy also is frequently used as a diagnostic tool to evaluate stomach pain, ulcers, gastritis, digestive tract bleeding, changes in bowel habits, and polyps or growths in the colon.²⁵ Studies have shown that upper endoscopy is more accurate than x-rays in detecting abnormal growths, such as cancer, and is more accurate for examination of the upper digestive system.²⁶ As a treatment method, upper endoscopy is used to identify and remove polyps, as well as to dilate strictures of the esophagus, stomach, or duodenum that result from cancer or other diseases.²⁷

²¹ Total cost data based on Medicare's 2024 payments and copayments rates.

²² Endoscopy?HEALTHLINE, <https://www.healthline.com/health/endoscopy> (last visited November 19, 2024).

²³ T.H. Ro et al, Value of Screening Endoscopy in Evaluation of Esophageal, Gastric and Colon Cancers. 21 WORLD J. OF GASTROENTEROLOGY, 33, 9693-706 (Sept. 7, 2015).

²⁴ Value of Screening Endoscopy, supra note 19.

²⁵ Colorectal Cancer Screening?AM. SOC'Y FOR GASTROINTESTINAL ENDOSCOPY, [https://www.gastrojournal.org/article/S0016-5085\(2017\)2935599-3/fulltext](https://www.gastrojournal.org/article/S0016-5085(2017)2935599-3/fulltext) (last visited November 19, 2024).

²⁶ Colorectal Cancer Screening, supra note 21.

²⁷ Colorectal Cancer Screening, supra note 21.

Routine endoscopy is most commonly used to help determine the cause of GI symptoms, to biopsy tissue, and/or to guide doctors during surgery.²⁸ Common routine endoscopic procedures include upper GI endoscopy or EGD, colonoscopy, and sigmoidoscopy.²⁹ A brief overview of the clinical application of each is as follows:

- **EGD** is an upper endoscopy passed through the mouth to examine the lining of the esophagus, stomach and start of the small intestine. The procedure is frequently used when patients present with epigastric symptoms such as heartburn, regurgitation, upper abdominal pain, unexplained anemia, unexplained weight loss, or pain or difficult swallowing.³⁰ EGD may also be utilized to monitor and treat individuals with diseases such as esophageal, stomach, or duodenum cancers, ulcers, Crohn's disease, cirrhosis, gastroesophageal reflux disease, or swollen veins in the esophagus.³¹
- **Colonoscopy** is a lower endoscopy procedure that passes the endoscope through the rectum into the large intestine.³² The procedure screens the entire colon and large intestine for colorectal polyps or cancer, and can serve as a diagnostic tool for patients who have bleeding from the anus, changes in bowel activity, pain in the abdomen, and unexplained weight loss. This procedure is recommended as a preventative measure for all adults 45+, as well as anyone with parents, siblings, or children with a history of colorectal cancer or polyps.³³ A colonoscopy shows irritated and swollen tissue, ulcers, polyps (which doctors may remove for biopsy during the procedure), and cancer.³⁴ Removal of polyps can prevent CRC, which is frequently not diagnosed until the disease is advanced.³⁵ Based on their clinical advantages, colonoscopy is considered the "gold standard" in detecting colorectal cancer.
- **Sigmoidoscopy** examines the lower part of the colon (sigmoid) to determine causes of abdominal pain, rectal bleeding, changes in bowel habits, and other intestinal issues.³⁶ As with colonoscopy, sigmoidoscopy is also used to screen for CRC. However, it does not provide a complete view of the colon. When clinically appropriate, this method may be preferred over colonoscopy because it takes less time to perform, often does not require an anesthetic, and is associated with lower risks such as perforation.³⁷

B. Benefits of Ambulatory Surgery Centers

ASCs achieve greater clinical and operational efficiencies compared to traditional hospital-based surgery departments because they are tailored to a limited set of medical specialties and associated low-risk procedures.³⁸ As a result, ASCs do not need to be staffed or stocked for a wide range of surgeries or be

²⁸ Colorectal Cancer Screening, supra note 21.

²⁹ Endoscopy?CLEVELAND CLINIC, <https://my.clevelandclinic.org/health/diagnostics/25126-endoscopy> (last visited November 19, 2024).

³⁰ Upper Endoscopy, MAYO CLINIC, <https://www.mayoclinic.org/tests-procedures/endoscopy/about/pac-20395197> (last visited November 19, 2024).

³¹ Upper Endoscopy, AM. SOC'Y FOR GASTROINTESTINAL ENDOSCOPY, <https://www.asge.org/list-pages/patient-informations/understanding-upper-endoscopy> (last visited November 19, 2024).

³² Colonoscopy?AM .SOC'Y FOR GASTROINTESTINAL ENDOSCOPY, [https://www.asge.org/list-pages/patient-informations/understanding-colonoscopy\(2\)](https://www.asge.org/list-pages/patient-informations/understanding-colonoscopy(2)) (last visited November 19, 2024).

³³ Colonoscopy, supra note 28.

³⁴ Colonoscopy, supra note 28.

³⁵ Colonoscopy, supra note 28.

³⁶ Flexible Sigmoidoscopy?MAYO CLINIC, <https://www.mayoclinic.org/tests-procedures/flexible-sigmoidoscopy/about/pac-20394189> (last visited November 19, 2024).

³⁷ Flexible Sigmoidoscopy, supra note 32.

³⁸ Position Statement?Ambulatory Surgical Centers, AM. ASS'N OF ORTHOPAEDIC SURGEONS, <https://www.aaos.org/globalassets/about/position-statements/1161-ambulatory-surgical-centers.pdf> (last visited January 15, 2025).

prepared for emergency surgeries.³⁹ Instead, ASCs are structured around the needs of its providers and patients, enabling ASCs to maximize the use of space and staff which leads to a more efficient use of time and cost-savings to both payors and patients. Further, by focusing on low acuity procedures, ASCs do not require the same level of overhead, such as staffing, laboratory, medication, and imaging costs, compared to hospital departments.⁴⁰ This contributes to significant cost savings as further discussed below. Overall, the ASC setting creates efficiencies that benefit patients and providers alike.

Hospital-based surgeries are frequently subject to scheduling delays created by emergency surgeries coming from the emergency department or inpatient admissions.⁴¹ Since ASCs are not subject to possible emergency surgeries, patients are seen as scheduled.⁴² Even when compared to hospitals with dedicated outpatient units, ASCs are able to maximize time efficiencies given the limited complexity of both cases and patients.⁴³ Procedures scheduled in an ASC are more likely to adhere to a schedule because they do not have to accommodate emergency and inpatient needs, contributing to both reduced appointment times and shorter wait times for an appointment.

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;

A. Improving Health Outcomes and Quality of Life

The Proposed Project will further enable the Applicant to provide patients with improved health outcomes and improved quality of life by creating additional access to high quality routine endoscopy in a freestanding setting. As more fully discussed in Factor F.1.b.i., shifting patients to an ASC setting allows for high-quality, lower-cost care. Moreover, the Proposed Project will improve the Center's ability to offer an efficient, patient-centered experience.

Most notably, expanded access to a convenient and cost-effective location for preventative CRC screenings, patient outcomes and experience will be positively impacted. To stem the rising incidence, deaths, and cost of treating CRC, emphasis is placed on preventative screening which allows for the simultaneous identification and removal of precancerous polyps before they develop into cancer.⁴⁴ Colonoscopies and the removal of precancerous polyps has led to a reduction in the incidence of CRC. Additionally, research has shown that organized screenings within a community produce higher rates of screening and led to a 25.5% reduction in annual CRC incidence, and a 52.4% reduction in cancer mortality between 2000 and 2015.⁴⁵ In response to several recent studies, the American Cancer Society (ACS) updated its guidelines for CRC screening in 2018. The current recommendation is that people at

³⁹ Elizabeth L. Munnich & Stephen T. Parente, Procedures Take Less Time at Ambulatory Surgery Centers Keeping Costs Down and Ability to Meet Demand Up, 33 HEALTH AFFAIRS 764 (2014), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.1281> (last visited January 15, 2024).

⁴⁰ Position Statement, supra note 34. See also Munnich et al., supra note 35.

⁴¹ Position Statement, supra note 34. See also Munnich et al., supra note 35.

⁴² Position Statement, supra note 34. See also Munnich et al., supra note 35.

⁴³ Report to the Congress, Medicare Payment Policy (March 2018). Chapter 5: Ambulatory Surgical Center Services, available at https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar18_medpac_entirereport_sec_rev_0518-pdf/. "Beneficiaries who are sicker may require more time to treat. We have found that, on average, beneficiaries receiving surgical services in HOPDs are not as healthy as beneficiaries receiving those services in ASCs, as indicated by risk scores from the CMS hierarchical condition categories risk adjustment model."

⁴⁴ Screening Methods for Early Detection of CRC and Polyps, MEDICAL ADVISORY SECRETARIAT, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3377498/>. Asymptomatic adenomatous polyps take approximately 10 years to become malignant therefore there is a significant window of time to remove the polyp before it becomes cancerous.

⁴⁵ T. R. Levin, Effects of Organized Colorectal Cancer Screening on Cancer Incidence and Mortality in a Large Community-Based Population, <https://doi.org/10.1053/j.gastro.2018.07.017> (last visited January 15, 2025).

average risk of CRC begin regular screening at age 45 and continue every 10 years through the age of 75.⁴⁶ Routine and timely preventative screenings increase the chances of identifying CRC early when treatment is typically more effective, less invasive, and the chance of recovery is high.⁴⁷

To that end, the Applicant seeks to further improve CRC screening compliance by providing community-based services. In addition to providing access in a convenient location with better scheduling and shorter recovery times, potential out-of-pocket costs are also greatly reduced by receiving endoscopy in an ASC. As a result, the Applicant anticipates that patients may be more likely to comply with screening recommendations if such traditional barriers are mitigated.

Through the Proposed Project, the Center will continue to provide high-quality care in the following ways:

- Ongoing process improvement initiatives – The Applicant is part of a national quality program and participates in a robust program reviewing quality of care outcomes, identifying best practices and implementing performance improvement initiatives;
- Single-specialty focus – The Center will continue to only provide GI-related endoscopy services, allowing physicians and staff to provide dedicated, expert care to patients for a limited range of needs and services; and
- Transforming the patient experience – Clinical and administrative staff can more effectively control scheduling because of the narrow range of procedures performed and decreased possibility of disruption due to the need to accommodate inpatient, emergent or urgent procedures as in a hospital setting, thereby eliminating delays, backlogs and rescheduled procedures.

In sum, these components create a more patient-centered experience. Accordingly, the Proposed Project will further improve patients' experience, quality of life and produce high quality outcomes.

B. Assessing the Impact of the Proposed Project

To assess the impact of the Proposed Project, the Applicant will track following quality metrics:

1. **Withdrawal Time:** Withdrawal time is based on the average number of minutes a physician took to withdraw the scope from the cecum during a screening colonoscopy when no maneuvers were performed. Longer withdrawal times during screening colonoscopies are associated with increased adenoma (polyp) detection rates, which is essential to making safe recommendations for intervals between screening and surveillance examinations.

Measure: Average withdrawal time in normal-result colonoscopies performed for colorectal cancer screening in average-risk patients with intact colons.

Numerator: Total number of withdrawal minutes for all patients.

Denominator: Total number of patients.

Quality Measure #1	Withdrawal time
2024 Baseline	11.71 minutes
Years 1-5 Projections	10 minutes

⁴⁶ Guideline for Colorectal Cancer Screening, supra note 6.

⁴⁷ Jian Li et al., Colorectal Cancer Screening: The Value of Early Detection and Modern Challenges, 30(2) WORLD J GASTROENTEROL (2024).

2. **Adenoma Detection Rate:** The Adenoma Detection Rate (ADR) is the minimum target for adenomas detected among an individual provider's patient panel. An increased ADR is associated with a reduction in CRC incidence and a reduction of cancer mortality.⁴⁸

Measure: Average rate of adenoma detection among an endoscopist's patient panel ages 50 years or older.

Numerator: The number of procedures for patients over 50 years of age where at least one adenoma was detected.

Denominator: Total number of procedures for patients over 50 years of age.

Quality Measure #2	ADR All Patients	ADR Men	ADR Women
2024 Baseline	52.0%	56.1%	48.6%
Years 1-5 Projections	54.7%	60.2%	49.1%

3. **Post-Procedure Infection** – This measure evaluates the number of patients with post-procedure infections.

Measure: The total number of patients with post-procedure infections.

Quality Measure #3	Post-Procedure Infections
2024 Baseline	2
Years 1-5 Projections	0

4. **Patient Satisfaction:** Patients that are satisfied with their care are more likely to seek additional treatment when needed. The Applicant will continue to review patient satisfaction levels with the ASC's surgical services and compare across like-facilities and regional benchmarks.

Measure: A Press Ganey Patient Satisfaction survey is provided to all eligible patients following their procedure. This survey focuses on the patient's experience in multiple areas, including, net promoter score (NPS), wait times, facility operations, care communication, nurse/physician treatment, and discharge. The survey also allows for anonymous comments from patients to further provide insight into areas of improvements and praises or concerns.

Quality Measure #4	Patient Experience (NPS Score)
2024 Baseline	89%
Years 1-5 Projections	>90%

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.gj. 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;

⁴⁸ Quality Indicators for GI Endoscopic Procedures, AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY, https://www.asge.org/docs/default-source/default-document-library/quality-indicators-for-gi-endoscopic-procedures.pdf?sfvrsn=e0d2ea51_0 (last visited January 15, 2025).

As detailed throughout this narrative, the Proposed Project will improve access to high quality and cost-effective care for all clinically appropriate patients in the Center's service area. The ASC will not discriminate based on ability to pay or payer source, physical ability, sensory or speech limitations, or religious, spiritual and cultural beliefs. Through the Proposed Project, the Applicant seeks to further improve access to cost-effective, convenient services for all patients. The following measures help facilitate equitable access to the ASC's services.

A. Promoting Cultural Competence

In order to ensure a welcoming and understanding environment for patients, the Center requires that all staff complete a cultural competency training upon hire and annually thereafter. Training is provided to employees through UKG Pro Learning and includes core courses "CLN Cultural Competence" and "Affordable Care Act Nondiscrimination and Limited English Proficiency". These courses promote understanding how clinical outcomes are associated with cultural competence, recognizing key terms, acknowledging common assumptions across cultures and best practices for improving the quality of interactions with patients and families. The Center is committed to fostering an environment of respect and understanding of its patients' cultural beliefs and practices.

B. Ensuring Language Accessibility

The Applicant strives to ensure that each patient understands the information they are provided about the care they receive. To this end, the Center provides language access services at no cost. Patients are screened prior to the procedure to identify level of assistance needed; however, services are always immediately available if not scheduled ahead of time. Specifically, translation services are provided through LanguageLine Solutions. Additionally, in-person interpreter services are available for persons with hearing impairment. For patients who are visually impaired, someone will be available to read printed materials in a location that protects patient privacy. Printed or recorded material can also be provided upon request. Through these policies, the Center works to minimize language barriers, promote health equity, and further equal access to endoscopy care.

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 seeks to expand access to cost-effective routine endoscopy in a non-hospital setting. By ensuring access to necessary screening and preventative services, patients will have improved health outcomes and quality of life. The Proposed Project will meaningfully impact health outcomes through increased rates of CRC screening because of the convenience afforded by the ASC setting. Patients may be more likely to comply with screening recommendations if services are provided outside of a hospital and at a lower cost to the patient. By increasing CRC screening rates, clinicians will be able to detect cancer earlier and provide more successful treatment options, ultimately leading to improved health outcomes and 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 provide continuity of care, improved health outcomes and enhanced quality of life through the Proposed Project, the Center has implemented processes to ensure patients and their providers receive all necessary information following each procedure. Before being discharged, all patients or the adult accompanying them, receive prescriptions for any medications needing to be filled, written instructions to promote their recovery from the procedure as well as warning signs of complications to be alert for, and information detailing how to contact the physician who will provide follow-up care to the patient if needed.

Additionally, policies are in place requiring copies of each procedure and pathology report to be shared with the referring physician. These steps are designed to ensure that patients and their care team are well-informed following all procedures at the Center.

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 individuals and agencies regarding the Proposed Project:

- Massachusetts Department of Public Health, including but not limited to: Dennis Renaud, Director, Determination of Need Program; Jennica Allen, Manager of Community Engagement Practices, Bureau of Community Health, and Prevention; Elizabeth Maffei, Program Manager, Bureau of Community Health, and Prevention; Katelyn Teague, Community Health Planning + Engagement Specialist, Bureau of Community Health, and Prevention
- Massachusetts Executive Office of Health and Human Services
- Health Policy Commission
- Center for Health Information and Analysis
- The Centers for Medicare & Medicaid Services

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;

In addition to relying on the data described throughout this application that demonstrates the need for the Proposed Project, the Applicant also engaged the community to elicit feedback from patients and families regarding the Proposed Project. Specifically, the Applicant met with Emerson Hospital's Patient and Family Advisory Committee (PFAC) to discuss the Proposed Project and address their questions. Additionally, the Applicant sought to inform and engage current patients by posting educational flyers around the Center with information about its plan to expand, the importance of cancer screening, and how to ask questions about the Proposed Project and/or provide feedback.

On November 21, 2024, the Administrator and Director of Nursing at the Center spoke at Emerson Hospital's PFAC meeting to discuss the Proposed Project and why a third procedure room is needed at the Center. PFAC members asked questions to better understand the relationship between Emerson Hospital and the Center, the Center's ability to handle new volume, and its plans for staffing. Overall, feedback was positive and was supportive of building additional capacity for outpatient endoscopy at the Center because of its demonstrated quality, convenience, and cost.

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 fPublic Health Valuef 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 fPatient Panelf need; and Linking the Proposed Project to fPublic Health Valuef;

To ensure sound community engagement throughout the development of the Proposed Project, the Applicant took the actions detailed in Factor F1.e.i. In addition, the Applicant published two legal notices announcing the Proposed Project in The Boston Herald on February 28, 2025, and also posted a copy of

such legal notice prominently on the Center's website. Please refer to Appendix 7 for copies of the legal notices.

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;

The goals for cost containment in Massachusetts center around providing low-cost care alternatives without sacrificing high quality. The HPC set the following goal for cost containment: better health and better care, at a lower cost, across the Commonwealth. The Proposed Project meets this goal by providing high quality surgical services in an affordable setting. More specifically, the Applicant anticipates that as a result of community-based CRC screenings, more patients will adhere to recommended screening guidelines leading to earlier detection rates. Once CRC is detected in the early stages of the disease, it can be treated more effectively and at a lower cost compared to when the disease is left undiagnosed for longer periods of time.

As discussed in F1.a.iii, ASC Medicare reimbursement rates are 50% of the amount paid to HOPDs.⁴⁹ Currently, Medicare savings associated with ASCs exceed \$4.2 billion annually.⁵⁰ Studies indicate ASCs are likely to reduce Medicare costs by \$73.4 billion from 2019 to 2028.⁵¹ Similarly, Medicaid, other insurers and patients benefit from lower prices for services performed in the ASC setting given lower levels of reimbursement and coinsurance.⁵² Furthermore, the lower reimbursement rates have not led to lower quality services; rather patients receiving surgical services in ASCs receive high-quality care from experienced surgeons and clinical staff. Lastly, their expertise and narrow focus on endoscopy results in care and cost efficiencies, and ultimately leads to overall reduced provider price, costs and TME. Accordingly, the Proposed Project will lower prices for payors and patients, in turn leading to overall reduced TME and total healthcare expenditures.

F2.b. Public Health Outcomes

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

Providing access to high-quality routine endoscopy in a non-hospital-based setting promotes improved public health outcomes and better patient experiences. The provision of endoscopy in an ASC setting promotes better health outcomes through increased adherence to CRC screening recommendations because of the convenience afforded by an ASC. Patients may be more likely to comply with recommendations if services are provided outside of a hospital and at a lower cost to the patient. By increasing CRC screening rates, clinicians will be able to detect cancer earlier and provide more successful treatment options, ultimately leading to improved health outcomes and quality of life. Additionally, the Center provides a better patient experience through convenient access to the facility,

⁴⁹ Reducing Medicare Costs, supra note 12.

⁵⁰ Medicare Cost Savings, supra note 13.

⁵¹ Medicare Cost Savings, supra note 13.

⁵² Commercial Insurance Cost Savings, supra note 7.

ample parking, expedited scheduling of procedures and shorter appointment times. Increased access to affordable and convenient services ultimately results in improved public health outcomes.

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 Center continues to work with patients and their referring providers to ensure patients have access to the resources available to them in the community. If concerns around social determinants of health are identified or suspected during pre-procedure screenings and appointments, staff will provide the patient with referral resources and update the medical record so that the patient's primary care provider is aware of the need for follow-up.

Additionally, as previously discussed in F1.a.iii, Massachusetts falls well below the national average number of ASC procedure rooms available with only half the number of ASC rooms per one million residents.⁵³ Moreover, Massachusetts only has 2.6 ASCs offering endoscopy services per one million residents compared to the national average of 5.9 per one million residents.⁵⁴ As a result of the limited number of ASCs, only 25% of colonoscopies and biopsies and 24% of upper gastrointestinal endoscopy and biopsies in Massachusetts are performed in ASCs.⁵⁵ Consequently, the vast majority of these services are performed in HOPDs at a significant higher cost.⁵⁶ To reduce the reliance on HOPDs, greater access to ASCs is needed in Massachusetts.

The Proposed Project will contribute to the Commonwealth's goal of delivery system transformation by increasing access to community-based care through additional capacity. Improving capacity for outpatient endoscopy at the Center will directly benefit the Applicant's patient panel which will continue to need endoscopy for cancers screenings and diagnostic care. By increasing the number of procedure rooms at the Center, the Applicant will be able to proactively address wait times that often disrupt patients' ability to timely receive an endoscopy. Maintaining reasonable wait times is critical to patient satisfaction and screening adherence necessary for early detection and treatment. To that end, the Proposed Project will ensure the Center has adequate capacity to promote CRC screening and improved health outcomes.

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 760 CMR. 766;876(A)(7). 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;

Alternative Proposal 1: Renovate and re-license an endoscopic procedure room at Emerson Hospital.

⁵³ HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, supra note 12.

⁵⁴ HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, supra note 12.

⁵⁵ Board Meeting June 2023, MASSACHUSETTS HEALTH POLICY COMMISSION, page 26, <https://www.mass.gov/doc/presentation-board-meeting-june-7-2023/download> (last visited February 18, 2025).

⁵⁶ Board Meeting June 2023, page 26, supra note 61.

Alternative Quality: This alternative option does not address the growing demand of patients to receive care in non-hospital settings, which are more convenient and are less expensive. Because the quality of care is at least equivalent when performed in an ASC compared to an HOPD, patient choice and satisfaction is an important factor in care delivery.

Alternative Efficiency: Increasing the provision of endoscopy in Emerson Hospital outpatient department will not take advantage of the operational efficiencies available at the Center.

Alternative Capital Expenses: The existing rooms at Emerson Hospital do not meet current FGI guidelines and would need significant renovations to be in compliance. Most notably, the two rooms that were closed under the original DoN do not meet square footage requirements so the Hospital would need to reconfigure the existing walls to create one new procedure room. Capital expenses for this alternative would be at least equal to or greater than the Proposed Project.

Alternative Operating Costs: Expanding the provision of outpatient endoscopy at Emerson Hospital would similarly result in increased operating costs, including additional staff to accommodate an increase in patients.

Alternative Proposal 2: Expand the ASC's hours of operation beyond Monday through Friday 7 a.m.-5 p.m.

Alternative Quality: This alternative would not provide a similar level of quality as the Proposed Project because patients tend to prefer procedures during the day as opposed to evening appointments. Because of this, patients may be more likely to delay care for a different appointment time.

Alternative Efficiency: Given staffing challenges associated with after-hours or weekend care, staffing these shifts are likely to require more recruitment effort than staffing coverage between 7am – 5pm. Moreover, extending hours of operation would not provide sufficient capacity to meet projected need. For example, opening the Center for a full weekend day would only increase case volume by 14 per week or 728 cases per year.

Alternative Capital Expenses: There are no capital expenses under this alternative.

Alternative Operating Costs: Expanding the ASC's hours of operation will likely result in higher operating costs than the Proposed Project in order to cover personnel expenses for evening and weekend shifts. As previously noted, there are considerable challenges with staffing weekend shifts at all levels. The Center would need to reconfigure schedules to mitigate overtime costs, or pay overtime, resulting in increased operating costs. Assuming non-physician staffing could be filled, there remains issues with physicians due to call coverage and other hospital commitments.