

**SOUTHCOAST HEALTH SYSTEM, INC.
DETERMINATION OF NEED APPLICATION # SHS-24050109-TO**

TRANSFER OF OWNERSHIP

SAME DAY SURGICARE OF NEW ENGLAND, INC.

**272 STANLEY STREET
FALL RIVER, MASSACHUSETTS 02720-6009**

May 1, 2024

**BY
SOUTHCOAST HEALTH SYSTEM, INC.
101 PAGE STREET
NEW BEDFORD, MASSACHUSETTS 02740**

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TABLE OF CONTENTS

Exhibit 1.	Project Description
Exhibit 2.	Narrative
Exhibit 3.	Notice of Intent
Exhibit 4.	Affidavit of Truthfulness and Compliance
Exhibit 5.	Affiliated Parties Form
Exhibit 6.	Change in Service Form
Exhibit 7.	Certification from an Independent Certified Public Accountant
Exhibit 8.	HPC Notice of Material Change
Exhibit 9.	Articles of Organization
Exhibit 10.	Filing Fee

Exhibit 1: Project Description

Southcoast Health System, Inc. (“Applicant” or “SHS”) located at 101 Page Street, New Bedford, Massachusetts 02740, is filing this application for a Notice of Determination of Need (“Application”) with the Massachusetts Department of Public Health (“Department”) for a proposed transfer of ownership of Same Day Surgicare of New England, Inc. (“SDS”), located at 272 Stanley Street, Fall River, Massachusetts 02720. The Applicant owns and operates an integrated health delivery system serving patients in Southeastern Massachusetts through three hospitals, urgent care facilities, physician offices, a visiting nurse association, and accountable care organizations participating in the Medicare Shared Savings Program and MassHealth Medicaid ACO program (collectively, the Applicant’s health system is referred to herein as “Southcoast Health”).

SDS is an existing freestanding, licensed ambulatory surgery center (“ASC”) that opened in 1984 and was the first multi-specialty ASC in the Commonwealth of Massachusetts. SDS offers a range of eye surgery, gastroscopy and colonoscopy, general surgery, gynecology, orthopedics, pain management, urology, plastic surgery, and podiatry services. SDS is currently operated as a joint venture with 49% owned by Southcoast Health Surgical Holdings, LLC (“SHSH”), a corporate subsidiary of the Applicant, and 51% owned by certain individual physician stockholders. The Applicant is the sole corporate member of Southcoast Hospitals Group, Inc. (“SHG”). SHG is the sole corporate member of SHSH.

The individual physician stockholders of SDS wish to wind down their practice over time and eventually retire. SHSH offered to purchase SDS in two stages in order to enable the ASC to continue to serve the outpatient surgical needs of the community and enable a smooth transition of the ASC by gradually incorporating clinicians from SHS and facilitating new physician leadership at the ASC over time. The first stage of the transition involved SHSH’s initial minority investment in SDS. The second stage of the transition will involve SHSH’s acquisition of the remaining 51% ownership interest in SDS upon receipt of all regulatory approvals (the “Project”). The terms of the Stock Purchase Agreement (“Definitive Agreement”) provide for the ASC’s current leadership to continue for a period of time in order to maintain continuity of care for the community.

The Project addresses the need to maintain access in the community to a high-quality, convenient, and cost-effective setting for ambulatory surgery for the Applicant’s and SDS’s patient panel. Historically, SHG has provided outpatient surgical services, including multi-specialty surgical services, at its three campuses (St. Luke’s Hospital at 101 Page Street, New Bedford, Massachusetts; Charlton Memorial Hospital at 363 Highland Avenue, Fall River, Massachusetts; and Tobey Hospital at 43 High Street, Wareham, Massachusetts), as well as at the Southcoast Health Surgery Center in Dartmouth, Massachusetts.

After reviewing its patient panel projections and related needs, and in recognition of the various benefits associated with ASC-based care, the Applicant determined that its patients and the

community would benefit from access to additional outpatient surgical services in an ASC setting in the Fall River area and, therefore, sought options to expand access to such care for its patients. Through this process, SHG determined that its acquisition of a majority ownership interest in SDS – a Medicare certified ASC located just off the campus of SHG’s Charlton Memorial Hospital in Fall River – will allow the Applicant to offer its patient panel access to a high-quality, cost-effective site of care for outpatient surgery that will advance Southcoast Health’s initiatives to coordinate and manage care for its patient population. SDS has an excellent reputation in the community for providing high-quality health care based on its longstanding commitment to utilizing industry-defined best practices for quality, efficiency and effectiveness, and to offering quality care by providing convenient access to specialized clinical personnel and state-of-the-art technology for eye surgery, gastroscopy and colonoscopy, general surgery, gynecology, orthopedics, pain management, urology, plastic surgery, and podiatry services. SDS’s reputation and commitment to quality and evidence-based practices aligns with the Applicant’s longstanding commitment to providing high-quality services utilizing best practices for its community. SDS and the Applicant have served a similar patient population in the same community for decades, and now seek to integrate in order to enhance care coordination and continue to provide community residents with this cost-effective site of surgical care. SDS patients will also benefit from access to Southcoast Health’s financial assistance and related charity care policies, as well as its commitment to serving all members of its community as a charitable institution.

In order to assess the effect of the Project on the Applicant’s patient panel, the Applicant and SDS evaluated the outpatient multi-specialty surgery service needs of Southcoast Health patients. As detailed throughout this narrative, historical data indicate an increasing volume of multi-specialty outpatient surgery services at SHG from FY21 to FY23. Moreover, the data show that SHG’s 65+ age cohort presently comprises approximately 45% of its surgery patient panel for FY21-FY23 and FY24 year to date, and preliminary data for CY24 and statewide population projections further suggest this number will increase substantially in the future as care moves from inpatient to lower cost outpatient sites. Given this projected increase in older patients, the Applicant anticipates a greater need to provide its patients with increased access to additional options for high-quality, convenient, community-based surgical services for the management of conditions that require surgery, including digestive health and orthopedic conditions, in the coming years. The Project will satisfy the identified need in multiple ways.

First, the Project will allow SHG to improve access to high-quality outpatient surgical services in an ASC setting for all of its patients, including those in the 65+ age cohort. Evidence suggests that ASCs offer high-quality care, even for the most vulnerable patients, through the provision of a smaller scope of procedures, by clinical staff who become highly proficient in providing these surgical services and procedures. In the case of the Project, post-transaction SDS will continue to offer multi-specialty surgical services that are clinically appropriate for an outpatient delivery setting. This continued commitment to high quality standards, along with the Applicant’s specialty clinical expertise, coordination of care practices, and resources for practice support will position SDS to continue operating as a high-quality ASC facility for patients and the community.

Second, the Project will benefit the Applicant's current patient population by providing such patients with the opportunity to receive care in a convenient ASC setting from experienced providers and staff with a longstanding reputation for quality. ASCs, such as SDS, are often preferred by patients for certain surgical procedures because they provide easier access, avoid a larger acute care facility setting and avoid the higher costs of hospital-based facilities. Through the Project, these benefits will be made available to the Applicant's patient panel who will have an increased opportunity to select SDS for their individual multi-specialty out-patient surgical needs. Moreover, the Project will benefit SDS's patient panel as well who may have been unable previously to fully access care at SDS due to financial constraints. SDS will become a site of care subject to Southcoast Health's financial assistance and charity care policies, and therefore patients will have access to financial assistance for certain medically necessary procedures.

Third, the Project will position SDS and Southcoast Health to formalize a relationship in the Medicare Shared Savings Program and will enable a collaborative partnership in the MassHealth (Medicaid) ACO program. Through these partnerships, SDS and Southcoast Health will be poised to provide highly coordinated care in a lower cost setting, in an accountable care environment. Accountable care performance often relies heavily on primary care; the introduction of surgical specialties as partners in the ACO will enable Southcoast Health to better control total cost of care. In turn, SDS will serve as a care setting for Southcoast Health ACO patients, which will allow, for example, high-risk patients receiving care at SDS to receive enhanced physician/hospital coordination, clinical integration and care navigation services, including through access to social work and care navigators, integrated records and systems, and the ability to have Southcoast physicians see patients in the office and operate at SDS. The care navigators would also follow the patients throughout the care continuum. In sum, these benefits demonstrate that the Project will provide Southcoast Health and community patients with access to high-quality, convenient, integrated ASC services that are ultimately expected to lead to improved patient outcomes, higher satisfaction levels, and overall better quality of life.

Finally, the Project will meaningfully contribute to Massachusetts' goals for cost containment by providing high-quality surgical services for clinically appropriate patients in a more cost-effective ASC setting. The services provided in ASCs are provided at lower rates than hospital outpatient departments ("HOPDs"). Accordingly, the Project will provide access to a lower-cost alternative for Southcoast Health patients, thereby contributing positively to the Commonwealth's goals of containing the rate of growth of total medical expenses ("TME") and total healthcare expenditures. The Project ultimately benefits all stakeholders, and therefore, it is appropriate for the Department to issue a Notice of Determination of Need.

Exhibit 2. Narrative

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.

Overview of SHS Patient Panel Determination

SHS is a not-for-profit, multi-institutional, integrated health care system that serves more than 719,000 residents across 33 communities throughout Southeastern Massachusetts and Rhode Island. SHS includes three community hospitals: Charlton Memorial Hospital, St. Luke's Hospital and Tobey Hospital. SHS also includes Southcoast Physicians Group, Inc., which has a network of more than 40 medical practices, and Southcoast Visiting Nurse Association, Inc., which provides home health care and hospice services. SHS has the region's only Level II trauma center at its St. Luke's Hospital campus, and is a major referral center for Southeastern Massachusetts, providing the highest level of emergency, acute and post-acute care for its patient panel. The chart included as Appendix A describes the demographics of SHS's overall patient panel and the demographics of patients living in SDS's service area for each of Fiscal Years 2021 through 2023 and those years combined. The data show an increasing number of outpatient surgical procedures for both SHS and SDS over time. The Applicant provides below the demographic and historical utilization data of SHS and SDS to establish the need for the Project.

SHS Patient Panel – Overall

Overall, SHS serves a large and diverse patient panel, caring for over 719,000 patients each year (the counts in FY21 and FY22 are most likely affected by the COVID-19 pandemic). The data on Appendix A represent the number of unique patients of SHS, rather than the number of visits. The SHS patient mix during FY21 through FY23 was approximately 56% female and 44% male for each of the three years. Age demographics show that approximately 62% of the patients were in the age range of 18-64. The patients aged 65 and older remained relatively consistent from 28% in FY21 to 25% in FY23. Approximately 12% of SHS's patients are aged 0-17. In terms of patient-reported race, in FY23, White patients make up 77%, Black or African American patients make up 5%, Asian patients make up 1%, American Indian or Alaska Native make up 1%, and 4% identify as Hispanic/Latino. Race and ethnicity are self-reported; 16% of SHS patients choose not to report, have races that are unknown and/or are in a category not reported here (e.g., "My race is not listed.").

As noted in SHS's 2022 Community Health Needs Assessment ("CHNA"), Fall River's student population is much more racially diverse than the city's population as a whole; 46.2% of students in Fall River public schools identify as White, compared to 73.4% of all residents of the city. This suggests that the community served by SDS will become more racially diverse in future years.

SHS provides care to patients primarily from the Commonwealth of Massachusetts (94%). The significant majority of patients (approximately 77%) cared for by SHS reside in SHS's primary service area in Southeastern Massachusetts. Approximately 37% of SHS's patients are from two (2) communities (New Bedford and Fall River). The following chart provides a further breakdown of the FY21-23 and FY24 YTD patients from each of the top fifteen (15) cities and towns in which SHS's patients reside. The preliminary data for FY24 show similar trends.

Table 1

Southcoast Health – FY21-FY24 YTD Patient Panel by Patient Origin **Top 15 Communities

***Table reflects Patient Origin attributed to all Active (Patient Status = Alive) unique patients' w/ an encounter within a Southcoast Health facility (i.e. – Hospital Based, Emergency Dept, Medical Practice, Urgent Care, Lab, Imaging, etc.) **Time Period: Oct 2020 – Mar 2024*

City/Town	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
New Bedford, MA	59,190	21%	65,461	20%	68,415	20%	61,251	20%
Fall River, MA	48,615	17%	54,847	17%	58,385	17%	52,819	17%
North Dartmouth, MA	11,095	4%	12,053	4%	12,476	4%	11,578	4%
Somerset, MA	10,535	4%	11,305	4%	11,736	3%	10,977	4%
Fairhaven, MA	10,316	4%	11,069	3%	11,433	3%	10,756	3%
Westport, MA	9,932	4%	10,696	3%	11,140	3%	10,529	3%
Swansea, MA	9,516	3%	10,382	3%	10,758	3%	10,179	3%
Tiverton, RI	7,259	3%	8,011	2%	8,378	2%	7,932	3%
Wareham, MA	7,152	3%	7,935	2%	8,295	2%	7,713	2%
South Dartmouth, MA	6,771	2%	7,338	2%	7,657	2%	7,065	2%
Portsmouth, RI	6,123	2%	7,060	2%	7,451	2%	7,237	2%
Acushnet, MA	6,473	2%	6,989	2%	7,188	2%	6,613	2%
Middleboro, MA	4,536	2%	5,937	2%	6,941	2%	5,862	2%
Middletown, RI	4,312	2%	5,191	2%	5,285	2%	5,153	2%
Lakeville, MA	3,699	1%	4,652	1%	5,114	1%	4,467	1%
Total	281,623	100%	321,998	100%	342,546	100%	310,931	100%

Table 2

Southcoast Health – FY21-FY24 Patient Panel by Service Area

***Table reflects Patient Panel by Service Area attributed to all Active (Patient Status = Alive) unique patients' w/ an encounter within a Southcoast Health facility (i.e. – Hospital Based, Emergency Dept, Medical Practice, Urgent Care, Lab, Imaging, etc.) **Time Period: Oct 2020 – Mar 2024*

Service Area	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Primary Service Area	226,331	80%	250,838	78%	262,513	77%	241,195	78%
All Other	55,292	20%	71,160	22%	80,033	23%	69,736	22%
Total	281,623	100%	321,998	100%	342,546	100%	310,931	100%

Southcoast Health – Primary Service Area

***Table reflects Demographics attributed to Zip Codes located in Southcoast Health's Primary Service Area (Source: Applied Geographic Solutions – 2022 Demographics)*

Zip	Population	Female Population	Male Population	% Population ≥ 65	Households	Median Household Inc
02347	12,407	6,230	6,177	18%	4,630	\$107,584
02538	4,112	2,099	2,013	18%	1,711	\$84,673
02558	1,970	1,018	952	26%	943	\$39,930
02571	11,117	5,704	5,413	23%	4,719	\$71,888
02576	4,362	2,276	2,086	25%	1,806	\$91,029
02702	4,408	2,165	2,243	14%	1,602	\$111,424
02717	4,912	2,389	2,523	18%	1,780	\$99,975
02719	16,384	8,413	7,971	24%	7,104	\$82,339
02720	32,435	16,836	15,599	19%	14,373	\$57,574
02721	28,569	14,732	13,837	16%	12,323	\$49,926
02723	15,442	8,046	7,396	17%	6,772	\$51,333
02724	17,997	9,458	8,539	18%	8,123	\$46,379
02725	2,491	1,326	1,165	29%	964	\$103,104
02726	15,838	8,138	7,700	25%	6,262	\$90,932
02738	5,327	2,793	2,534	26%	2,132	\$95,432
02739	6,587	3,348	3,239	27%	2,829	\$96,656
02740	45,793	23,935	21,858	18%	19,476	\$53,296
02743	10,225	5,177	5,048	20%	4,039	\$79,559
02744	12,733	6,442	6,291	16%	5,146	\$51,235
02745	25,914	13,358	12,556	18%	10,759	\$70,553
02746	16,887	8,490	8,397	14%	6,811	\$40,917
02747	22,403	11,006	11,397	17%	7,249	\$89,952
02748	11,557	5,975	5,582	28%	4,855	\$94,765
02770	5,654	2,779	2,875	17%	2,015	\$114,433
02777	16,594	8,375	8,219	21%	6,507	\$97,022
02790	16,775	8,458	8,317	24%	6,814	\$82,615
02791	230	114	116	37%	109	\$96,739
02837	3,551	1,775	1,776	32%	1,545	\$106,768
02842	17,400	8,748	8,652	23%	7,212	\$84,125
02871	17,604	8,813	8,791	24%	7,185	\$103,057
02878	16,169	8,226	7,943	28%	6,958	\$90,474
Total	423,847	216,642	207,205	20%	174,753	\$73,180

SHS Surgery Patient Panel

SHS has historically provided the types of surgical services that are provided at SDS, including general surgery, urology, digestive health, plastic/reconstructive, ophthalmology, gynecology, pain management, podiatric, cardiothoracic, otolaryngology (i.e., ENT), dental, and orthopedic procedures. The Project will result in SHS having ownership of SDS, and will allow SHS to offer its patients access to a convenient, low-cost alternative for outpatient surgery. Accordingly, in addition to reviewing the demographic and utilization data for all SHS patients, the Applicant also conducted a focused review of SHS's surgery patient panel's historical use rates and demographic profile to determine the need for the Project. The information for this focused panel is provided at Appendix A.

Historical volume for outpatient surgical services, including the foregoing specialties at SHS has increased over the past several years. In FY21, there were 38,646 outpatient surgical procedures and in FY23, this number rose to 40,944. The largest volumes of outpatient surgical are consistently orthopedics, general surgery, urology and pain procedures, the majority of which are well suited to an ambulatory surgery center environment like SDS. In addition, while SHS has seen growth in outpatient surgical cases, it has also seen more than a 20% increase (FY21 to FY23) in routine colonoscopy procedures which are also well suited for SDS.

The Applicant notes that SHS's multi-specialty surgery services continue to operate at a high volume that supports the Project. In addition, SDS's physician stockholders plan to retire over time and discontinue providing surgical services. As a result, the Project allows necessary out-patient surgical services to remain in the community. Moreover, as discussed in further detail in Factor F1.a.ii, demand for these services is expected to increase into the future due to various factors influencing demand. Most significant among these factors is age and increased co-morbidities for patients in the 18-64 and 65+ age cohorts.

With respect to age, the data indicate that the majority of SHS's surgery patients are between the ages of 18-64 (55% in FY23), followed by patients 65+ (44% in FY23) and patients between the ages of 0-17 (1% in FY23). Based on this data, as well as preliminary data for CY24 and the forecasted volume and growth in the ASC procedures in SHS's primary service area provided by the Advisory Board on Appendix D, it is expected that SHS will continue to see increases in the number of adults and older adults seeking outpatient surgery services into the future.

The Applicant also offers information regarding the other demographic characteristics of SHS's multi-specialty surgery patient panel. Data for SHS's multi-specialty surgery patient panel is largely consistent with the data for SHS's total patient panel in terms of gender and geographic origin. SHS's multi-specialty surgery patient mix consists of approximately 54% females and 46% males based on FY23 data. With respect to patient origin, the data indicate that the majority of SHS's multi-specialty surgery patients originate from the greater New Bedford and Fall River communities. Specifically, during the FY23 period, approximately 39% of SHS's surgery patients originated from the New Bedford/Fall River area:

Table 3

Southcoast Health – FY22-FY24 Surgical Procedural Volume by Patient Origin **Top 15 Communities

***Table reflects all procedural volume by Patient Origin occurring within Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024*

City/Town	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
New Bedford, MA	9,053	23%	8,963	23%	9,416	23%	4,772	23%
Fall River, MA	6,490	17%	6,291	16%	6,616	16%	3,313	16%
Fairhaven, MA	1,674	4%	1,915	5%	2,016	5%	1,034	5%
Wareham, MA	1,663	4%	1,734	4%	1,729	4%	845	4%
North Dartmouth, MA	1,582	4%	1,672	4%	1,807	4%	931	4%
Somerset, MA	1,591	4%	1,506	4%	1,625	4%	805	4%

Westport, MA	1,574	4%	1,451	4%	1,576	4%	835	4%
Swansea, MA	1,336	3%	1,301	3%	1,458	4%	728	4%
South Dartmouth, MA	1,027	3%	1,078	3%	1,126	3%	568	3%
Acushnet, MA	1,036	3%	1,041	3%	1,109	3%	520	3%
Tiverton, RI	1,016	3%	908	2%	996	2%	524	3%
Mattapoisett, MA	750	2%	830	2%	823	2%	463	2%
Marion, MA	599	2%	694	2%	693	2%	313	2%
West Wareham, MA	619	2%	636	2%	634	2%	321	2%
Rochester, MA	587	2%	636	2%	634	2%	310	1%
Total	38,646	100%	38,894	100%	40,944	100%	20,784	100%

SDS served approximately 6,138 patients in 2023. SDS's patients generally reside in the Massachusetts towns of Fall River, Somerset, Swansea, Westport, Dartmouth, New Bedford and in the Rhode Island towns of Portsmouth, Tiverton, and Little Compton. SDS does not track demographic data for its patients including age, race, ethnicity, gender and socioeconomic status. Although SDS does not track race and ethnicity data, based on the proximity of SDS to Charlton Memorial Hospital (less than 1 mile), SHS and SDS expect that the SDS patient panel is very similar to the Charlton Memorial Hospital patient panel in terms of race and ethnicity as depicted on Appendix A.

As reported on Appendix B, approximately 62% of the patients served by SDS in FY23 are female and approximately 38% are male. A greater number of patients cared for by SDS are aged 18-64 (approximately 73% of the patient panel) than SHS (55%). Approximately 26% are aged 65 and older and 1% are aged 0-17.

Payor Mix – Socioeconomic Status

SHS serves a very high percentage of patients insured by government payors. According to the chart included as Appendix A, during FY23, SHS served approximately 28% commercially insured patients, 20% Medicaid, 50% Medicare and 2% all other payor classes. Approximately 72% of SHS's overall patient panel is insured by government payors or receive charity care. According to the chart included as Appendix B, during 2023, SDS served approximately 74% commercially insured patients, 3% Medicaid, 19% Medicare and 6% all other payor classes. Approximately 22% of SDS's patient panel is reimbursed by government payors.

F1.a.ii.: Need by Patient Panel:

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

The proposed change in the ownership of SDS will enhance the ability of the Applicant to satisfy both existing and future needs for the management of multi-specialty surgery related conditions for patients in a clinically appropriate, cost-effective setting. The need for the Project is demonstrated by the volume of multi-specialty surgery services at SHS from CY21-23, and the anticipated growth in the number of patients with underlying multi-specialty surgery conditions within the 65+ age cohort seeking care at SHS who would benefit from care in an ASC setting. In addition to SHS's patient panel, the Project will also benefit SDS's patient panel through integration with SHS as a result of better coordinated care across the care continuum. Further, the integration of SDS into a non-profit charitable health system will expand access to surgical care for the most vulnerable populations in the community, which is intended to reduce inequalities and support public health initiatives of the Commonwealth and the Department.

The ASC Setting

The number of surgeries performed in ASC settings in the United States continues to increase each year.¹ This increase is attributable to several factors, including, but not limited to, medical and technological advancements that have made ambulatory surgery more feasible; advances in medical devices and pharmaceuticals that facilitate the migration of lower-acuity surgical procedures from inpatient to outpatient care and allow for faster recovery and same-day discharge; and changes in reimbursement rules to enable payments for surgical procedures performed at locations other than a hospital, such as ASCs.² Moreover, because ASCs like SDS focus on a subset of specialties and procedures, the clinicians in ASC settings are able to gain high proficiency and efficiency in performing such procedures.³ Clinical teams at ASCs are specially-trained and highly-skilled for specific types of surgery, have well-suited equipment and supplies at their disposal, and enjoy the opportunity of being able to conveniently schedule procedures in

¹ Ambulatory Surgery Center Association, *Ambulatory Surgery Centers: A Positive Trend in Health Care*, [hereinafter "ASCA Report"], <https://www.ascassociation.org/advancingsurgicalcare/aboutasc/industryoverview/apositivetrendinhealthcare> ("Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers."); Pooja Kumar and Ramya Parthasarathy, McKinsey & Company, *Walking out of the hospital: The continued rise of ambulatory care and how to take advantage of it*, Sept. 18, 2020, [hereinafter "McKinsey ASC Report"], <https://www.mckinsey.com/industries/healthcare/our-insights/walking-out-of-the-hospital-the-continued-rise-of-ambulatory-care-and-how-to-take-advantage-of-it> (projecting the ASC market to grow "at a compound annual growth rate of 6 percent between 2018 and 2023—reaching around \$36 billion by 2023."); Makanji HS, Bilolikar VK, Goyal DKC, Kurd MF. *Ambulatory surgery center payment models: current trends and future directions*, J Spine Surg. 2019 Sep;5(Suppl 2):S191-S194, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790812/> ("In 2017, more than 50% of all outpatient surgeries were conducted in ambulatory surgery centers (ASCs)—a market which is projected to reach \$40 billion in 2020. At the center of this massive growth are ASCs.").

² ASCA Report, *supra* note 1 ("While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all."); McKinsey ASC Report, *supra* note 1 (identifying innovation and technology, consumer demand, payer pressure, and provider opportunity as drivers of ASCs); *see also*, Medicare Payment Advisory Commission, *March 2024 Report to the Congress: Medicare Payment Policy* (March 15, 2024), Chapter 10: Ambulatory Surgical Center Services: Status Report, [hereinafter "MedPac ASC Report"], p. 297, https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch10_MedPAC_Report_To_Congress_SEC.pdf.

³ ASCA Report, *supra* note 1; Makanji HS, et al., *supra* note 1 ("ASCs exclusively provide outpatient surgeries (same-day or 23-h stay) which typically focus on a small subset of routine procedures and treatments. This approach allows ASCs to reduce the overall perioperative costs of surgery—largely those associated with post-operative care—while still being able to produce equivalent outcomes and maintain a high rate of patient satisfaction[.]").

a timely fashion.⁴ In turn, this leads to clinical and operational efficiencies that are not readily attainable in a hospital setting where personnel and operating rooms must be able to accommodate a wide range of medically complex, high-acuity, and emergency procedures.⁵

Moreover, clinical outcomes in the ASC setting are comparable to those of hospital outpatient surgery departments.⁶ A recent study confirms the clinical benefits of ASCs based on the finding that “patients treated in an ASC are less likely to be admitted to a hospital or visit an emergency room a short time after outpatient surgery.”⁷ Studies indicate that surgical procedures performed in outpatient settings such as ASCs are associated with reduced infection rates and other complications, low hospital admission rates, and that patients also experience shorter surgery and recovery times.⁸ Together, these factors contribute to increased patient convenience and satisfaction, which drive demand for the election of services in the ASC setting.⁹

⁴ ASCA Report, *supra* note 1 (“In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients.”).

⁵ ASCA Report, *supra* note 1 (explaining that ASCs “Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management”); McKinsey ASC Report, *supra* note 1 (“Often more conveniently located than hospitals, ASCs allow patients to be discharged within 23 hours of care, reducing their risk of infection and allowing recovery to take place in the comfort of their own homes. The ASC is often more intimate than the hospital, giving patients a greater sense of personalized care and contact with their care team. Perhaps most persuasively, costs to both patients and payers can be significantly less at ASCs, as their entire operating chassis is often configured at a lower cost base across staffing, space, and some types of supplies”).

⁶ See Massachusetts Health Policy Commission, *HPC Datapoints: Trends in Ambulatory Surgical Centers in Massachusetts*, Issue 26: Feb. 2024, [hereinafter, “HPC Datapoints”], <https://www.mass.gov/info-details/hpc-datapoints-issue-26> (“Available evidence suggests that safety and quality metrics at ASCs are comparable to and in some cases better than those in HOPDs, including the rates of adverse events, although many studies caveat the need to appropriately select patients for surgery at ASCs based on the complexity of the case”); *see also*, American Academy of Orthopedic Surgeons, *Ambulatory Surgical Centers Position Statement*, [hereinafter “AAOS Position Statement”], <https://www.aaos.org/globalassets/about/position-statements/1161-ambulatory-surgical-centers.pdf> (providing support for the role of ASCs and stating with respect to patient safety that: “It has been reported that ASCs treat lower acuity patients when compared to HOPD’s. In the absence of standardized and widely reported quality measures with respect to patient safety, this is probably prudent. Preliminary patient safety data shows problem occurrence rates less than 0.1 percent on all four indicators. One study has demonstrated even high-risk Medicare patients are no more likely for re-admission after treatment in an ASC compared to a hospital”).

⁷ Munnich EL, Parente ST, *Returns to specialization: Evidence from the outpatient surgery market*, J. of Health Econ., v. 57, 2018, p. 147-167, <https://www.sciencedirect.com/science/article/abs/pii/S0167629617310743> (explaining that these effects were valid even after accounting for differences in patient health and case mix).

⁸ Levitt L, *The Benefits of Outpatient Surgical Centers*. The Centers for Advanced Orthopedics (Jun. 15, 2017), <https://www.cfaortho.com/media/news/2017/06/the-benefits-of-outpatient-surgical-centers> (“Surgeries are often shorter, recovery is faster and the infection rate is half that of hospitals when surgeries are performed in an ASC setting.”); Crawford DC, et al., *Clinical and Cost Implications of Inpatient Versus Outpatient Orthopedic Surgeries: A Systematic Review of the Published Literature*, 7 ORTHOPEDIC REVIEW 116 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4703913/pdf/or-2015-4-6177.pdf> (“All of the reviewed studies reported that outpatient surgeries had similar or improved level of pain and rates of nausea. This review found that outpatient procedures in North America appear to be less expensive and safe alternatives to inpatient care for patients who are at lower risk for complications and procedures that do not necessarily require close hospital level care monitoring following same day surgery.”); Cook D, et al., *From ‘Solution Shop’ Model to ‘Focused Factor’ In Hospital Surgery: Increasing Care Value and Predictability*, 33 HEALTH AFFAIRS 746 (2014), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1266> (advancing the idea of a “focused factory” model of healthcare, which is “characterized by a uniform approach to delivering a limited set of high-quality products”) to “increase[] care value and the predictability of care process, outcomes, and costs while preserving []the strengths of the solution shop”).

⁹ ASCA Report, *supra* note 1 (“patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs. Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs”); Hall MJ, Schwartzman A, Zhang J, et al. Ambulatory surgery data from hospitals and

Further, the capacity constraints experienced by hospitals during the COVID-19 and potential reluctance by patients to return to hospital and emergency settings, has reportedly “heightened the important role that ambulatory care can and does play in the healthcare landscape by providing an alternative site for necessary procedures.”¹⁰

Given the benefits of providing care in the ASC setting, SHS reviewed the demand for certain lower-acuity and less-invasive procedures at SHG’s hospital campuses over the last three (3) years. Specifically, SHS staff reviewed its historical volume for those outpatient surgical procedures that are available at SDS; namely, orthopedics, general surgery, plastic/reconstructive, ophthalmology, gynecology, pain management and otolaryngology surgeries. As outlined in Factor F1.a.i above, it is estimated that more than 33,000 patients (9,000 in FY21, in 11,400 FY22, and 12,600 in FY23) may have been eligible to have their surgical procedure at an outpatient facility, such as SDS. Based on this historical demand, as well as the projections on Appendix D that suggest demand for these services is expected to increase in the future, SHS sought to develop an alternative for patients to provide them with convenient access to surgical services outside of, but still nearby, the main hospital campuses. Through this process, SHS determined that the acquisition of SDS, located blocks away from SHG’s Charlton Memorial Hospital campus in Fall River, would allow patients to receive high-quality ambulatory surgery services in a cost-effective, operationally efficient, community-based and convenient setting.

Aging Population and Growing Demand

Growth in Aging Population

The Project will also allow the Applicant to address the needs of an aging patient panel and the need for access to ambulatory surgical services. According to the UMDI *Long-Term Population Projections for Massachusetts Regions and Municipalities*, the overall Massachusetts population is projected to grow 11.8% from 2010 to 2035.¹¹ Review of these findings demonstrates that population growth is distributed unevenly by age and that there is a trend in the state toward an aging population. Specifically, the UMDI data demonstrates that from 2010 to 2035, much of the Commonwealth’s population growth will be individuals ages 40 years and older.¹² Additionally, this data indicates that from 2015 to 2035, the state’s 65+ population is projected to increase at

ambulatory surgery centers: United States, 2010. Nat Health Stat Rep 2017;102:1-14, <https://pubmed.ncbi.nlm.nih.gov/28256998/> (“This report presents national estimates of surgical and nonsurgical ambulatory procedures performed in hospitals and ambulatory surgery centers (ASCs) in the United States during 2010. . . Only 2% of visits with a discharge status were admitted to the hospital as an inpatient.”).

¹⁰ McKinsey ASC Report, *supra* note 1.

¹¹ UMass Donahue Institute, *Long-Term Population Projections for Massachusetts Regions and Municipalities, Section II. State Level Summary*, [hereinafter “UMDI Report”], (March 2015), p. 11, https://pep.donahue-institute.org/downloads/2015/new/UMDI_LongTermPopulationProjectionsReport_SECTION_2.pdf.

¹² *Id.* at 14, Fig. 2.5 (demonstrating the growing proportion of population in the 40-64 and 65+ age groups between 2010 and 2035); *see also, id.* at p. 13 (“In Massachusetts the effect of this aging is even more pronounced as the state is already older than the United States on average, with a share of its population in the older age-groups and a smaller share in the younger.”).

a higher rate compared to all other age groups (from 15.8% in 2015 to 23% in 2035).¹³ Therefore, by 2035, the 65+ age cohort will represent nearly a quarter of the state's population.¹⁴

The general trend towards an aging population appears consistent in Southeastern Massachusetts, where SHS and SDS are located. Specifically, the UMDI findings suggest a 6.9% increase in population growth from 2010 to 2035 in the Southeast region of Massachusetts.¹⁵ More recent estimates from UMDI which are specific to Bristol County, the county in which SHS and SDS are located, appear to validate the reported UMDI projections in the UMDI *Long-Term Population Projections for Massachusetts Regions and Municipalities*. These more recent estimates indicate that: as of July 2022, 51.5% of the total Bristol County population was 40 years or older; 33.5% of the population of Bristol County was ages 40-64 in July 2022 (down from 33.8% in July 2021 and 34.1% in July 2020) and 18% of the population of Bristol County was 65 years or older (up from 17.5% in July 2021 and 17.2% in July 2020).¹⁶ These recent trends demonstrate the growth of the 65+ age cohort and contraction of the 40-64 age cohort in Bristol County with relative consistency as compared to the UMDI projections for these age cohorts specifically for the period of 2020-2025 (i.e., for ages 40-64: 33.9% - 32.7% from 2020-2025, and for ages 65+: 18% - 20.2% from 2020-2025).¹⁷

Growth in Aging Population's Demand for Surgical Procedures

The growth in the 65+ population cohort, as referenced in the prior section, results in increased demand for surgical services, such as gastroenterology surgery procedures.¹⁸ Over the last 20 years, the rate of surgical procedures in the older population has been rising.¹⁹ Specifically, the 65+ age cohort has experienced the greatest increase in the number of surgical procedures since 1990.²⁰ This increase is likely related to improved life expectancy rates, patient expectations and improved outcomes after surgery, the need to treat age-related comorbidities, and changes in

¹³ *Id.* at p. 14 (“By 2035, the 65-and-over population will represent 23% of the state’s population.”).

¹⁴ *Id.*

¹⁵ *Id.* at p. 15-16, Fig. 2.7.

¹⁶ UMass Donahue Institute, Massachusetts Population Estimates Program, *Massachusetts Population Estimates by County* [hereinafter “UMDI County Population Estimates”], <https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-estimates-by-massachusetts-geography/by-county> (applying the interactive filters of the Massachusetts County Population by Characteristics to identify the population distribution for Bristol County, by Year and Age Groups).

¹⁷ *Compare*, UMDI Report, *supra* note 11, at p. 14, Fig. 2.5, and UMDI County Population Estimates, *supra* note 16.

¹⁸ See Becher RD, Vander Wyk B, Leo-Summers L, Desai MM, Gill TM, *The Incidence and Cumulative Risk of Major Surgery in Older Persons in the United States*, *Ann Surg.* 2023 Jan 1;277(1):87-92, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8758792/> (“While the expanding geriatric population will affect all areas of medicine, one field that will be especially impacted is surgery.”); Gill TM, Vander Wyk B, Leo-Summers L, Murphy TE, Becher RD, *Population-Based Estimates of 1-Year Mortality After Major Surgery Among Community-Living Older US Adults*, *JAMA Surg.* 2022;157(12):e225155, <https://jamanetwork.com/journals/jamasurgery/fullarticle/2797666#:~:text=Question%20What%20are%20the%20population,%20Dyear%20mortality%20was%2013.4%25>.

¹⁹ Partridge JSL, et al., *Frailty in the older surgical patient: a review*, 41 *AGE AND AGEING* 142 (2012), available at <https://academic.oup.com/ageing/article/41/2/142/47699>; Yang R, et al., *Unique Aspects of the Elderly Surgical Population: An Anesthesiologist's Perspective*, 2 *GERIATRIC ORTHOPAEDIC SURGERY & REHABILITATION* 56 (2011), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3597305/>.²⁰ Partridge JSL, et al., *supra* note 19; Yang R, et al., *supra* note 19.

²⁰ Partridge JSL, et al., *supra* note 19; Yang R, et al., *supra* note 19.

anesthetic and surgical techniques.²¹ Consequently, estimates suggest that roughly 53% of all surgical procedures are performed on patients 65+, with nearly 40% being performed on patients 65+ in hospital settings.²² Indeed, recent studies conclude that major surgery is a “common event” for individuals 65+ residing in the community such that, on average, there are 8.8 major surgeries performed per year for every 100 individuals aged 65+ living in the community.²³ Moreover, as further medical advancements are made, it is projected that nearly half of the 65+ population will require surgery once in their lives.²⁴

With respect to digestive health conditions, evidence suggests that the prevalence of these conditions increases with age.²⁵ Reports indicate that aging is a factor in digestive health disorders, and specifically, that “older adults are more likely to develop diverticulosis and to have digestive tract disorders . . . as a side effect of taking certain drugs.”²⁶ Consequently, the need for endoscopic procedures to diagnose and treat these conditions is increasing with the aging population as well.²⁷ Demand for digestive health services is growing, especially for the 65+ age cohort. As described in Factor F1.a.i, this trend is similar across SHS’s older adult digestive health patient panel.

Further, in its recent *HPC Datapoints*, the Health Policy Commission reports that, in 2021, gastrointestinal services (mainly endoscopies and colonoscopies) performed at ASCs in the state represented 64% of all ASC encounters by volume and 50% of payments in the commercially-insured population; for MassHealth and other public payors, gastrointestinal services are also one of the top ASC service lines.²⁸ Given the UMDI population growth projections for Massachusetts, this demand for gastrointestinal services is likely to grow with the continued aging of the population. Southcoast gastroenterology service currently already operates at SDS with lower use of anesthetic services and increased use of moderate/conscious sedation compared to hospital settings. This value-based approach is part of a multi-site approach for screening for and early diagnosis of colorectal cancers. In a presentation to Southcoast’s leadership, Board of Trustees, and the CRICO/Ambulatory Safety Net on February 12, 2024, Dr. Dani Hackner, Chief Clinical Officer of Southcoast Health, presented about how a successful, multisite program can reduce waits and delays and produce high efficiency screening for colorectal cancers. Full oversight of SDS will further the use of lower cost, ambulatory settings for gastrointestinal services for population health.

²¹ Partridge JSL, et al., *supra* note 17; Yang R, et al., *supra* note 19.

²² Partridge JSL, et al., *supra* note 19; Yang R, et al., *supra* note 19; Graham J, KFF Health News, *Should Older Seniors Risk Major Surgery? New Research Offers Guidance*, November 28, 2022 (citing Berian JR, Rosenthal RA, Baker TL, Coleman J, Finlayson E, Katlic MR, Lagoo-Deenadayalan SA, Tang VL, Robinson TN, Ko CY, Russell MM. *Hospital Standards to Promote Optimal Surgical Care of the Older Adult: A Report From the Coalition for Quality in Geriatric Surgery*, *Ann Surg.* 2018 Feb;267(2):280-290, <https://pubmed.ncbi.nlm.nih.gov/28277408/>).

²³ Becher RD, et al. *supra* note 18; Gill TM, et al., *supra* note 18.

²⁴ Partridge JSL, et al., *supra* note 19; Yang R, et al., *supra* note 19.

²⁵ Travis A, et al., *Endoscopy in the Elderly*, 107 AM. J. GASTROENTEROLOGY 1495 (2012).

²⁶ Bartel M, Merck Manual, Consumer Version, *Effects of Aging on the Digestive System* (last modified May 2023), <https://www.merckmanuals.com/home/digestive-disorders/biology-of-the-digestive-system/effects-of-aging-on-the-digestive-system>.

²⁷ See generally, Healthcare Purchasing News, *The Growing Demand for Endoscopy*, Oct. 26, 2022, <https://www.hpnonline.com/surgical-critical-care/article/21284716/the-growing-demand-for-endoscopy>.

²⁸ HPC Datapoints, *supra* note 6.

Similarly, age is a leading factor in the prevalence of certain ENT conditions.²⁹ The effects of aging on the ear, nose and throat are the result of various factors including, but not limited to, overuse of the voice, repeated exposure to loud noise, the cumulative effect of infections, and the effects of the use of drugs, alcohol, and tobacco.³⁰ Accordingly, adult and older adult patients account for a disproportionately large and increasing number of outpatient ENT visits.³¹ According to data from 2010, of an estimated 20 million visits to non-federally employed ENT physicians and surgeons, adults ages 45-64 accounted for 32% of visits and older adults ages 65+ accounted for 21% of visits.³² As the statewide and SHS-specific aging population continues to grow, it is expected that the number of individuals with risk factors for ENT related conditions will continue to grow, thereby leading to increases in demand for ENT procedures among older adults.

Finally, the Applicant notes that orthopedic conditions, including those involving the hand increase with age.³³ Specifically, studies suggest that older age is correlated with bone fragility, loss of cartilage resilience, reduced ligament elasticity, loss of muscular strength, and fat redistribution that decreases the ability of the tissues to carry out their normal functions, all of which leads to age-related orthopedic issues such as arthritis, degenerative disc disorders, fractures and fall-related injuries.³⁴ Consequently, the growing geriatric population with orthopedic conditions is associated with an increase in the number of elderly patients presenting for orthopedic surgeries, including those involving the hand.³⁵ Southcoast has programmatic strength that will support the increasing demand for ambulatory orthopedic surgeries. First, Southcoast has an Advanced Total Hip and Knee Program, certified by The Joint Commission ("Joint Commission"). The program uses risk stratification, patient navigation, and evidence-based guidelines that enable safe use of ambulatory settings as well as triage to hospital settings for appropriate inpatients. Extending the program to SDS will enhance safe, value-based care. Secondly, Southcoast has been developing a Center of Excellence for Osteoporosis to identify and prevent fractures, optimally treat post-operative osteoporosis patients and refer appropriate cases for timely surgery at the right level of care. Lastly, Southcoast has an effective Physician Advising program that includes subspecialty review for appropriateness of level of care. All of these active areas

²⁹ Kaylie DM, Merck Manual, Consumer Version, *Effects of Aging on the Ears, Nose, and Throat*, (last modified Sept. 2022), <https://www.merckmanuals.com/home/ear,-nose,-and-throat-disorders/biology-of-the-ears-nose-and-throat/effects-of-aging-on-the-ears-nose-and-throat>; Kost KM, *Geriatric Otolaryngology: Why It Matters*, 34 CLINICAL GERIATRIC MED IX (2018), available at [https://www.geriatric.theclinics.com/article/S0749-0690\(18\)30012-0/fulltext](https://www.geriatric.theclinics.com/article/S0749-0690(18)30012-0/fulltext); Creighton Jr. FX et al., *The growing geriatric otolaryngology patient population: A study of 131,700 new patient encounters*, 123 LARYNGOSCOPE 97 (2012).

³⁰ Kaylie, *supra* note 29.

³¹ Kost, *supra* note 29; CDC, National Ambulatory Medical Care Survey, *Factsheet – Otolaryngology*, https://www.cdc.gov/nchs/data/ahcd/NAMCS_2010_factsheet_otolaryngology.pdf.

³² *Factsheet – Otolaryngology*, *supra* note 31.

³³ Gheno R, et al., *Musculoskeletal Disorders in the Elderly*, 2 J. CLINICAL IMAGING SCI. 1 (2012), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424705/>.

³⁴ *Id.*; Freemont AJ, Hoyland JA, *Morphology, mechanisms and pathology of musculoskeletal ageing*, 211 J. PATHOLOGY 252 (2007); see also, Merck Manual, Consumer Version, *Effects of Aging on the Musculoskeletal System* (modified Sept. 2022), <https://www.merckmanuals.com/home/bone,-joint,-and-muscle-disorders/biology-of-the-musculoskeletal-system/effects-of-aging-on-the-musculoskeletal-system>.

³⁵ Gheno R, et al., *supra* note 33; Bajwa SJS, *Clinical conundrums and challenges during geriatric orthopedic emergency surgeries*, 5 INT'L J. CRITICAL ILLNESS & INJURY SCI. 38 (2015), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4366827/>.

will bring safety and effectiveness to the growing ambulatory orthopedic procedures as SDS becomes an important value-based site of care. As the discussion in Factor F1.a.i indicates, this trend is similar across SHS's older adult hand surgery patient panel.

Meeting Growing Demand for Surgical Procedures in ASC Setting

The projected increase in the older adult population in conjunction with the volume of older adults seeking lower-acuity multi-specialty surgical services requires additional options for SHS patients to obtain outpatient surgical care. Acknowledging these increases and understanding the benefits of providing care in an ASC setting (particularly for the 65+ population cohort who often finds it difficult to navigate the complex infrastructure of a hospital and finds ASC experiences less complicated and easier to access³⁶), SHS seeks to expand access to non- and less-invasive surgical capacity in the community through the Project. The acquisition will allow SHS to improve access to outpatient surgical services in an ASC setting for all of its patients, including those in the 65+ age cohort. This will allow for high-quality surgical services to be provided in a more convenient and cost-effective community setting for appropriate patients and will also allow for improved patient outcomes, higher patient and provider satisfaction.

Improving Access to Outpatient Surgical Services via Expanded Site of Care and Reduced Wait Times

The Project will have immediate, concrete benefits for Southcoast patients in the form of a new site of care for outpatient surgical services, with reduced wait times for patients needing outpatient surgery.

First, as noted above SHS currently offers outpatient surgical services on its three hospital campuses, and at the Southcoast Surgery Center in Dartmouth, Massachusetts. The addition of SDS as an outpatient surgical facility of SHS will provide patients with a convenient and accessible location for surgery, close to SHG's Charlton Memorial Hospital campus, in the same community where many of SHS's patients live and work.

Second, SHS has studied current wait times for elective outpatient surgery at its facilities. The SHS 2022 CHNA revealed that 55% of respondents cited long wait times for appointments as their top concern. The current scheduling wait time for elective outpatient surgery is approximately 1-3 months, depending on the specialty, and is directly impacted by resource constraints such as Operating Room availability, perioperative support staff and anesthesia resources. If the Project is approved, SHS anticipates that the wait time will be greatly improved as SDS will provide additional resources where outpatient cases can be scheduled, allowing patients more immediate access to essential surgical treatment. The reduced wait times can improve patient outcomes,

³⁶ See generally, ASCA Report and McKinsey ASC Report, *supra* note 1.

improve patient satisfaction with services, and allow providers to deliver surgical services more efficiently and also maintain ambulatory care practices.

Ensuring Continued Community Access to Outpatient Surgical Services at SDS

The Project is also being proposed by SHS in order to ensure continued access for SHS's patients, and current SDS patients, to high-quality outpatient surgical services in the community. SDS was founded in 1984 by community physicians, many of whom are on the SHG Medical Staff and have long collaborated with SHS in the delivery of patient care services. SDS was solely owned by physicians until 2022 when SHS acquired a minority interest through SHSH. SDS physician-owners have successfully operated SDS as an extension of their practice for three decades, and a number of those physician-owners sought to sell their interests as part of the winding down of their practices. SHS therefore offered to purchase SDS in two stages (with an initial minority investment followed by the acquisition of all interests in SDS upon regulatory approval) and to maintain its current leadership in order to maintain continuity of care and access for community patients.

Management of ACO Patients

The Applicant, through its direct subsidiaries Southcoast Health Network, LLC ("SHN") and Southcoast Accountable Care Organization, LLC ("SACO"), is a Health Policy Commission ("HPC") certified ACO that provides population health support and resources to its members, including via participation by SHN in the MassHealth Medicaid ACO program with WellSense Health Plan f/k/a BMC HealthNet, and participation by SACO in the Medicare Shared Savings Program.³⁷ As an HPC-certified ACO, the Applicant has prioritized programs and initiatives to support patient-centered care and governance, drive quality improvement, advance health equity, and invest in population health. An example of these programs is SHN's integrated care navigation program which supports the ACOs' most complex, highest need populations via a portfolio of services, including complex medical, behavioral, social and pregnancy care management, bridge counseling, and pharmacy navigation. Through the activities of SHN and its affiliates, SHS works to provide and promote value-based cost-effective care across the continuum.

The Project aligns with the state's goals to accelerate care delivery transformation in Massachusetts and promote a high-quality, efficient health system.³⁸ Specifically, SHS's acquisition of ownership in SDS brings the ASC within Southcoast Health. This allows SDS to serve as a setting for SHS to manage ACO patients and provides such patients with the benefits of physician/hospital cooperation, further clinical integration and medical management services.

Integration and Coordination for SDS's Patient Panel

In addition to benefitting the SHS patient panel, the Project will also benefit the existing SDS patient panel. Specifically, because SHS will have ownership of the ASC, SDS's patients will benefit

³⁷ Massachusetts Health Policy Commission, *The HPC Accountable Care Organization (ACO) Certification Program* <https://www.mass.gov/service-details/the-hpc-accountable-care-organization-aco-certification-program> (identifying SHS, inclusive of its SACO and SHN entities, as a HPC-certified ACO)..

³⁸ *Id.*

from integration of SDS's specialty surgical services with the larger Southcoast Health provider network. Such integration will improve patient access to Southcoast Health's primary care, specialty care, and post-acute care programs and services, and will allow for greater coordination and integration of services, information, and care management systems, all of which is instrumental in achieving better outcomes and improved quality of life. SHS will also bring experience and success in weathering a tumultuous operating environment, as well as economies of scale and diversification of risk with a larger portfolio of operations.

F1.a.iii.: Competition:

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

The Project is not anticipated to have an adverse impact on the competition in the Massachusetts health care market based on price, total medical expense, provider costs or other recognized measures of health care spending as evidenced by the chart included as Appendix C. The chart reports SHS's total medical expense (TME), the TME trend and the commercial relative prices compared to the other similarly sized health care systems in Massachusetts. Southcoast Health is also well below the median relative price in its cohort of community high public payer hospitals. As set forth in Appendix C, the median relative price in Southcoast Health's cohort is .92 and Southcoast Health's relative price is .83.

The Project seeks to promote utilization of the ASC setting for appropriate patients as a high-quality, lower-cost alternative to outpatient surgery performed in a hospital outpatient department (HOPD). On an annual basis, ASCs perform more than 7 million procedures for Medicare beneficiaries requiring same-day procedures.³⁹ As discussed in Factor F1.a.ii, by specializing in specific procedures, ASCs, like SDS, are able to maximize efficiency and quality outcomes for patients.⁴⁰ These efficiencies lead to cost savings.⁴¹

According to the *March 2024 Report to the Congress: Medicare Payment Policy* section concerning ASCs, because Medicare reimbursement rates for ASCs are lower than HOPDs, "the cost to Medicare (and the taxpayers who fund the program) is lower if a surgical procedure is provided in an ASC rather than an HOPD."⁴² This trend is consistent in Massachusetts, as reported

³⁹ Ambulatory Surgery Center Association, *The ASC Cost Differential*, <https://www.ascassociation.org/advancingsurgicalcare/reducinghealthcarecosts/paymentdisparitiesbetweenascsandhopds#:~:text=Today%2C%20procedures%20performed%20in%20the,for%20performing%20the%20same%20surgery> (last updated Aug. 2016).

⁴⁰ *Id.*

⁴¹ See Makanji HS, et al., *supra* note 2 ("ASCs . . . typically focus on a small subset of routine procedures and treatments. This approach allows ASCs to reduce the overall perioperative costs of surgery . . . since the adoption of the Affordable Care Act (ACA), reimbursements to ASCs have become approximately 42% less when compared to hospitals for the same procedure").

⁴² See MedPac ASC Report, *supra* note 2 at p. 298; Ambulatory Surgery Center Association, *Reducing Medicare Costs* (October 2020), [hereinafter "ASCA Medicare Costs Report"], https://www.ascassociation.org/asca/about-ascs/savings/medicare-cost-savings/reducing-medicare-costs?_gl=1*1uyzq16*_ga*MTYxMjE1MzMyMy4xNzExNTQ5NTgw*_ga_5DE4L5HXFY*MTcxMTYzNTM1Ny41LjEuMTcxMTYzNTU

in the Health Policy Commission's most recent issue of the *HPC DataPoints*, which focuses on ASC trends.⁴³ The HPC concludes in this report that ASC prices are generally "far lower" than in HOPDs across commercial insurers, MassHealth, and Medicare, and in 2021, ranged from 27% to 57% lower in ASCs than HOPDs in the commercial population for common surgeries.⁴⁴ The HPC attributes these lower prices primarily to lower facility payments in ASCs.

Studies estimate that the provision of surgical procedures in an ASC setting rather than a HOPD resulted in annual savings to the Medicare program and its beneficiaries which increased steadily from \$3.1 billion in 2011 – to \$4.2 billion in 2018.⁴⁵ Earlier studies estimated that the Medicare program could save an additional \$2.5 billion annually if half of the eligible surgical procedures were shifted from HOPDs to ASCs, and that savings to commercial payers could be even higher (estimated at as much as \$55 billion in savings annually).⁴⁶ A more recent study from 2020 projects Medicare savings from 2019 to 2028 as totaling \$73.4 billion, with projected increases from \$4.3 billion in 2019 to \$12.2 billion in 2028.⁴⁷

As reimbursement programs increasingly seek to pay providers for value over volume and to reduce reimbursement differentials based on site of service,⁴⁸ it is appropriate for the Applicant to pursue more opportunities for its patient panel to access ambulatory services in a high-quality established site, in its community. SHS's acquisition of the ASC is further supported by the recent *HPC Datapoints* report which states that despite ASCs being lower priced, having lower cost-sharing, and being more convenient than HOPDs, ASCs seem to be underutilized within the state due to historical regulatory barriers and likely due to other factors such as referral patterns, location accessibility given the reported relative sparsity of ASCs in Massachusetts relative to other states, and general lack of patient awareness.⁴⁹ The Project increases utilization of a high-quality, lower cost setting, with important implications for health care spending as well as access to care for an aging population. For these reasons, the Project advances policy and cost-containment goals as well as clinical goals based on increased coordination and management of care.

[2NS40MC4wLjA](#) ("ASCs continue to offer substantial savings to the Medicare program."); *see also*, *The ASC Cost Differential*, *supra* note 39.

⁴³ HPC Datapoints, *supra* note 6.

⁴⁴ *Id.*

⁴⁵ ASCA Medicare Costs Report, *supra* note 42, section on Past Savings (Appendix B – Table 1) ("During the eight-year period from 2011 to 2018, the total FFS Medicare savings generated by ASCs was \$28.7 billion. The savings per year increased from \$3.1 billion in 2011 to \$4.2 billion in 2018."); *see also*, ASCA Report, *supra* note 1 (noting average annual increases of \$2.6 billion per year prior to 2011); *The ASC Cost Differential*, *supra* note 39.

⁴⁶ ASCA Report, *supra* note 1; Ambulatory Surgery Center Association, et al, *Commercial Insurance Cost Savings in Ambulatory Surgery Centers*, available <https://www.ascassociation.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=829b1dd6-0b5d-9686-e57c-3e2ed4ab42ca&forceDialog=0>.

⁴⁷ ASCA Medicare Costs Report, *supra* note 42, section on Future Savings (Appendix B – Table 2).

⁴⁸ *See* MedPac ASC Report, *supra* note 2 (advising CMS to require ASCs to report quality and cost data to support value-based care and evaluation of reimbursement rates); *see also*, DHHS, OIG, *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates* (April 2014), <https://oig.hhs.gov/oas/reports/region5/51200020.pdf>.

⁴⁹ HPC Datapoints, *supra* note 6.

Other studies address cost savings at ASC settings that are attributable to procedure length.⁵⁰ Specifically, researchers conducting these studies have found that, due to operating efficiencies, ASCs are substantially faster than hospitals at performing outpatient procedures and that these shorter procedure times lead to cost reductions.⁵¹ According to the data, procedures performed in ASCs take, on average, “31.8 fewer minutes than those performed in hospitals – a 25% difference relative to the mean procedure time.”⁵² Consequently, an ASC will be able to perform more procedures per day than a HOPD with the same number of staff and of operating and recovery rooms.⁵³ Researchers estimate the associated cost savings at \$363 – \$1,000 per outpatient case.⁵⁴ These results further demonstrate that ASCs are a lower cost alternative to hospitals.

Overall, the Applicant’s Project aims to lower the cost of multi-specialty surgery services for SHS’s patient panel and community. Through its acquisition of SDS, SHS seeks to provide its patients with another option for ambulatory surgery, in addition to its existing sites, and to encourage patients to consider the cost-effective ASC setting at SDS for appropriate surgical procedures instead of utilizing hospital surgical facilities that can be more appropriately deployed for higher-level surgical services and more acute patients. SDS will become integrated within Southcoast Health as an essential site for surgical care, while retaining its staff and location to maintain consistency and enhancing its service offerings and policies through Southcoast Health. The overall effect of the Project will have a positive impact on the Massachusetts healthcare market through the creation of operating efficiencies that lead to cost reductions in overall care and ultimately total medical expense (TME).

Additionally, the management of patient care along the continuum of inpatient, acute care to post-acute and ambulatory care will be enhanced by keeping the patients in the integrated SHS network of providers and facilities. When care that can be provided locally instead goes outside of SHS, to Boston or even Western Massachusetts, the care risks becoming fragmented, communication becomes more difficult and slowed, and utilization is often increased unnecessarily. Such disruptions in care can also disproportionately affect the most vulnerable members of the community, who may be forced to choose between forgoing needed care or overcoming significant barriers to access care. The acquisition of SDS by SHS will allow for better communication and more coordinated care, closer to home and within the community. This is better for the patients and better for the financial success of value-based programs by reducing unnecessary emergency department usage, inpatient surgeries, readmissions, and the overall cost of care.

⁵⁰ Munnich EL, Parente ST, *Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up*, *Health Aff (Millwood)* 2014;33:764-9. 10.1377/hlthaff.2013.1281.

⁵¹ *Id.* (explaining that “[i]t is the nature of outpatient procedures that the patient spends most of his or her time in a surgical facility preparing for and recovering from surgery, not actually undergoing the surgery. This suggests that organization, staffing, and specialization may play a large role in the cost differences between ASCs and hospital outpatient departments. Our estimates of the time savings for ASC treatment suggest that ASCs are substantially faster than hospitals at performing outpatient procedures, after procedure type and observed patient characteristics are controlled for.”).

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

**F1.b.i.: Public Health Value /Evidence-Based:
Provide information on the evidence-base for the Proposed Project. That is,
how does the Proposed Project address the Need that Applicant has identified.**

The Project will expand access to high quality ambulatory surgery in a convenient, well-coordinated, cost-effective setting. To address this need, SHS will focus not only on providing access, but also on the challenge of managing the costs associated with surgical services. The Project seeks to meet this need by allowing SHS to offer its patients access to ASC care a convenient, low-cost, high-quality alternative for outpatient multi-specialty surgery. In addition, the Project will preserve an important lower cost care setting in the community for the SHS and SDS patient panels. While the benefits of providing care in an ASC setting are discussed briefly in Factor F1.a.ii, below are more detailed evidence-based arguments supporting the provision of lower-acuity surgical procedures in an ASC facility. As an overview, this review focuses on quality, efficiency, and convenience. Cost savings are also associated with care in ASCs, however, these arguments are addressed in Factors F1.a.iii and F2.a.

High-Quality, High Value Care

As discussed in Section F1.a.ii, there are several benefits associated with the provision of services in the ASC setting. In fact, it is widely recognized that ASC facilities can provide the same or higher quality services, and access to highly-skilled and specialized physicians, when compared with hospital settings.⁵⁵ Specifically, ASC facilitates enhance patient care by: (i) giving physicians the opportunity to focus on a small subset of procedures in a single setting; (ii) allowing physicians to intensify quality control processes, since ASC settings are focused on a smaller space as compared to large hospital campuses; and (iii) providing patients with improved access to physicians, which allows patients to interact directly with physicians and care teams concerning their case and proposed treatment.⁵⁶

The assertion that ASCs provide high-quality care is further supported by data and evidence-based research related to high-quality surgical service delivery.⁵⁷ For instance, rates of revisit one-week post-surgery are lower for ASC patients⁵⁸ and infection rates for procedures performed in ASCs are also lower.⁵⁹ Further, the HPC Datapoints reports that clinical outcomes in ASCs are generally comparable to or better than HOPDs, including with respect to adverse events.⁶⁰

With respect to SDS specifically, as more fully discussed in Factor F1.bii, the ASC is accredited by the Joint Commission and is licensed by the Commonwealth of Massachusetts. Accordingly, SDS is held to the highest standards of quality care.⁶¹ Following the proposed transaction, SDS will

⁵⁵ See Munnich & Parente (2018), *supra* note 7; see also discussion and references *supra* F1.a.ii, The ASC Setting.

⁵⁶ ASCA Report, *supra* note 1; see also discussion and references *supra* F1.a.ii, The ASC Setting.

⁵⁷ See *generally*, *supra* note 6-8 (discussing clinical benefits and patient safety associated with ASCs).

⁵⁸ Munnich & Parente (2018), *supra* note 7.

⁵⁹ Hall MJ, et al, *supra* note 9; see also, McKinsey ASC Report, *supra* note 1 (“ASCs allow patients to be discharged within 23 hours of care, reducing their risk of infection and allowing recovery to take place in the comfort of their own homes.”).

⁶⁰ HPC Datapoints, *supra* note 6.

⁶¹ The Joint Commission, *Ambulatory Care Accreditation Fact Sheet*, <https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-ambulatory-care-accreditation/>; HPC Datapoints (discussing Massachusetts’ relatively low

continue to operate as a high-quality ASC facility and will be incorporated into SHS's clinical quality initiatives.

Operational Efficiencies

As discussed in Factor F1.a.ii, ASCs also offer clinical and operational efficiencies. This is due to the fact that ASCs, by design, focus on performing a subset of medical specialties and surgical procedures through ASC-credentialed staff surgeons.⁶² Moreover, ASCs provide care for specific categories of lower-acuity patients who may be at lower risk for surgical complications.⁶³

With a more narrow scope of surgical cases, schedules are more predictable, and the ASC facility is able to accurately plan the resources it needs and maintain lower costs for operation.⁶⁴ ASCs accommodate routine, scheduled procedures, and thus are not hampered by some of the clinical and schedule disruptions for emergency procedures that can affect larger facilities with more acute patient demands.⁶⁵ Additionally, continuous delivery of a relatively limited range of procedures by highly-skilled, specially-trained surgeons allows for refining of techniques and provision of high-quality care in less time.⁶⁶ Overall, these factors lead to improved operational efficiency and economies of scale, which in turn facilitate increased productivity, with a greater number of patients receiving quality care with shorter wait times, and cost savings.⁶⁷

Increased Choice and Improved Satisfaction and Convenience

Finally, ASCs provide patients with high-quality options to choose from when selecting an appropriate setting for outpatient surgical services, promote enhanced convenience and satisfaction, and are often selected by patients and families as they are accessible and focused specifically on surgical services.⁶⁸ Generally, and as is the case at SDS, patients enter the easily navigable ASC facility directly from the free parking lot, a setup that facilitates access by ill, injured, or elderly patients. Through the Project, these benefits will be made available to patients in the community who select the ASC for their individual multi-specialty surgical needs.

number of ASCs compared to other states due to the state's active DON regulation and licensure approval process); *see also*, Massachusetts Association of Ambulatory Surgery Centers, <https://maasc.org/about/>; Accreditation Association For Ambulatory Health Care, <https://www.aaahc.org/>.

⁶² Munnich & Parente (2014), *supra* note 50; AAOS Position Statement, *supra* note 6; ASCA Report, *supra* note 1.

⁶³ Munnich & Parente (2014), *supra* note 50 (noting that "ASCs tend to treat a healthier mix of patients than hospitals do"); Crawford et al., *supra* note 8.

⁶⁴ Munnich & Parente (2014), *supra* note 50; AAOS Position Statement, *supra* note 6; Cook, et al., *supra* note 8.

⁶⁵ Munnich & Parente (2014), *supra* note 50; AAOS Position Statement, *supra* note 6; ASCA Report, *supra* note 1; Cook, et al., *supra* note 8.

⁶⁶ Munnich & Parente (2014), *supra* note 50; AAOS Position Statement, *supra* note 6; ASCA Report, *supra* note 7; Cook, et al., *supra* note 8.

⁶⁷ Munnich & Parente (2014), *supra* note 50; AAOS Position Statement, *supra* note 6; ASCA Report, *supra* note 7; Cook, et al., *supra* note 8; Levitt, *supra* note 9.

⁶⁸ MedPac ASC Report, *supra* note 2 ("For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments.").

Increased Capacity and Care Coordination

SHS has experience leveraging its resources to tailor programs and services to meet the needs of the communities it serves. The Applicant's hospitals – St. Luke's Hospital, Charlton Memorial Hospital, and Tobey Hospital – are essential institutions in their respective communities, and SHS has unified these institutions to expand access to essential care from a high-quality non-profit system. The opportunity to add another high-quality site of care, in one of Southcoast Health's core communities, which itself has a history of providing high-quality care through community providers is a significant benefit of the Project. SHS values the capacity that an ambulatory surgical center can provide and seeks to coordinate care at the right setting by keeping patients in their local communities when appropriate and bringing patients to a tertiary hospital only as needed. SHS has multidisciplinary team in place with extensive experience in community benefit programs, value-based care and risk contracting; these resources will be brought to bear as part of this Project.

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.

Improving Health Outcomes and Quality of Life

The Applicant anticipates that the Proposed Project will provide SHS's and SDS's patient panel with improved access to integrated ASC services, thus providing for improved outcomes and quality of life. As more fully discussed in Factors F1.a.ii and F1.b.i, shifting patients to an ASC setting allows for high-quality and lower-cost care. As a proxy for outcomes and quality, research findings indicate that ASCs offer high-quality care, even for the most vulnerable patients. Specifically, researchers have found that highest-risk Medicare patients are less likely to visit an emergency department or be admitted to a hospital following outpatient surgery in an ASC setting.⁶⁹ Moreover, provision of care in the ASC setting is associated with efficiencies, convenience, and cost savings, all of which promote patient satisfaction and may lead to improved quality of life.⁷⁰

As indicated above, the ASC is Joint Commission-accredited. The Joint Commission advocates for the provision of high-quality health care through the development and adoption of nationally recognized standards, and the Joint Commission Certificate of Accreditation demonstrates an organization's commitment to provide safe, high-quality services to its patients.⁷¹ Following the proposed transaction, SDS will continue to operate as a high-quality ASC facility.

Finally, the Applicant anticipates that the Project will benefit SDS's patient panel and promote improved outcomes and quality of life for these patients. Specifically, because SHS will own the

⁶⁹ Munnich & Parente (2018), *supra* note 7; AAOS Position Statement, *supra* note 6;.

⁷⁰ Munnich & Parente (2014), *supra* note 50; AAOS Position Statement, *supra* note 6; ASCA Report, *supra* note 1; Levitt, *supra* note 8; *The ASC Cost Differential*, *supra* note 39.

⁷¹ Accreditation Association for Ambulatory Health Care, *supra* note 61.

ASC, SDS's patients will benefit from integration of SDS's specialty surgical services with SHS. Such integration will allow for greater care coordination with other SHS clinicians and integration of services, information and care management systems, all of which is instrumental in achieving better outcomes and improved quality of life.

Assessing the Impact of the Proposed Project

To assess the impact of the proposed Project, the Applicant developed the following quality metrics and reporting schematic, as well as metric projections for quality indicators that will measure patient satisfaction and quality of care. The measures are discussed below:

1. **Patient Satisfaction:** Patients that are satisfied with their care are more likely to seek needed diagnostics, appropriate treatments and follow-up services. The Applicant and SDS staff will review patient satisfaction levels with SDS's surgical services.

Measure: The Outpatient and Ambulatory Surgery Community Assessment of Healthcare Providers and Systems ("OAS-CAHPS") Survey will be provided to eligible patients. The OAS-CAHPS Survey is a patient experience survey administered to patients of ambulatory and outpatient facilities that includes questions related to six key areas: (1) Before a patient's procedure; (2) Facility and staff; (3) Communications about the procedure; (4) Recovery; (5) Overall experience; and (6) Patient demographics. OAS-CAHPS results are reported as "top-box," "middle-box," and "bottom-box" scores; the top-box is the most positive response to survey items, the middle-box captures intermediate responses, and the bottom-box is the least positive response category.

The Applicant has selected three indicators of care experience across the continuum from the OAS CAHPS slate:

- I. Before the Procedure
 - Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?
- II. About the Facility and Staff
 - Did the doctors and nurses treat you with courtesy and respect?
- III. Communication about the Procedure / Transitions
 - Discharge instructions include things like symptoms you should watch for after your procedure, instructions about medicines, and home care. Before you left the facility, did you get written discharge instructions?

Projections: As the Project relates to the change in ownership of SDS, the Applicant has established a new benchmark for this measure to be implemented post-transaction.

Specifically, the Applicant has established a benchmark of 88% for top-box scores for “Overall Experience” at SDS, which is the top decile for reporting providers.

Monitoring: Results will be reviewed on a quarterly basis and reported to DPH, as required.

- 2. Clinical Quality and Safety:** As with all health care delivery, quality and safety are a top priority. The Applicant and SDS staff will review clinical quality and safety performance in accordance with Ambulatory Surgical Center Quality Reporting Specifications Manual Versions 13.0a. which is published by CMS and allows for national benchmarking including the measures targeted below:

Measure: As defined by Ambulatory Surgical Center Quality Reporting Specifications Manual Versions 13.0a, we will track the web-based and claims based measures:

Measure	Description
ASC -3 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	The number of admissions (patients) who experience a wrong site, side, patient, procedure, or implant
ASC -4 All Cause Hospital Transfer/Admission	The percentage of ASC admissions (patients) who are transferred or admitted to a hospital upon discharge from the ASC
ASC -9 Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
ASC -12 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy Measure, hereafter referred to as the colonoscopy measure, estimates a facility-level rate of risk- standardized, all-cause, unplanned hospital visits within seven days of an outpatient colonoscopy among Medicare Fee-for-Service (FFS) patients aged 65 years and older.
ASC -17 Risk-Standardized Hospital Visits within 7 Days after Orthopedic	The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of an orthopedic surgery at an ambulatory surgical center (ASC) among Medicare

Ambulatory Surgical Center Procedures	Fee-for-Service (FFS) patients aged 65 years and older.
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While SHS will track the entire ASC panel of quality for indicated cases, SHS has selected this subset for special emphasis to drive safety (wrong site surgery), coordination with hospital, emergency and office-based sites of care (hospital visits after ambulatory surgery), and to drive population health (colorectal cancer prevention). For the hospital visits, SHS has selected two populations, orthopedics and gastroenterology, that we anticipate will have high utilization in the region. SHS has placed a high emphasis on colorectal screening procedure access and throughput and also has achieved Joint Commission Advanced Total Joint Replacement certification. In both areas, the Applicant anticipates bringing added value to the ASC.

Projections: As the Project relates to the change in ownership of SDS, the Applicant intends to meet or exceed the ASC Quality Collaboration (“ASC-QC”) and/or CMS benchmarks.

Monitoring: Results will be reviewed on a quarterly basis and reported to DPH, as required.

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

SHS has a longstanding commitment to and responsibility for advancing health equity in its community and actively addressing social determinants of health. SHS uses internal and external data to assess trends in health needs and health outcomes of its patients and surrounding community.

SHS’s 2022 Community Health Needs Assessment (“CHNA”) indicates the strong impact that social determinants of health (“SDoH”) have on the health of residents in communities served by SHS.⁷² SDoH are the conditions in the environments in which people live, learn, work, play, and age; they affect a wide range of health, functioning, and quality-of-life outcomes and risks.⁷³ Examples

⁷² Southcoast Health Community Health Needs Assessment 2022, available here: <https://www.southcoast.org/wp-content/uploads/2022/09/Southcoast-Health-CHNA-2022.pdf>.

⁷³ See generally, DHHS, Healthy People 2030, *Social Determinants of Health*, <https://health.gov/healthypeople/priority-areas/social-determinants-health>.

of SDoH include, socioeconomic status, education and employment opportunities, housing and transportation needs, and food security. In SHS's and SDS's service area, the population experiences a number of SDoH-related barriers, as described in SHS's 2022 CHNA. Specifically, social and economic challenges experienced by the population affect access to health-promoting resources and contribute to disparities in health outcomes among vulnerable populations, including low-income households, minoritized racial and ethnic groups, and older adults. As detailed below, the Applicant's parties will help to address these challenges by ensuring equitable access to the health benefits created by the Project.

Non-Discrimination

As described in SHS's 2022 CHNA, many of the cities and towns in SHS's and SDS's service area struggle with high poverty rates and low levels of income, which are essential SDoH that affect the Applicant's patient population and services. 12.6% of individuals and 9.8% of families in the South Coast region are below the state poverty levels (of 9.8% and 6.6%, respectively. SHS's service area is centered on Fall River and New Bedford, Massachusetts, each of which have poverty rates that are nearly double the state average (according to SHS's 2022 CHNA). Additionally, more than 62% of the region's public school students are classified as economically disadvantaged. Contributing to these challenges, average annual wages in the Southcoast region are a 63.3% of the state average. Given these demographics and challenges, residents often face difficulties meeting their basic food, housing, transportation, and healthcare needs.

Throughout this Project, SHS will maintain its commitment to meeting the needs of medically indigent, and/or Medicaid eligible individuals. As a charitable health system, the Applicant does not discriminate based on ability to pay or payer source, and the Applicant has a robust financial assistance policy available for patients in accordance with federal and state requirements. The Project will expand access to the Applicant's anti-discrimination and financial assistance policies by newly including SDS as a covered site of care under such policies. Accordingly, as further detailed throughout this narrative, the Project will increase access to high-quality surgical services for SHS's patients and will ensure continued access to such services for SHS's and SDS's current patient panel.

Culturally Appropriate Care and Language Access

The diversity of SHS's patient panel and communities, as well as SHS's obligations as a charitable health system, will enable the Applicant to further expand access to culturally and linguistically appropriate services that address the unique needs of SHS' and SDS' patients. SHS's 2022 CHNA supports the need for health information and resources to be understandable and accessible, including provider education about how to communicate with patients about medical information, and training in cultural humility as a means to deliver culturally sensitive care. The Project will allow SHS to incorporate SDS into its language access initiatives and will enable patients presenting at SDS to have access to robust health services regardless of preferred language.

In this regard, the Applicant notes that SDS provides effective, understandable, and respectful care with an understanding of patients' cultural health beliefs and practices and preferred

languages. Specifically, SDS currently uses AMN Healthcare Services, Inc. which acquired Stratus Video, a leading provider of video remote language interpretation services for the healthcare industry.

SHS offers access to interpreter and translation services via Language Services Associates at no cost to limited-English speaking and hearing-impaired patients. Language Services Associates' services are available 24 hours/day, 7 days/week both in person, over the phone, or a combination of in person, video and/or audio services and offer patients access to qualified interpreters skilled in 200+ languages including American Sign Language. Moreover, SHS offers documents in both English and Spanish and also employs several bilingual staff members. Following the transaction, SDS will continue to provide these services with an understanding of patients' cultural health beliefs and practices and preferred languages. The Applicant anticipates that these steps will help to eliminate language barriers for patients, promote health equity and ensure equal access to SDS's services.

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 Project will allow SHS's patients in need of lower-acuity surgical services to receive care in a high-quality ASC setting and preserve SDS's patient ability to access care in an ASC setting. An alternative point of access is more convenient for many patients and also may be a lower-cost option, while remaining a high-quality site of care. Moreover, SHS has pre-existing systems in place to ensure health equity, which will be continued post-transaction. This includes: (1) system-wide efforts to improve data collection to advance health equity (e.g., the collection of self-reported race, ethnicity, language, disability, sexual orientation, and gender identity [RELD SOGI] data), (2) staff training to ensure competency in collecting this data from our patient population, (3) stratified analyses of RELD SOGI data to identify disparities, and (4) targeted initiatives, including clinical-community partnerships, to address identified disparities. This work is prioritized through dedicated staffing resources as well as engagement from clinical and administrative leadership at SHS. SDS will participate in SHS's system-wide health equity efforts. Accordingly, the Applicant asserts that the Project will result in improved health outcomes and quality of life while providing reasonable assurances of health equity.

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.

Improving Continuity and Efficiency

As discussed in Factor F1.a.ii, the Project aligns with the state's goals to accelerate care delivery transformation in Massachusetts and promote a high-quality, efficient health system. Specifically, SHS's acquisition of SDS brings the ASC within the Southcoast Health network of

providers and facilities. This allows SDS to serve as a setting for ACO patients and provides such patients with the benefits of physician/hospital cooperation, further clinical integration and medical management services. SDS patients will have the benefit of integrated access to primary care and wellness services to manage conditions and allow for earlier interventions, urgent and emergency services for acute management of conditions, referrals for specialty consultations and treatment, hospital and outpatient sites for surgical care and other procedures, and post-acute and post-surgical follow-up teams and facilities (including rehabilitation care) to manage recoveries and enable patients to avoid complications. SHS patients will benefit from another convenient site for high-quality surgical services that is linked to their other providers. This will all be done via an integrated and coordinated delivery network, with providers and staff able to communicate in real time to manage and treat patients effectively and address their needs. This will also be done in the setting of a community hospital, with providers and staff who live in the community and prioritize community health and wellness.

The Applicant anticipates that the Project will allow SDS to become an integrated site of care for its ACOs and benefit further from Southcoast Health's care coordination, utilization, and quality and performance improvement initiatives led by SHN.

Coordinated Care

The Project will enable SHS to integrate SDS into its care coordination initiatives. Most care coordination needs for ambulatory surgical procedures are managed in advance of the procedure day. Should SDS care coordination needs arise on the day of surgery, SHS has a patient-centric approach and has made internal and cross continuum infrastructure investments to support a "longitudinal" approach to care. SHS's high-fidelity to its mission of clinical excellence and a uniquely caring experience to every life we touch facilitates our focus on equitably and consistently supporting care coordination within SHS and through integration with local community organizations to successfully impact the health of SHS's patients. To equitably impact quality, utilization, and patient experience, population health must be viewed beyond the walls of SHS itself. Health begins in the community and homes where individuals live, work and play. SHS care entities, from its emergency departments and hospitals, to post-acute care settings, primary and specialty care providers, and care coordination, are well-positioned to support longitudinal, integrated, collaborative care.

The parties anticipate that the SDS patient panel will also become included in SHS's population health infrastructure. This population health infrastructure has been developed to leverage resources such as medical directors, group leadership, provider champions, practice improvement facilitators, care management teams, and community-based organizations all utilizing data/analytics to guide its strategies across all settings and in the SHS and SDS communities.

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 conducted a formal consultative process with individuals at regulatory agencies with relevant licensure, certification or other regulatory oversight of the Applicant and the Project. Specifically, the following agencies and individuals were consulted with respect to the Project:

- Health Policy Commission: Lois Johnson, Esq., General Counsel; Katherine Mills, Senior Director, Market Oversight and Transparency; Megan Wulff, Director, Market Oversight and Monitoring.
- Department of Public Health: Dennis Renaud, Director, Determination of Need Program; Rebecca Kaye, Deputy General Counsel; Rodrigo Monterrey, Acting Director, Office of Health Equity; Jennica Allen, Division of Community Health Planning and Engagement Manager; Katelyn Teague, Division of Community Health Planning and Engagement; Elizabeth Maffei, Division of Community Health Planning and Engagement; Stephen Davis, Director, Division of Health Care Facility Licensure and Certification; Judy Bernice, Division of Health Care Facility Licensure and Certification.

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.

The Applicant, as a community-based non-profit health system, is led by a community board and driven by the needs of its patients and community. Changes across the health care industry described throughout this Application, including advances in surgical techniques and technologies, as well as changing reimbursement models and increased incentives for providing care outside of the hospital and in lower-acuity, lower-cost settings such as ASCs, have led the Applicant to seek additional opportunities for its patients to elect such settings for their care.

The need for the Proposed Project is outlined in Factor F1.a. However, to inform and consult the community about the Proposed Project, the Applicant sought to engage the patient panel, family members, community members and local stakeholders that may be affected by the Project. Engagement occurred through the following activities:

As a first step in the engagement process, SHS presented the Project at its Patient and Family Advisory Council (“PFAC”) meeting on April 8, 2024. The PFAC represents the voice of SHS’s patients, families and communities and is an important forum for creating partnerships and ensuring the delivery of high-quality, safe and positive health care experiences. The goals of the PFAC are to: (1) enhance the delivery of care and services; (2) ensure representation of the community’s perspective; (3) foster a culture of patient-centered care. During the PFAC meeting on April 8, 2024, overall, feedback from the meeting was positive with PFAC members supportive of the Project.

In addition to the SHS PFAC meeting presentation, the Applicant is working with SDS's individual physician owners to inform their patients in the greater Fall River community about the Project. The Applicant felt it was important to engage these patients because they will benefit from SDS's increased integration with SHS post-transaction. Accordingly, on May 29, 2024, SDS will host a community forum regarding the Project. The forum will be publicized to the community in order to provide patients with notice of the forum and inform them of the opportunity to discuss the Project.

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 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."

SHS has demonstrated its commitment to developing and maintaining strong linkages with community partners. Through these partnerships, SHS is able to provide more robust, community-informed services while more effectively addressing social determinants of health and advancing health equity. Community voice is central to SHS's work and decision-making.

- **PFAC:** SHS worked closely with its PFAC Committee to understand and address patients' interests, needs and concerns, and will solicit feedback from patients and local residents; foster ethnic/racial diversity representation; provide interpreter services for Limited English speaking and the deaf and hard of hearing to members if needed. As referenced above, the Project was presented to SHS's PFAC Committee on April 8, 2024. The agenda minutes and slides for the PFAC meeting are attached as Appendix E.
- **Community Forum:** On May 29, 2024, SHS and SDS will host an open forum in Fall River regarding the Project. The Applicant will provide the community with notice of the forum and inform them of the opportunity to discuss the Project.
- **Community Benefits:** SHS has a robust Community Benefits Advisory Committee (CBAC) that is representative of the community we serve, as well as inclusive of stakeholders across a variety of sectors, including but not limited to transportation, recreation, and immigrant assistance services, and faith-based organizations. SHS is committed to fostering and sustaining an ongoing communication and engagement strategy to foster transparency, accountability, and shared decision-making.
- **Engage Local Public Health:** SHS has built strong relationships with local departments of public health, including in New Bedford and Fall River. These partnerships have been instrumental in conducting community needs assessments (including SHS's CHNA), as well as coordinating action plans to address community needs. SHS will continue to engage with local departments of Public Health to share knowledge about the community and ensure that cross-sector projects are aligned to meet community needs.

- **Community Health Needs Assessment Review and Update:** SHS has partnered with local departments of health to review its 2022 CHNA findings with community stakeholders. SHS has also formed a partnership with the New Bedford Health Department to develop a Community Health Improvement Plan (CHIP). This included recently co-hosting an all-day, interactive planning process to develop the components of the CHIP with over 40 participants representing a wide variety of community organizations. SHS will continue to build on this engagement as it conducts future CHNAs (including in 2025) and CHIPs.
- **Community Benefits Reporting and Regulatory Requirements:** SHS will be responsible for compliance with all reporting and regulatory requirements.

Integration of a Health Equity Lens: SHS has prioritized health equity system-wide, including through the data collection and analysis, training, and improvement project efforts described above. SHS has also created a multidisciplinary Health Equity Committee to advise on these efforts. SHS and its Health Equity Committee leadership will work closely with SDS leadership and community stakeholders to integrate SDS into these existing efforts. This may include conducting additional education and outreach and expanding data collection and analysis capabilities to identify equity-related opportunities and facilitate access to care. In addition, SHS will expand its equity-focused assessment of services to include SDS. In particular, interpreter services, disability-related accommodation processes, and other access-related initiatives will be examined to ensure that such services meet the needs of the SDS patient population.

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

In Massachusetts, the goals for cost containment center around providing low-cost care alternatives without sacrificing high quality. The HPC, an independent state agency established in 2012 and charged with monitoring health care spending growth in the state and providing data-driven policy recommendations regarding health care delivery and payment system reform, has set the following goal for cost containment: “better health and better care – at a lower cost – across the Commonwealth.”⁷⁴ The Project aligns with this goal by ensuring continued access to high-quality surgical services in a cost-effective setting for lower-acuity patients.

⁷⁴ Mass.gov, *About the Health Policy Commission (HPC)*, <https://www.mass.gov/about-the-health-policy-commission-hpc>.

The pricing for services at SDS will remain the same following implementation of the Project. Specifically, the contracted rates under the Applicant's ownership will be the same as those rates currently utilized by SDS. As outlined at Factor F1.a.iii, ASC rates are substantially lower than hospital-based rates and ASCs are a more cost-effective option for providing high-quality surgical services. Public payers, commercial insurers and patients all benefit from lower prices for services performed in the ASC setting due to lower levels of reimbursement and lower coinsurance payments. Given that no change will be occurring to the price of services post-transaction and given that the services at SDS will continue to be provided at lower ASC rates, the Project will not negatively impact the overall cost growth benchmark set for the state. Rather, the Applicant anticipates that the Project will meaningfully contribute to Massachusetts' goals for cost containment by promoting utilization of the ASC setting for appropriate SHS patients as a high-quality, lower-cost alternative to outpatient surgery performed in a HOPD.

Massachusetts FY22 Health Systems Financial Performance

***Table reflects Financial Performance attributed to healthcare systems in MA (Source: CHIA)*

System	Net Patient Service Revenue	Total Operating Revenue	Total Expenses	Operating Margin
Baystate Health, Inc.	\$1,694,765,000	\$2,866,368,000	\$3,044,020,000	-6.5%
Berkshire Health Systems, Inc.	\$649,927,554	\$777,190,432	\$756,877,470	2.8%
Beth Israel Lahey Health	\$5,797,628,000	\$7,067,832,000	\$7,267,359,000	-2.9%
Boston Children's Hospital and Subsidiaries	\$2,444,524,000	\$3,127,496,000	\$3,176,142,000	-1.8%
Boston Medical Center Health System, Inc.	\$1,126,099,000	\$4,824,430,000	\$4,823,547,000	0.0%
Cambridge Health Alliance	\$367,632,789	\$807,104,572	\$847,340,156	-4.7%
Cape Cod Healthcare, Inc.	\$947,875,142	\$1,032,034,831	\$1,038,344,587	-0.6%
Dana-Farber Cancer Institute, Inc. and Subsidiaries	\$1,910,604,371	\$2,387,975,277	\$2,571,430,228	-7.2%
Emerson Health System, Inc. and Subsidiaries	\$315,140,993	\$349,436,190	\$348,236,207	0.3%
Heywood Healthcare System, Inc.	\$171,348,219	\$197,742,567	\$230,973,263	-17.0%
Lawrence General Hospital and Affiliates	\$299,128,000	\$328,166,000	\$347,331,000	-5.8%
Mass General Brigham	\$11,869,451,000	\$16,710,367,000	\$17,142,029,000	-2.9%
Milford Regional Medical Center, Inc. and Affiliates	\$344,787,942	\$361,215,387	\$375,429,042	-4.0%
Shriners Hospitals for Children	\$174,003,000	\$770,152,000	\$1,053,274,000	-26.0%
Signature Healthcare Corporations	\$347,320,692	\$425,195,788	\$435,736,408	-2.5%
South Shore Health and Educational Corporation and Subsidiaries	\$814,746,858	\$877,602,295	\$912,266,910	-4.4%
Southcoast Health Systems, Inc.	\$1,075,874,859	\$1,226,826,320	\$1,279,868,874	-4.7%
Steward Health Care Systems, LLC	\$0	\$0	\$0	0.0%
Sturdy Memorial Foundation, Inc. and Affiliates	\$270,298,074	\$281,880,341	\$310,679,626	-11.6%
Tenet Healthcare Corporation	\$19,174,000,000	\$19,584,000,000	\$18,484,000,000	5.8%
Trinity Health	\$17,042,517,740	\$19,933,677,752	\$20,139,945,750	-1.1%
UMass Memorial Health Care, Inc.	\$3,079,429,275	\$3,317,335,000	\$3,608,293,000	-8.4%
Valley Health System, Inc.	\$204,386,910	\$245,383,613	\$244,912,895	0.2%
Wellforce, Inc.	\$1,822,463,000	\$2,288,691,000	\$2,687,242,000	-18.5%

F2.b.: Public Health Outcomes:

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

The Applicant anticipates that the Project will improve public health outcomes in several ways. First, the Project will ensure continued access to SDS's ASC services for patients in the greater South Coast region. As discussed in Factors F1.aii, F1.b.i and F1.b.ii, a variety of benefits are

associated with the provision of care in the ASC setting, including but not limited to high-quality, operational efficiencies, convenience and cost savings. More specifically, ASCs offer patients access to expedited surgical care provided in convenient locations by highly skilled, specially trained clinical teams that are able to gain high proficiency and efficiency in performing a specific subset of procedures. Consequently, studies indicate that this creates care efficiencies that lead to process improvements as well as cost savings, improved patient experience, and overall better clinical outcomes. These benefits are available to patients seeking care at SDS.

Moreover, as a Medicare-certified, accredited ASC, SDS offers the highest level of ASC services that, in turn, help to improve health outcomes. Following the proposed transaction, SDS will continue to operate as a high-quality ASC facility with additional resources from SHS to promote high quality care.

Finally, the Applicant anticipates that the Project will improve public health outcomes by improving care coordination. Specifically, because SHS will own the ASC, SDS's patients will benefit from integration of SDS's specialty surgical services with SHS's broad array of clinical offerings. Such integration will improve patient access to the Southcoast Health's network and providers and will allow for greater coordination and integration of services, information and care management systems, all of which is instrumental in achieving better outcomes and improved quality of life.

**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**

As discussed in Factor F1.b.iii, SDoH are the conditions and environments in which people are born, grow, live, eat, work, play and age, that affect access to the healthcare system and a wide range of health risks and outcomes. Socioeconomic status, education, employment, housing, food security, transportation, social protective factors, social support, and language/literacy are all examples of SDoH that have an impact on the physical and mental well-being of the population. As outlined in Factor F1.b.iii, through the Project, patients will be provided with services designed to address the SDoH and reduce health inequities. Additionally, as is described in Factors F1.a.ii and F1.c, SHS's acquisition of ownership in SDS will allow SDS to serve as a setting for SHS to manage ACO patients and provide such patients with the benefits of physician/hospital cooperation, further clinical integration and medical management services. In total, these efforts will help link patients with appropriate community resources to address SDoH.

Appendix A

Southcoast Health – Overall Patient Panel

Southcoast Health – FY21-FY24 Patient Panel by Age

***Table reflects Age Cohort attributed to all Active (Patient Status = Alive) unique patients' w/ an encounter within a Southcoast Health facility (i.e. – Hospital Based, Emergency Dept, Medical Practice, Urgent Care, Lab, Imaging, etc.) **Time Period: Oct 2020 – Mar 2024*

Age Cohort	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
0 - 17	27,981	10%	38,830	12%	42,910	13%	35,902	12%
18 - 64	175,324	62%	200,907	62%	213,869	62%	198,840	64%
65+	78,318	28%	82,261	26%	85,751	25%	76,169	25%
N/A	0	0%	0	0%	16	0%	0	0%
Total	281,623	100%	321,998	100%	342,546	100%	310,931	100%

Southcoast Health – FY21-FY24 Patient Panel by Race

***Table reflects Race attributed to all Active (Patient Status = Alive) unique patients' w/ an encounter within a Southcoast Health facility (i.e. – Hospital Based, Emergency Dept, Medical Practice, Urgent Care, Lab, Imaging, etc.) **Time Period: Oct 2020 – Mar 2024*

Race	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
White or Caucasian	225,111	80%	253,263	79%	264,043	77%	242,231	78%
Black or African American	13,832	5%	16,477	5%	17,697	5%	15,983	5%
My race is not listed	12,919	5%	15,077	5%	16,692	5%	15,749	5%
Hispanic	12,816	5%	15,316	5%	15,253	4%	9,045	3%
N/A	7,972	3%	11,371	4%	16,782	5%	2,491	1%
I don't know	7,899	3%	11,180	3%	14,427	4%	12,671	4%
I choose not to answer	5,269	2%	6,127	2%	7,335	2%	8,260	3%
Asian	2,930	1%	3,478	1%	3,773	1%	3,474	1%
American Indian	557	0%	644	0%	682	0%	674	0%
Native Hawaiian	217	0%	245	0%	289	0%	308	0%
Total	281,623	100%	321,998	100%	342,546	100%	310,931	100%

Southcoast Health – FY21-FY24 Patient Panel by Ethnicity ****Top 10 Ethnicities**

***Table reflects Ethnicity attributed to all Active (Patient Status = Alive) unique patients' w/ an encounter within a Southcoast Health facility (i.e. – Hospital Based, Emergency Dept, Medical Practice, Urgent Care, Lab, Imaging, etc.) **Time Period: Oct 2020 – Mar 2024*

Ethnicity	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Not Hispanic or Latino	124,583	44%	133,446	41%	146,042	43%	166,113	53%
American	77,783	28%	96,015	30%	94,033	27%	57,622	19%
Hispanic or Latino	14,807	5%	17,255	5%	19,143	6%	19,698	6%
Portuguese	10,788	4%	11,843	4%	11,699	3%	7,515	2%
Puerto Rican	3,878	1%	4,382	1%	4,121	1%	2,503	1%
African American	2,617	1%	3,205	1%	3,129	1%	1,754	1%
Cape Verdean	2,121	1%	2,488	1%	2,441	1%	1,386	0%
European English	1,145	0%	1,616	1%	1,771	1%	1,004	0%
European-Irish	1,018	0%	1,109	0%	1,213	0%	855	0%
European-French	1,057	0%	1,118	0%	1,121	0%	838	0%
Total	281,623	100%	321,998	100%	342,546	100%	310,931	100%

Southcoast Health – FY21-FY24 Patient Panel by Gender

****Table reflects Gender attributed to all Active (Patient Status = Alive) unique patients' w/ an encounter within a Southcoast Health facility (i.e. – Hospital Based, Emergency Dept, Medical Practice, Urgent Care, Lab, Imaging, etc.) **Time Period: Oct 2020 – Mar 2024**

Gender	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Female	159,852	57%	180,941	56%	192,418	56%	177,952	57%
Male	121,713	43%	140,989	44%	150,010	44%	132,858	43%
N/A	58	0%	68	0%	118	0%	121	0%
Total	281,623	100%	321,998	100%	342,546	100%	310,931	100%

Southcoast Health – Surgical Patient Panel

Southcoast Health – FY21-FY24 Procedural Volume by Service Type

****Table reflects all procedural volume by Service Type occurring at Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024**

Service Type	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Inpatient	10,744	100%	10,239	100%	10,476	100%	4,920	22%
Cardiovascular	2,193	20%	2,368	23%	2,177	21%	1,097	22%
Gastroenterology	2,221	21%	1,941	19%	1,947	19%	925	19%
General	2,202	20%	1,835	18%	1,909	18%	850	17%
Orthopedics	1,517	14%	1,600	16%	1,670	16%	833	17%
Urology	868	8%	748	7%	882	8%	349	7%
Vascular	613	6%	674	7%	696	7%	326	7%
Neurosurgery	348	3%	346	3%	327	3%	179	4%
Gynecology	207	2%	172	2%	199	2%	47	1%
Thoracic	140	1%	198	2%	214	2%	100	2%
Pulmonary	186	2%	121	1%	117	1%	58	1%
Trauma Surgery	64	1%	93	1%	164	2%	84	2%
Podiatry	46	0%	44	0%	55	1%	21	0%
ENT	42	0%	34	0%	42	0%	N/A	0%
Plastics	32	0%	19	0%	31	0%	17	0%
Maxillofacial	17	0%	24	0%	26	0%	11	0%
All Other	48	0%	22	0%	20	0%	23	0%
Outpatient	27,902	100%	28,655	100%	30,468	100%	15,864	100%
Gastroenterology	7,234	26%	8,643	30%	9,334	31%	4,915	31%
Pain Management	6,099	22%	6,244	22%	6,498	21%	2,691	17%
Orthopedics	3,307	12%	3,197	11%	3,444	11%	1,938	12%
General	2,878	10%	2,458	9%	2,688	9%	1,468	9%
Cardiovascular	2,196	8%	2,166	8%	2,087	7%	1,314	8%
Urology	2,160	8%	1,998	7%	2,030	7%	1,081	8%
Gynecology	1,414	5%	1,330	5%	1,520	5%	860	5%
ENT	505	2%	601	2%	855	3%	478	3%
Vascular	638	2%	530	2%	441	1%	250	2%
Neurosurgery	561	2%	509	2%	448	1%	241	2%
Plastics	279	1%	338	1%	469	2%	311	2%
Ophthalmology	186	1%	179	1%	184	1%	61	0%
Thoracic	138	0%	197	1%	203	1%	88	1%
Podiatry	118	0%	126	0%	109	0%	68	0%
Pulmonary	80	0%	78	0%	76	0%	46	0%
All Other	109	0%	61	0%	82	0%	25	0%

Southcoast Health - YOY Procedural Volume by Patient Origin **Top 15 Communities

**Table reflects all procedural volume by Patient Origin occurring within Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024

City/Town	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
New Bedford, MA	9,053	23%	8,963	23%	9,416	23%	4,772	23%
Fall River, MA	6,490	17%	6,291	16%	6,616	16%	3,313	16%
Fairhaven, MA	1,674	4%	1,915	5%	2,016	5%	1,034	5%
Wareham, MA	1,663	4%	1,734	4%	1,729	4%	845	4%
North Dartmouth, MA	1,582	4%	1,672	4%	1,807	4%	931	4%
Somerset, MA	1,591	4%	1,506	4%	1,625	4%	805	4%
Westport, MA	1,574	4%	1,451	4%	1,576	4%	835	4%
Swansea, MA	1,336	3%	1,301	3%	1,458	4%	728	4%
South Dartmouth, MA	1,027	3%	1,078	3%	1,126	3%	568	3%
Acushnet, MA	1,036	3%	1,041	3%	1,109	3%	520	3%
Tiverton, RI	1,016	3%	908	2%	996	2%	524	3%
Mattapoisett, MA	750	2%	830	2%	823	2%	463	2%
Marion, MA	599	2%	694	2%	693	2%	313	2%
West Wareham, MA	619	2%	636	2%	634	2%	321	2%
Rochester, MA	587	2%	636	2%	634	2%	310	1%
Total	38,646	100%	38,894	100%	40,944	100%	20,784	100%

Southcoast Health – FY21-FY24 Procedural Volume by Payor

**Table reflects all procedural volume by Payor occurring at Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024

Payor	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Medicare	13,768	36%	13,399	34%	13,219	32%	6,496	31%
Medicare Managed Care	7,142	18%	7,027	18%	7,325	18%	3,843	18%
Medicaid Managed Care	5,795	15%	5,730	15%	6,367	16%	3,268	16%
BCBS MA – Commercial	2,629	7%	2,719	7%	3,130	8%	1,548	7%
Harvard Pilgrim – Commercial	2,182	6%	2,431	6%	2,563	6%	1,320	6%
Commercial	1,503	4%	1,724	4%	1,952	5%	964	5%
BCBS Other	1,475	4%	1,535	4%	1,640	4%	918	4%
Medicaid	1,170	3%	1,300	3%	1,503	4%	816	4%
BCBS RI – Commercial	699	2%	642	2%	752	2%	413	2%
United Healthcare – Commercial	639	2%	661	2%	706	2%	386	2%
Self-Pay	619	2%	586	2%	580	1%	227	1%
Tufts – Commercial	413	1%	482	1%	424	1%	218	1%
Free Care / Charity	260	1%	281	1%	382	1%	143	1%
Government	267	1%	292	1%	287	1%	179	1%
Attorney / Motor Vehicle	83	0%	85	0%	110	0%	44	0%
All Other	2	0%	0	0%	4	0%	1	0%
Total	38,646	100%	38,894	100%	40,944	100%	20,784	100%

Southcoast Health – FY21-FY24 Procedural Volume by Age

**Table reflects all procedural volume by Age Cohort occurring at Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024

Age Cohort	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
0 - 17	201	1%	263	1%	459	1%	270	1%
18 - 64	20,134	52%	20,696	53%	22,559	55%	11,449	55%

65+	18,311	47%	17,935	46%	17,926	44%	9,065	44%
Total	38,646	100%	38,894	100%	40,944	100%	20,784	100%

Southcoast Health – FY21-FY24 Procedural Volume by Race

***Table reflects all procedural volume by Race occurring within Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024*

Race	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
White or Caucasian	33,286	86%	33,498	86%	34,802	85%		
Black or African American	1,671	4%	1,680	4%	1,784	4%		
My race is not listed	1,234	3%	1,370	4%	1,751	4%		
Hispanic	1,217	3%	1,022	3%	877	2%		
I choose not to answer	597	2%	603	2%	761	2%		
N/A	270	1%	355	1%	516	1%		
Asian	248	1%	261	1%	311	1%		
American Indian	97	0%	78	0%	82	0%		
All Other	26	0%	27	0%	60	0%		
Total	38,646	100%	38,894	100%	40,944	100%		

Southcoast Health – FY21-FY24 Procedural Volume by Ethnicity **Top 10 Ethnicities

***Table reflects all procedural volume by Ethnicity occurring at Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024*

Ethnicity	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Not Hispanic or Latino	19,110	49%	20,829	54%	25,529	62%		
American	8,894	23%	7,981	21%	5,353	13%		
Hispanic or Latino	1,698	4%	1,617	4%	2,113	5%		
Portuguese	2,099	5%	1,778	5%	1,205	3%		
Puerto Rican	494	1%	399	1%	316	1%		
European-French	342	1%	265	1%	134	0%		
Cape Verdean	263	1%	274	1%	163	0%		
European English	308	1%	202	1%	136	0%		
African American	261	1%	207	1%	144	0%		
European-Irish	227	1%	174	0%	103	0%		
Total	38,646	100%	38,894	100%	40,944	100%		

Southcoast Health – FY21-FY24 Procedural Volume by Gender

***Table reflects all procedural volume by Gender occurring at Charlton Memorial Hospital, St. Luke's Hospital, Tobey Hospital & Southcoast Hospitals Group Surgery Center (300D Faunce Corner Rd – North Dartmouth, MA) **Time Period: Oct 2020 – Mar 2024*

Gender	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Female	20,728	54%	20,732	53%	21,960	54%	11,037	53%
Male	17,909	46%	18,159	47%	18,969	46%	9,701	47%
N/A	9	0%	3	0%	15	0%	46	0%
Total	38,646	100%	38,894	100%	40,944	100%	20,784	100%

Charlton Memorial Hospital – Surgical Patient Panel

Charlton Memorial Hospital – FY21-FY24 Procedural Volume by Service Type

***Table reflects all procedural volume occurring at Charlton Memorial Hospital by Service Type **Time Period: Oct 2020 – Mar 2024)*

Service Type	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Inpatient	5,640	100%	5,398	100%	5,579	100%	2,723	100%
Cardiovascular	2,081	37%	2,223	41%	2,059	37%	1,021	37%
Gastroenterology	1,031	18%	915	17%	945	17%	443	16%
General	797	14%	674	12%	736	13%	365	13%
Urology	552	10%	462	9%	576	10%	228	8%
Orthopedics	508	9%	440	8%	513	9%	289	11%
Vascular	233	4%	270	5%	298	5%	149	5%
Thoracic	85	2%	146	3%	158	3%	77	3%
Neurosurgery	60	1%	60	1%	70	1%	51	2%
Pulmonary	110	2%	61	1%	60	1%	29	1%
Gynecology	78	1%	60	1%	57	1%	18	1%
Podiatry	46	1%	44	1%	55	1%	21	1%
Maxillofacial	17	0%	24	0%	26	0%	11	0%
All Other	42	1%	19	0%	26	0%	9	0%
Outpatient	9,104	100%	8,986	100%	9,505	100%	5,361	100%
Gastroenterology	2,862	31%	3,103	35%	3,275	34%	1,692	32%
Cardiovascular	2,022	22%	1,961	22%	1,955	21%	1,216	23%
Urology	1,263	14%	1,201	13%	1,287	14%	709	13%
General	1,012	11%	891	10%	1,040	11%	582	11%
Gynecology	608	7%	514	6%	581	6%	320	6%
Orthopedics	479	5%	484	5%	576	6%	369	7%
Neurosurgery	225	2%	206	2%	194	2%	87	2%
Vascular	288	3%	185	2%	172	2%	89	2%
Plastics	95	1%	163	2%	163	2%	139	3%
Thoracic	52	1%	114	1%	121	1%	73	1%
Podiatry	108	1%	114	1%	91	1%	57	1%
Pulmonary	32	0%	32	0%	32	0%	24	0%
Maxillofacial	18	0%	12	0%	13	0%	N/A	0%
All Other	40	0%	6	0%	5	0%	4	0%

Charlton Memorial Hospital - Procedural Volume by Patient Origin **Top 15 Communities

***Table reflects all procedural volume occurring at Charlton Memorial Hospital by Patient Origin **Time Period: Oct 2020 – Mar 2024)*

City/Town	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Fall River, MA	4,291	29%	4,230	29%	4,304	29%	2,222	27%
New Bedford, MA	1,547	10%	1,569	11%	1,625	11%	881	11%
Somerset, MA	1,110	8%	1,052	7%	1,109	7%	573	7%
Swansea, MA	953	6%	876	6%	963	6%	488	6%
Westport, MA	967	7%	865	6%	922	6%	505	6%
Tiverton, RI	716	5%	606	4%	700	5%	376	5%
North Dartmouth, MA	455	3%	480	3%	478	3%	273	3%
Portsmouth, RI	439	3%	403	3%	412	3%	220	3%
Fairhaven, MA	329	2%	395	3%	379	3%	203	3%
South Dartmouth, MA	240	2%	273	2%	259	2%	160	2%
Wareham, MA	267	2%	250	2%	255	2%	141	2%
Acushnet, MA	221	1%	235	2%	211	1%	124	2%
Assonet, MA	152	1%	182	1%	195	1%	93	1%

Middletown, RI	148	1%	173	1%	174	1%	108	1%
Rehoboth, MA	150	1%	159	1%	178	1%	136	2%
Total	14,744	100%	14,384	100%	15,084	100%	8,084	100%

Charlton Memorial Hospital - YOY Procedural Volume by Payor

***Table reflects all procedural volume occurring at Charlton Memorial Hospital by Payor **Time Period: Oct 2020 – Mar 2024*

Payor	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Medicare	5,563	38%	5,254	37%	5,354	35%	2,798	35%
Medicare Managed Care	3,058	21%	2,955	21%	3,113	21%	1,746	22%
Medicaid Managed Care	1,936	13%	1,803	13%	1,937	13%	1,051	13%
BCBS MA - Commercial	871	6%	877	6%	1,037	7%	503	6%
Harvard Pilgrim - Commercial	799	5%	893	6%	817	5%	425	5%
Commercial	490	3%	592	4%	688	5%	362	4%
BCBS Other	560	4%	574	4%	583	4%	353	4%
BCBS RI - Commercial	378	3%	374	3%	407	3%	244	3%
United Healthcare - Commercial	274	2%	259	2%	288	2%	165	2%
Medicaid	258	2%	233	2%	279	2%	181	2%
Self-Pay	224	2%	193	1%	180	1%	64	1%
Tufts - Commercial	141	1%	161	1%	157	1%	70	1%
Government	86	1%	114	1%	106	1%	78	1%
Free Care / Charity	94	1%	86	1%	124	1%	39	0%
Attorney / Motor Vehicle	12	0%	16	0%	14	0%	N/A	0%
Total	14,744	100%	14,384	100%	15,084	100%	8,084	100%

Charlton Memorial Hospital - Procedural Volume by Age

***Table reflects all procedural volume occurring at Charlton Memorial Hospital by Age Cohort **Time Period: Oct 2020 – Mar 2024*

Age Cohort	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
0 - 17	28	0%	33	0%	39	0%	29	0%
18 - 64	6,667	45%	6,644	46%	7,139	47%	3,821	47%
65+	8,049	55%	7,707	54%	7,906	52%	4,234	52%
Total	14,744	100%	14,384	100%	15,084	100%	8,084	100%

Charlton Memorial Hospital - Procedural Volume by Race

***Table reflects all procedural volume occurring at Charlton Memorial Hospital by Race **Time Period: Oct 2020 – Mar 2024*

Race	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
White or Caucasian	13,275	90%	13,416	93%	13,416	89%		
Black or African American	437	3%	468	3%	468	3%		
My race is not listed	337	2%	453	3%	453	3%		
Hispanic	290	2%	198	1%	198	1%		
I choose not to answer	178	1%	223	2%	223	1%		
Asian	124	1%	146	1%	146	1%		
N/A	59	0%	129	1%	129	1%		
American Indian	37	0%	27	0%	27	0%		
All Other	7	0%	24	0%	18	0%		
Total	14,744	100%	14,384	100%	15,084	100%		

Charlton Memorial Hospital - Procedural Volume by Ethnicity **Top 10 Ethnicities

***Table reflects all procedural volume occurring at Charlton Memorial Hospital by Ethnicity **Time Period: Oct 2020 – Mar 2024*

Ethnicity	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Not Hispanic or Latino	7,334	50%	7,785	54%	9,806	65%		
American	3,688	25%	3,214	22%	2,076	14%		
Portuguese	974	7%	741	5%	502	3%		
Hispanic or Latino	420	3%	423	3%	528	4%		
Puerto Rican	141	1%	135	1%	93	1%		
European-French	165	1%	126	1%	60	0%		
European English	113	1%	71	0%	45	0%		
European-Irish	88	1%	80	1%	48	0%		
African American	90	1%	62	0%	48	0%		
Cape Verdean	49	0%	64	0%	32	0%		
Total	14,744	100%	14,384	100%	15,084	100%		

Charlton Memorial Hospital - Procedural Volume by Gender

Table reflects all procedural volume occurring at Charlton Memorial Hospital by Gender **Time Period: Oct 2020 – Mar 2024

Gender	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Female	7,341	50%	7,058	49%	7,365	49%	3,860	48%
Male	7,399	50%	7,324	51%	7,711	51%	4,197	52%
N/A	4	0%	2	0%	8	0%	27	0%
Total	14,744	100%	14,384	100%	15,084	100%	8,084	100%

Appendix B

Same Day Surgicare of New England – Surgical Patient Panel

Same Day Surgicare of New England – FY21-FY24 YTD Procedural Volume by Service Type

****Table reflects all procedural volume by Service Type occurring within Same Day Surgicare of New England **Time Period: Oct 2020 – Mar 2024**

Service Type	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Gastroenterology	3,417	60%	3,862	67%	4,478	73%	1,079	81%
Ophthalmology	770	14%	658	11%	523	9%	43	3%
Plastic/Reconstructive	682	12%	598	10%	441	7%	71	5%
Gynecology	405	7%	436	8%	518	8%	110	8%
Pain Management	250	4%	159	3%	134	2%	17	1%
ENT	91	2%	60	1%	0	0%	N/A	0%
Oral Surgery	55	1%	31	1%	21	0%	N/A	0%
All Other	3	0%	0	0%	0	0%	6	0%
Total	5,673	100%	5,804	100%	6,115	100%	1,326	100%

Same Day Surgicare of New England – FY21-FY24 YTD Procedural Volume by Payor

****Table reflects all procedural volume by Payor occurring within Same Day Surgicare of New England **Time Period: Oct 2020 – Mar 2024**

Payor	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
BCBS	1,467	26%	1,620	28%	1,732	28%	446	34%
Medicare	1,463	26%	1,258	22%	1,157	19%	195	15%
BMC (Wellsense)	656	12%	730	13%	772	13%	165	12%
United Health	499	9%	493	8%	543	9%	131	10%
Commercial	221	4%	445	8%	525	9%	74	6%
Cosmetic Self Pay	424	7%	406	7%	295	5%	38	3%
Tufts Products	307	5%	404	7%	347	6%	68	5%
Harvard Pilgrim	233	4%	248	4%	524	9%	18	9%
MassHealth	242	4%	167	3%	181	3%	30	2%
Others	161	3%	49	1%	60	1%	61	5%
Total	5,673	100%	5,820	100%	6,136	100%	1,326	100%

Same Day Surgicare of New England – FY21-FY24 YTD Procedural Volume by Age

****Table reflects all procedural volume by Age Cohort occurring within Same Day Surgicare of New England **Time Period: Oct 2020 – Mar 2024**

Age Cohort	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
0 - 17	48	3%	40	2%	25	1%	7	1%
18 - 64	1,028	60%	1,438	69%	1,526	73%	1,054	79%
65+	627	37%	602	29%	543	26%	265	20%
Total	1,703	100%	2,080	100%	2,094	100%	1,326	100%

Same Day Surgicare of New England – FY21-FY24 YTD Procedural Volume by Gender

****Table reflects all procedural volume by Gender occurring within Same Day Surgicare of New England **Time Period: Oct 2020 – Mar 2024**

Gender	FY21 (Count)	FY21 (%)	FY22 (Count)	FY22 (%)	FY23 (Count)	FY23 (%)	FY24TD (Count)	FY24TD (%)
Female	901	53%	1,261	61%	1,290	62%	892	67%
Male	802	47%	819	39%	804	38%	434	33%
Total	1,703	100%	2,080	100%	2,094	100%	1,326	100%

Appendix C

Community-High Public Payer Hospitals – Statewide Relative Price

***Table reflects Statewide (Cross-Payer) Relative Price attributed to Community-High Public Payer Hospitals in MA (Insurance Category = Commercial – Self & Fully Insured); table sorted in descending order by CY21 RP (Source: CHIA)*

Hospital	System	Public Pay (FY21)	CY17 (RP)	CY18 (RP)	CY19 (RP)	CY20 (RP)	CY21 (RP)
Falmouth Hospital	Cape Cod Healthcare	71.8%	1.394	1.391	1.450	1.438	1.480
Cape Cod Hospital	Cape Cod Healthcare	74.7%	1.304	1.312	1.339	1.350	1.360
Fairview Hospital	Berkshire Health Systems	67.0%	1.380	1.333	1.349	1.086	1.190
Steward Saint Anne's Hospital	Steward Health Care System	71.6%	0.955	0.988	0.999	1.051	1.060
Sturdy Memorial Hospital	Sturdy Memorial Foundation	65.0%	1.023	1.102	1.124	1.088	1.060
Berkshire Medical Center	Berkshire Health Systems	72.6%	1.235	1.231	1.215	1.019	1.040
Steward Good Samaritan Medical Center	Steward Health Care System	69.8%	0.916	0.872	0.974	1.005	0.980
Baystate Franklin Medical Center	Baystate Health	72.7%	1.047	1.110	1.002	0.967	0.960
North Shore Medical Center	Mass General Brigham	70.0%	1.000	1.000	0.980	0.962	0.960
Steward Holy Family Hospital	Steward Health Care System	69.5%	0.873	0.853	0.907	0.950	0.950
Marlborough Hospital	UMass Memorial Health Care	66.1%	0.878	0.876	0.908	0.907	0.940
Morton Hospital	Steward Health Care System	69.0%	0.848	0.835	0.912	0.928	0.940
Nashoba Valley Medical Center	Steward Health Care System	64.3%	0.952	0.867	0.897	0.898	0.940
Cooley Dickinson Hospital	Mass General Brigham	70.4%	1.068	1.067	1.011	0.975	0.920
MetroWest Medical Center	Tenet Healthcare	66.6%	0.897	0.953	1.003	0.931	0.920
Beth Israel Deaconess Hospital - Plymouth	Beth Israel Lahey Health	68.7%	0.869	0.905	0.881	0.939	0.910
Athol Memorial Hospital	Heywood Healthcare	70.1%	0.901	0.797	0.825	0.861	0.900
Melrose Wakefield Healthcare	Tufts Medicine	65.0%	0.916	0.915	0.924	0.920	0.900
Signature Healthcare Brockton Hospital	Signature Healthcare Corporation	76.0%	0.798	0.808	0.827	0.889	0.900
Harrington Memorial Hospital	UMass Memorial Health Care	68.8%	0.895	0.852	0.841	0.894	0.850
HealthAlliance-Clinton Hospital	UMass Memorial Health Care	72.8%	0.827	0.866	0.807	0.859	0.850
Northeast Hospital	Beth Israel Lahey Health	65.0%	0.847	0.857	0.832	0.858	0.850
Mercy Medical Center	Trinity Health	77.1%	0.785	0.792	0.838	0.829	0.840
Southcoast Hospitals Group	Southcoast Health System	74.6%	0.868	0.875	0.824	0.856	0.830
Lawrence General Hospital	Lawrence General Hospital and Affiliates	75.8%	0.739	0.790	0.777	0.823	0.810
Lowell General Hospital	Tufts Medicine	66.5%	0.789	0.826	0.846	0.847	0.810
Holyoke Medical Center	Valley Health System	79.8%		0.771	0.727	0.726	0.760
Baystate Wing Hospital	Baystate Health	70.5%	0.840	0.786	0.773	0.734	0.740
Baystate Noble Hospital	Baystate Health	69.1%	0.684	0.718	0.736	0.692	0.730
Heywood Hospital	Heywood Healthcare	66.8%	0.712	0.728	0.719	0.728	0.730

Appendix D

Ambulatory Surgery – Forecasted Volume & Growth in Primary Service Area

***Table reflects Forecasted Ambulatory Surgery Center Volume & Growth within Southcoast Health's Primary Service Area (Source: Advisory Board – Market Scenario Planner)*

Service Line	2022 Volume	2027 Volume	2032 Volume	5 Yr. Growth	10 Yr. Growth
Spine	443	656	866	48.0%	95.4%
Pain Management	2,812	3,529	4,099	25.5%	45.7%
Orthopedics	12,632	14,587	16,286	15.5%	28.9%
Vascular	3,201	3,704	4,112	15.7%	28.5%
Ophthalmology	8,286	9,511	10,581	14.8%	27.7%
General Surgery	1,484	1,684	1,868	13.5%	25.9%
Gastroenterology	4,437	4,960	5,326	11.8%	20.0%
Podiatry	1,513	1,658	1,790	9.6%	18.3%
Neurosurgery	362	386	417	6.5%	15.2%
Trauma	895	944	998	5.5%	11.4%
ENT	10,379	10,810	11,246	4.1%	8.4%
Dermatology	5,515	5,743	5,934	4.1%	7.6%
Urology	6,328	6,596	6,752	4.2%	6.7%
Cosmetic Procedures	4,173	4,322	4,344	3.6%	4.1%
Gynecology	2,567	2,583	2,644	0.6%	3.0%
Thoracic Surgery	103	106	105	3.3%	2.0%