1. You have described a wait time of 1-2 weeks for hand surgery, and several weeks for other types of orthopedic surgeries. Please explain the impact of these wait times on the proposed patient panel if any.) How will you measure improved wait times for surgery for the proposed project relative to the *status quo*?

   The wait times noted in the application narrative are based on anecdotal input from the surgeons that plan to perform surgeries at the proposed surgery center. Historically, their patients have had to delay surgeries until such time that the local hospital-based operating rooms can accommodate their surgery. As noted in the narrative, ASCs are able to adhere more uniformly to a surgical schedule due to lack of higher acuity, trauma or urgent surgeries, which ultimately can allow more surgeries to be scheduled in a day. As such, the ASCs can expedite the scheduling process and allow patients to receive treatment in a timelier manner. Longer wait times result in decreased patient satisfaction[1], and are associated with higher rates of medical complications[2]. Decreased wait times allow patients to quickly get back to work, life or sport. The proposed ASC will monitor the time from scheduled surgery to the time of the procedure using the centers Electronic Medical Record System. This will allow the applicant to continuously monitor wait time performance against our established benchmark.

2. Please provide additional explanation of what appears to be an adaptation of the Advisory Board's methodology to project ASC utilization by specialty. Has this methodology been reviewed and tested in a broader context than in Massachusetts? Please further explain the Advisory Board's 66,159 patients (p4), and whether they are included in the projections or additional to the totals provided in Table 4?

   It is important to note that the volume shown in year 2 of the application is based on existing volume currently performed by the surgeons that plan to perform surgeries at the proposed ASC. This volume is only a portion of the total surgical volume performed by these surgeons as we excluded cases that were not deemed ASC eligible. The definition of ASC eligible is dictated by cases that are currently reimbursable under the Medicare ASC fee schedule, lower patient acuity (ASA <3), and patient origin (within ASC Primary Service Area).

   The applicant utilized the Advisory Board's Market Scenario Planner tool to provide insight on anticipated growth in years 3 and 4. The Advisory Board tool allows users to specifically identify projected utilization within a zip code defined service area – in this case the, the proposed Primary Service Area. Further, the tool can be adjusted to focus on the procedures that are anticipated at the proposed ASC. These Advisory Board's supplied growth rates based on these criteria were subsequently applied to the baseline (year 2) volume. The growth rates provided by the Advisory Board are based on a proprietary algorithm that factors demographic, epidemiologic, and regulatory influence on the PSA and procedure specific utilization over the next 5 years. The 66,159 surgical cases noted in the application is the aggregate of the Advisory Board's estimated

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5513615/
[2] https://www.ncbi.nlm.nih.gov/pubmed/21844548

current total surgical cases that could be performed at the proposed ASC. This figure is meant to offer context of the proposed surgery center's position in the market. Our assumption is that this tool and subsequent methodology is an industry accepted best practice and widely utilized both inside and outside of Massachusetts.

3. You have stated that having greater ability to manage costs for ACO and other managed care patients was a rationale for the proposed project, while these patient types account for approximately 20% of the payer mix. What is the anticipated growth rate for ACO/Managed care patients vs. fee-for-service patients for the proposed project?

   As noted in a previous dialogue with the DPH, the applicant believes the number of patients in risk (Managed) contracts will continue to grow in the years ahead. This is supported by several industry supplied and accepted statistics. Most notably, the CMS has championed the move to value-based payments, meeting its goal to tie 30% of reimbursements to alternative payment models by 2016. The agency hopes to increase this percentage to 50% in the years ahead. According to an analysis of Leavitt Partners' ACO database, the growth of covered lives under ACO management (risk arrangements) has increased by ~6% compared to 2017. Given the triple aim objective of payment reform – 1)Better Outcomes, 2)Better Experience, 3) Lower Costs; The applicant believes that the proposed ASC is well positioned to facilitate the change in care delivery and address needs of the growing panel of patients in risk contracts.[3] [4] [5] Data from our ACO partners associated with the application suggest a sustained growth of 2%for members in managed contracts.

   It is also important to note that the downstream cost reduction offered by the ASC would not only be limited to patients in managed/risk arrangements. The reduced cost structure associated with the proposed ASC translates to reduced out-of-pocket expense for patients in traditional fee-for-service arrangements in the form of lower deductibles and copays. [6]

4. Please describe your social determinants of health (SDOH) referral process. The Application states that patients are screened for SDOH post-surgical needs related to prior to discharge. How are you able to ensure that patients can obtain needed services at that late date? How will you track the effectiveness of this process?

   Appropriate and high-quality care for our patients is paramount – particularly for those patients impacted by social determinants of health. The applicant's Administrative, Nurse Management, and Care Management teams will establish a proactive dialogue with primary care practices and social work resources within the referral networks directing patients to the ASC. This communication can be technology enabled by relaying patient specific needs prior to their procedure via HL7 based notes on their medical record or other means of secure information

[3] https://www.managedhealthcareexecutive.com/benefit-design-and-pricing/value-based-payment-update-where-we-are-and-who-most-successful
[4] https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/
[5] https://www.healthaffairs.org/do/10.1377/hblog20170203.058589/full/
[6] http://www.piercestreetsurgery.com/ascs-reduce-out-of-pocket-costs-for-patients-with-private-health-insurance/

exchange. Through this process, the proposed ASC will work with the referring community to ensure that unique patient specific needs related to social determinants of health are addressed early in their engagement with the ASC. As noted in the application, this communication plan includes a discharge evaluation by the case manager to evaluate each patient that may be impacted by a social determinant of health post-discharge. This longitudinal approach ensures that engagement and intervention is available to the patient throughout the care continuum. If additional resources are required to address the patient's needs, the proposed ASC will have the technology enable communication infrastructure to ensure a seamless recovery plan. The proposed ASC will track the effectiveness of this process through continuous engagement via post-discharge follow-up phone call. Depending on the patients specific needs, the propose ASC is prepared to follow-up multiple times to ensure that the recovery of at-risk patients is going smoothly. The patient's ASC based care team may reach out to the referring provider or other social support services to coordinate additional care as needed.

5. Given the suburban location of the proposed project, how will patients without transportation have access to your facility?

   The majority of patients that will be receiving care at the proposed ASC will be recovering from general anesthesia. As such, our policy requires that any patient receiving care at the surgery center is accompanied by a family member or other home care individual. Given the nature of the care provided at the proposed ASC, it will be the patient's responsibility to acquire transportation to and from the surgery center – ideally from this same individual. Our research suggests that this policy is no different than most hospitals or other ASCs. In the rare occurrence that a patient is unable to find transportation, the ASC would require the patient to remain in the post-operative care unit until such time that the Head of Anesthesiology can sign-off on their discharge and send the patient home via cab or ride-share.

   The proposed ASC will provide pre-operative phone call, usually the day before surgery. The patient will be informed of needing to have a ride and someone accompanying them at the time of check-in on the day of surgery. If the ride, or person, are not present the surgeon will have to determine if it is safe to proceed given the patient's situation.

6. What percentage of the patient panel received surgeries at the HOPD rate rather than the ASC rate? How will you measure efficiencies and savings associated with this project?

   100% of the patients referenced in the year 2 baseline volume assumption receive their care at a hospital under the HOPD rate, and will continue to do so until a free standing ASC, under ASC reimbursement model, is available to this patient panel. As noted in the application, the same care performed at HOPD rates cost as much as 48% higher for a Medicare patient. For example, a $1,000 procedure as the ASC will cost $1,480 at a Hospital Outpatient Department; meaning a savings of $480.

7. You describe that access will be improved with price transparency on your website. Please provide more information on how you will ensure price transparency. What will be posted on your website, and will patients have access to that information prior to registration? Will prices be

compared to other settings? Does your price transparency tool accommodate various levels of financial literacy? How is access to financial counseling ensured?

Currently we offer a price transparency tool for Shields Health Care imaging services and we are working on adding in the option for pricing information for ambulatory surgery services. When this is complete, a price transparency tool will be available on the surgery center website to any person who wishes to use it. The tool requests specific information from the patient (i.e., insurance plan) that is needed to calculate their estimate. The pricing received by the patient gives specific out-of-pocket cost of their exam based on their insurance. A person does not have to be a patient with a scheduled procedure to obtain this information, and it will be available to all consumers. The pricing tool does not compare our cost with other providers. This would be a helpful feature, but because pricing information of other providers is proprietary, it is not available in any of the price transparency tools we have viewed. We may consider referencing resources that elaborate on freestanding ASC vs. HOPD pricing as a means to offer context for pricing. If a patient is confused about the estimate or would like to discuss payment options then they are directed to call our Patient Financial Services team to walk through the details. The Patient Financial Services team member can also discuss Medicaid Eligibility, HSA Funds, Care Credit Financing and Payment Plans.

8. You state that you will not discriminate based on ability to pay, but also that patients will have access to prices of procedures to understand the affordability of their care. How will patients who cannot afford the cost receive needed treatment?

   The ASC will have programs in place to assist patients in understanding payment options for procedures. For example, ASC staff will explain to qualifying patients their eligibility for MassHealth and how to complete a MassHealth application. Moreover, staff will provide patients with information on financing and payment plans, so payment for services is not due immediately, making procedures more affordable and therefore feasible for some patients. Finally, the ASC will accept all types of insurance.

9. How will you measure improved patient clinical and functional outcomes for surgeries performed at this ASC compared to the status quo? Please provide a measure(s) upon which you will assess clinical and functional outcomes with baselines and benchmarks.

   The administrative team has identified over 50 primary metrics to continuously monitor the clinical and functional performance of the proposed ASC. These metrics range from Cost per Case, OR Time, On-Time Starts, and Block Utilization – all the way to clinical outcomes such as Patient Burns, Patient Falls, Post-Op Bleeding, Hospital Transfers, and Medication Errors. These metrics are in addition to the quality metrics already noted in the application. Most (if not all) of these metrics have industry defined benchmarks or historical performance to measure success. Our objective is to meet or exceed these benchmarks and offer the highest value care to our patients.

10. As an ASC that is not affiliated with a larger health care system, how will surgeons operating at the proposed location ensure that they are part of each patients' extended care team?

As noted previously, the care team will establish a robust dialogue and communication plan with the patient's specialist, PCPs and social workers as needed. This longitudinal communication plan covers the pre-admission and post discharge time-frame to offer a holistic engagement process that ensures the highest quality of care. Communication is enabled through a strong technology infrastructure that allows surgeons to share Operation Notes, Discharge Instructions and even Video-Based consultation and follow-up. All of this information is can be shared via secure web-based portal, email or EMR system.

11. How will the health record for the ASC patients be integrated with patients' primary care records for ACO, managed care and for fee for service patients? Will electronic interfaces be developed to ensure interoperability?

    Shields will implement the ability to exchange data into and out of the surgical facility. Shields will take advantage of the HL7 standard and SFTP for data exchange to assure that there is interoperability between the surgery center and the referring community. Shields and its partner will link medical record numbers so that the demographic and patient information can be synced between systems. To assure a complete medical record the information product from the surgery, operation notes and relevant images, will be electronically shared between EHRs.

12. Where will patients requiring diagnostic imaging before, during, and after surgery obtain the necessary studies? How will these results be integrated into their medical records?

    Typically, a PCP will refer patients requiring diagnostic imaging to a specialist, and the specialist will order imaging at a location convenient to the patient. There are many alternatives for imaging in the proposed ASC primary service area. The specialist will confirm he/she has access to the imaging report in advance of the schedule surgery. The image can be electronically incorporated into the patients' medical record, whether received electronically, or via disc or hard copy. Systems employed by the proposed ASC including Nuance are designed to facilitate the incorporation of the Medical Image into a patient's medical record

13. Please explain whether the participating physicians explored the possibility of obtaining privileges to perform surgeries and treating patients at other ASCs in the vicinity and why this was not presented as an option in the Relative Merit portion of the application?

    To our knowledge, this is on the only freestanding ASC offering the identified services in the defined Primary Service Area. The surgeons participating in the proposed ASC are free to maintain privileges at additional sites. However, the PSA for the proposed ASC was defined by the patient origin representing ~75% of the panel treated by the participating surgeons. As such, the relative merit of the proposed ASC is strictly in contrast to HOPD based sites of care.