NEW ENGLAND SURGERY CENTER, LLC

DoN APPLICATION# -20072809-AS

ATTACHMENTS

APPLICATION FOR DETERMINATION OF NEED FOR

AMBULATORY SURGERY SERVICES

August 14, 2020

BY

NEW ENGLAND SURGERY CENTER, LLC

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BEVERLY, MA 01915

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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.

New England Surgery Center serves patients 4 years and older with multiple range of needs, as demonstrated by the patient demographic information for the period for FY2017-2019 which is included in the Determination of Need application.

During this time period, NESC has served 3,752 individuals. NESC served, 1427 patients in FY 2017, 1,301 in FY2018, and 1,024 in FY2019

Since 2017, NESC providers have performed increasingly more complex procedures which require more OR time per procedure. Specifically:

- NESC has shifted from patient pain injections towards providing more advanced pain procedures that require the use of insertable devices that are placed into the patient's spine (i.e. neurostimulators implants, Superion Vertiflex[1] procedures, and MILD [2]procedures.) While pain injections take approximately 30 minutes per patient from registration to discharge, these spine procedures are more complex and require greater OR time Mild procedures have scheduled OR time of one hour, neurostimulator implants and Vertiflex procedures have scheduled OR time of two hours.
- A change in otolaryngology procedures from high-volume pediatric care including tubes, tonsils and adenoids to more complex frontal sinus surgeries. Insertion of tubes bilaterally requires approximately 30 minutes of OR time, while sinus surgery may require three hours in the operating room. Both require general anesthesia.
- Although procedure volume is down, scheduled time in the OR remains high due to the complexity of the current case load. With the recent addition of four general surgeons and three orthopedic surgeons who perform cases requiring general anesthesia, the center will quickly have a lack of time available in the one OR that is equipped for general anesthesia. The general surgeons are projected to bring ten to fifteen new cases per month. This will bring the NESC operating room near its maximum capacity. The additional surgeries are anticipated to include large mass removal, open hernia repairs, breast biopsies and hemorrhoid procedures. These procedures are not appropriate for the surgeon's office and moving these cases to NESC will provide patients with a lower cost, high quality alternative to the hospital outpatient facility.

[1] CMS ClinicalTrials.gov Identifier NCT03072927
[2] National Coverage Determination (NCD) for Percutaneous Image-guided lumbar decompression for lumbar spinal stenosis (150.13) 12/7/2016

- The orthopedic surgeons will perform arthroscopic shoulder and knee procedures along with closed reductions of wrist/arm and foot/ankle under general anesthesia.
- With the additional volume from these new surgeons, NESC expects demand for the operating room equipped for general anesthesia will meet or exceed its capacity. Currently the operating room is seeing reserved time usage at 58-62% with cases running an average of 60 minutes. Taking into account 15-minute turnovers, the number of cases that would require general anesthesia is limited to 6 per day.[3]

Patient Panel.

Patient Age and Gender. Of those NESC patients served between 2017 and 2019, 48% (1,811) were male, and 52% (1,941) were female.

Patients by Gender	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
Female	748	52%	677	52%	516	50%	-31%
Male	679	48%	624	48%	508	50%	-25%
Total	1,427	100%	1,301	100%	1,024	100%	-28%

For the period from FY 2017 through FY 2019 NESC experienced a decline of 28% in patients served, as noted above. All cohorts declined, although the decline was sharpest in the number of patients aged 0 to 17, consistent with the previously-described shift away from uncomplicated pediatric otolaryngology services, to more complex frontal sinus cases and the move of the otolaryngologist doing the bulk of these cases. Additionally, in 2018 one of the otolaryngologists left his practice and moved to France.

In FY2019, 9% of NESC patients were younger than 18 years of age, 58% were aged 18 to 64, and 32% were aged 65 years old or older.

Patients by Age Cohort	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
0-17	134	9%	100	8%	96	9%	-28%
18-64	746	52%	679	52%	598	58%	-20%
65+	547	38%	522	40%	330	32%	-40%
Total	1,427	100%	1,301	100%	1,024	100%	-28%

[3] https://www.impact-advisors.com/implementation/surgical-block-utilization/

Patients by Self-Reported Race/Ethnicity. NESC's patient panel includes patients from many races. Self-reported patient data indicates that in 2019, 90% of patients were non-Hispanic white, 4% were Hispanic, 2% were Black, 2% were multiracial, 1% were Asian and 1% were of another race. This reflects 768 patients, or 75% of 1,024 patients served in 2019.

Race or Ethnicity*							
Self-Reported Race/Ethnicity	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
White	515	89%	637	88%	691	90%	34%
Spanish/Hispanic/Latino	19	3%	35	5%	33	4%	74%
Other	23	4%	8	1%	4	1%	-83%
Multiracial	3	1%	12	2%	15	2%	400%
Asian	5	1%	12	2%	10	1%	100%
Not Specified	7	1%	17	2%	0	0%	-100%
Black/African American	3	1%	5	1%	15	2%	400%
Native	1	0%	0	0%	0	0%	-100%
Total Respondents	576	100%	726	100%	768	100%	33%

Patients by Self-Reported Language. Nearly all patients speak English as primary language. One percent of patients speak Spanish, and one percent report speaking Portuguese as primary language.

Primary Language*							
Self-Reported Primary Language	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
English	1,162	98%	1,073	98%	1,004	97%	-14%
Spanish	9	1%	16	1%	14	1%	56%
Portuguese	3	0%	1	0%	6	1%	100%
Russian	2	0%	1	0%	3	0%	50%
Arab	3	0%	0	0%	1	0%	-67%
Italian	2	0%	1	0%	0	0%	-100%
Greek	0	0%	2	0%	0	0%	0%
Cantonese	0	0%	1	0%	0	0%	0%
German	1	0%	0	0%	0	0%	-100%
Crotian	1	0%	0	0%	0	0%	-100%
Hatian/Creole	0	0%	0	0%	0	0%	0%
Albanian	0	0%	0	0%	0	0%	0%
Asian	0	0%	0	0%	0	0%	0%
Other	1	0%	5	0%	3	0%	200%
Total Respondents	1,184	100%	1,100	100%	1,031	100%	-13%

*Not all patients responded

Patient Origin. NESC attracts patients primarily from Essex County. 87% of patients served between 2017 and 2019 lived in Essex County. In 2018, 75% of patients travel from fourteen communities: Beverly (144 patients,) Gloucester (126,) Lynn (89,) Peabody (84,) Danvers (76,) Salem (70,) Wilmington (70,) Marblehead (38,) Ipswich (36,) Manchester (31,) Rockport (28,) Swampscott (24,) Middleton (24,) and Topsfield (18.)

A count of patients by zip code is included in the appendix.

Payor Mix. NESC accepts: Medicare, Commercial, Medicaid, Workmen's Compensation and Self-Pay payments.

In FY 2019, 51% of cases were paid by commercial payor, 30% by Medicare, 12% by Medicaid, 6% by Workmen's Compensation and 2% were self-pay.

Patients by Payment Source							
Payment Source	2017		2018		2019		3-Year Change
	#	%	#	%	#	%	
Medicare	566	40%	545	42%	306	30%	-46%
MassMedicaid	197	14%	125	10%	118	12%	-40%
BCBS	272	19%	248	19%	285	28%	5%
Tufts	71	5%	111	9%	75	7%	6%
Harvard Pilgrim	79	6%	70	5%	52	5%	-34%
United Health	43	3%	33	3%	47	5%	9%
Cigna	25	2%	27	2%	17	2%	-32%
Aetna	19	1%	1	0%	16	2%	-16%
Other Commercial	75	5%	58	4%	27	3%	-64%
Workmen's Comp	66	5%	64	5%	65	6%	-2%
Self Pay	14	1%	19	1%	16	2%	14%
Total	1,427	100%	1,301	100%	1,024	100%	-28%

Patient Diagnosis. The most prevalent patient diagnoses are related to otolaryngology, urology, ophthalmology, pain management and orthopedics. Among the top diagnoses for each group are:

Otolaryngology: septal deviation, hypertrophy of tonsils with hypertrophy of adenoids, acute tonsillitis and fracture of nasal bones

Urology: calculus of kidney, enlarged prostate with lower urinary tract symptoms, male/female incontinence

Ophthalmology: dermatochalasis, myogenic ptosis, and senile ectropion of the eyelid

Pain management: spinal stenosis, post laminectomy syndrome, radiculopathy

Orthopedics: rotator cuff tear or rupture of shoulder, carpal tunnel syndrome, shoulder instability, and meniscus tears

A list of the top ten diagnoses for each service line is included in the Patient Panel Data under local or monitored anesthesia. The new spine implant cases are moving into the OR and performed with general anesthesia, preventing involuntary movement by the patients. Safety is of the utmost importance in spine cases.

With the addition of four general surgeons, performing biopsies, large mass removal and open hernias NESC will experience a shortage in available OR time.

TOTAL PATIENT PANEL							
Specialty	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
Otolaryngology	425	30%	329	25%	294	29%	-31%
Urology	334	23%	355	27%	209	20%	-37%
Ophthalmology	237	16%	275	21%	207	20%	-13%
Pain Management	274	19%	153	12%	125	12%	-54%
Orthopedics	131	9%	147	11%	138	13%	5%
Podiatry	28	2%	43	3%	26	3%	-7%
Anesthesia	7	0%	20	2%	0	0%	-100%
Plastics	1	0%	2	0%	18	2%	1700%
General	0	0%	0	0%	6	1%	N/A
Unclassified	0	0%	0	0%	1	0%	N/A
Total	1,437	100%	1,324	100%	1,024	100%	-29%

The specialties of urology and pain management have patients who require multiple visits, the overall case numbers are 2017 – 1621 visit; 2018 – 1500 visits and 2019 – 1474

Additional detail on procedures performed by specialty is included in the patient panel data.

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.

Demand for Ambulatory Surgery Centers (ASCs) is projected to rise in coming years. A study by Berkeley University of California states that as America's baby boomers age (those born between 1946 and 1964), there is increasing demand for the services ASC's provide. More than 49 million people, or 15% of the U.S. population, are now 65 or older. The share of Americans 65 and older will grow from 15% in 2016 to 24% of the overall population in 2018. Among the factors causing the increase in utilization are a growing older adult population, the increased prevalence of certain diseases (1, 2, 3, 4, 5), a shift in surgeries from an inpatient to outpatient setting due to technological developments and evidence-based improvements in surgical techniques, a continued focus on increasing value and controlling cost of care, and consumer preference. (6, 7, 8, 9, 10, 11)

Increased demand due to population growth. More than 85% of NESC patients live in Essex County. The county's total population in 2015 was 783,531 persons. While the total population is projected to grow at a modest rate of 2% over 5 years, the older adult population is projected to grow at a brisk pace of 16% between 2020 and 2025. This cohort aged 65+ represents a growing proportion of NESC patients, and use health care services, including outpatient surgery, at a high rate. (12)

Population in Essex County*, 2015 to 2025 (13)

	Essex County Population			
	All Ages	<20	20-64	65+
Essex County 2015	783,531	139,925	516,061	127,545
Essex County 2020	798,824	138,561	509,965	150,298
Essex County 2025	813,666	135,517	503,118	175,031
2015-2020 Projected Growth	15,293	-1,364	-6,096	22,753
2015-2020 Projected Growth %	2%	-1%	-1%	18%
2020-2025 Projected Growth	14,842	-3,044	-6,847	24,733
2020-2025 Projected Growth %	2%	-2%	-1%	16%
10-Year Projected Growth	30,135	-4,408	12,943	47,486
10-Year Projected Growth %	4%	-3%	-3%	37%

*87% of NESC patients travel from one of these counties.

(1) Eric N. Taylor, MD; Meir J. Stampfer, MD, DrPH; Gary C. Curhan, MD, ScD, Obesity, Weight Gain, and the Risk of Kidney Stones." JAMA. 2005;293(4):455-462 accessed at https://jamanetwork.com/journals/jama/fullarticle/200248 .

(2) Hootman, Jennifer, Helmick, Charles et. al, "Updated Projected Prevalence of Self-Reported Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation Among US Adults, 2015–2040," Arthritis & Rheumatology, March 25, 2016. Population data from UMass Donahue Institute.

(3) Taylor et al.

(4) Laxmaiah Manchikanti, MD1,2, Vidyasagar Pampati, MSc1, Frank J.E. Falco, MD3, and Joshua A. Hirsch, MD4, "Updated Assessment of Utilization of Interventional Pain Management Techniques in the Medicare Population: 2000 – 2013," Pain Physician 2015; 18:E115-E127.
(5) "Study Forecasts New Breast Cancer Cases by 2030," National Cancer Institute website at https://www.cancer.gov/news-events/cancer-currents-blog/2015/breast-forecast accessed on 9-15-2019.
(6) MedPAC Report to Congress, March 2019, Chapter 5, p. 134
(7) Dyrda, Lauren, "10 Key Trends for ASCs and Outpatient Surgery in the Next 10 Years, Beckers's ASC Review, obtained from beckersasc.com
(8) Samii, Nader, "The Evolution of Total Joint Replacements from the Hospital to the Surgery Center, Becker's ASC Review, February 19, 2019, obtained from beckersasc.com
(9) MedPAC Report to Congress, March 2019. Figure 5-1, Number of ASCs per Beneficiary Varies Widely Across States, p.133.
(10) Hollenbeck, Brent K et al, "Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery, published in Health Services Research October 2015. Obtained from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4600358/
(11) "Commercial Insurance Cost Savings in Ambulatory Surgery Centers," published by Healthcare Bluebook. Ambulatory Surgery Center Association, and Healthsmart, June 2016.
(12) Relin Yang, MD, MPH, Matthew Wolfson, and Michael C. Lewis, MD, "Unique Aspects of the Elderly Surgical Population An Anesthesiologist's Perspective," Geriatric Orthopedic Surgery & Rehabilitation. 2011 Mar; 2(2): 56–64. Accessed from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3597305/#bibr4-2151458510394606 on 1-2-2019.
(13) UMass Donahue Institute

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 lower construction cost of this project, and the overall lower cost of care to both payers and patients, will ensure that the proposed project will compete with other providers on the basis of price, medical expenses, provider costs and other quality measures.

Projected Cost of Construction. The Applicant has an opportunity to utilize available space within its footprint and this offers a cost-effective option to add needed ambulatory surgery capacity. NESC is requesting approval to add an operating room utilizing general anesthesia, one enclosed pediatric room for both pre-op/post-op usage, two additional post-op beds, a new enlarged central sterile area, and relocate office area within the existing footprint of the building, which will result in significantly lower construction costs compared to construction of an addition. The shell space where these new areas will be located is adjacent to the original construction, which was completed prior to Determination of Need Requirements being applicable to the Applicant, and was acquired due to lack of storage and office space. This space was included on original drawings for the current center as a plan for future growth. NESC is working with WEL Designs, who specializes in facility consulting and design for healthcare, and projects that the buildout of this space could be accomplished with little or no effect on the daily workings of the current facility.

Cost of Care to Payers and Patients: In its March, 2019 report to Congress, ASCA MedPAC stated "evidence suggests that ASCs are a lower cost setting than HOPDs."(1) Nationally, shifting appropriate procedures to ambulatory surgery centers may reduce healthcare costs by nearly $40 billion, including $5 billion for patient out of pocket copayments and deductibles. (2)

The American College of Surgeons estimated that as many as 40% of hospital outpatient surgeries could be performed in an ambulatory surgery center at 40% to 70% of the cost. (3) There are many reasons for this price difference. Ambulatory surgery centers typically provide a limited range of surgeries and procedures, allowing centers to design for improved efficiency for those procedures and greater standardization of care. Surgery takes less time in an ASC than in a hospital outpatient setting. (4) This creates the opportunity to reduce staffing and fixed costs per case.

In order to ensure that costs are optimized, NESC moved from Novation to the HealthTrust Group Purchasing organization in May, 2016. Supply cost savings were 5.6% in 2016, 25.5% in 2017 and 24.9% in 2018. All requests for new supplies and equipment require a thorough review involving an evaluation of cost, clinical efficacy and ease of use for clinicians.

Medicare reimburses ambulatory surgery centers at rates that are 50% of the reimbursement rates for the same procedure performed in a hospital outpatient department. (5) For many surgeries, Medicare beneficiaries pay a lower copayment for surgeries performed in an ASC that in a hospital outpatient setting. (6)

CMS's Medicare Procedure Price Lookup shows a significant difference in the average price and copay in an ambulatory surgery center versus a hospital outpatient department. Following are a Medicare Fee for Service prices and copays sample of common orthopedic procedures. (7)

Procedure	Ambulatory Surgery Center (Average)			Hospital Outpatient Department (Average)		
	Total	Medicare Payment	Copay	Total	Medicare Payment	Copay
Repair of shoulder rotator cuff using endoscope	$2,803	$2,242	$560	$5,981	$4,785	$1,196
Arthroscopy, knee, surgical (medial or lateral)	$1,286	$1,029	$257	$2,737	$2,189	$547
Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method	$1,286	$1,029	$257	$2,737	$2,189	$547
Suture of quadriceps or hamstring muscle rupture; primary	$2,803	$2,242	$560	$5,981	$4,785	$1,196
Removal of deep bone implant	$994	$795	$198	$2,318	$1,855	$463

Medicare, many commercial insurers, and some employers are increasing coverage for services at ambulatory surgery centers to encourage patients to seek care in the most cost-effective appropriate setting. (8) The Applicant has value-based contracts (Medicare, Blue Cross, Tufts Medicare Preferred and participates with numerous MassMedicaid products) and continues to strive to lower cost and provide high quality, accessible services.

(1) MedPAC Report to Congress, March 2019, Chapter 5, p. 134.

(2) "Commercial Insurance Cost Savings in Ambulatory Surgery Centers," published by Healthcare Bluebook. Ambulatory Surgery Center Association, and Healthsmart, June 2016.

(3) O'Neill, Sean M., M.D, Ph.D., Frencher, Stanley K., MD, PhD, et al., "Should your health care system invest in an ambulatory surgery center? A decision-making framework," Bulletin of the American College of Surgeons, November 1, 2017.

(4) Hall, Margaret J., PhD et al, "Ambulatory Surgery Data from Hospitals and Ambulatory Surgery Centers: United States, 2010," National Health Statistics Reports No. 102, February 28,2017, p. 5.

(5) Stewart, Angie, "HOPD vs. ASCs: 5 Insights on the Reimbursement Gap," Becker's ASC Review, 4/6/2018.

(6) MEDPAC, p. 134.

(7) Medicare.gov website. National average prices are based on 2019 Medicare payments and copayments, and do not include physician fees.

(8) Ambulatory Surgery Center Association, "Ambulatory Surgery Centers: A Positive Trend in Health Care", p.2

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 proposed reconfiguration of existing space to create an additional operating room responds to the health needs of aging population. The population aged 65+ is projected to grow by 37% over 10 years from 2015 to 2025. For many conditions including arthritis and cancer, increased age is correlated with higher disease prevalence. (1, 2) This suggests that the demand for services is likely to increase faster than the population.

The Robert Wood Johnson Foundation County Health Rankings estimates that 25% of Essex County adults are obese, with a Body Mass Index of 30 or higher. Increased weight puts individuals at greater risk of osteoarthritis, cancer, diabetes, poor health status, and other conditions. (3)

The proposed project will create space for additional surgeries, being generated by the addition of a general surgery group (four surgeons) and an additional three surgeons from an orthopedic group already affiliated with the center. This project will provide increased capacity to meet the projected growth in demand for musculoskeletal procedures, breast biopsies, mass removal, kidney stones and cancer.

Research has shown that patients in an outpatient setting, as compared to inpatients, report increased satisfaction with the care they received. Since opening, NESC patient satisfaction survey scores affirm this with 95% for "overall Quality" and "Willingness to Recommend". ASCs offer a more consumer-centric setting with minimally invasive procedures which enable them to return home the same day. (4) As noted previously, the patient's out of pocket cost for care in an ASC is lower than in a hospital setting. (5)

Patient Satisfaction

Patients receive a satisfaction survey as part of the packet they receive upon discharge from the facility. They also have the option of an online survey provided through out registration software, One Medical Passport. As the table below shows, patients are extremely happy with their treatment and are happy to recommend the center.

Date of Report	Patient Satisfaction%	% Returned
March 2017	100	24
October 2017	100	10
December 2017	100	22
March 2018	96	22
July 2018	100	23
October 2018	100	27
December 2018	100	37
March 2019	100	33
June 2019	99.75	27.6
September 2019	100	27

ASCs offer quality outcomes which are comparable to outcomes for outpatient surgery in a hospital setting. (6) There are two robust ASC quality reporting programs that make their results accessible online: Medicare's Ambulatory Surgical Center Quality Reporting (ASCQR) Program and a program coordinated by the ASC Quality Collaboration (ASC QC). According to the published findings of both programs, the incidences of unplanned or adverse events that occur in ASCs is extremely low. (7) ASCs also report quality metrics equal to or better than other sites of care, including hospitals.

(1) Arthritis: Centers for Disease Control, Arthritis-Related Statistics, accessed from https://www.cdc.gov/arthritis/data_statistics/arthritis-related-stats.htm on 9-15-2019.

(2) Cancer: National Cancer Institute, Age and Cancer Risk from https://www.cancer.gov/about-cancer/causes-prevention/risk/age, accessed 9-15-2019

(3) Https://www.countyhealthrankings.org/app/massachusetts/2019/rankings/essex/county/outcomes/overall/snapshot

(4) Hollenbeck, Brent K et al, "Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery, published in Health Services Research October 2015. Obtained from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4600358/

(5) "Commercial Insurance Cost Savings in Ambulatory Surgery Centers," published by Healthcare Bluebook. Ambulatory Surgery Center Association, and Healthsmart, June 2016.

(6) Hollenbeck, et al.

(7) https://www.advancingsurgicalcare.com/safetyquality/ascqualityreporting

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.

The addition of one operating room, two pre-op/post-op beds and one enclosed recovery bay will allow NESC to increase volume and expand services which improve the health and quality of life of a broader patient panel. The proposed project will also allow NESC to recruit and retain surgeons and continue to offer a full range of outpatient surgical procedures to patients. The previously mentioned growth projections would place greater constraints on the existing single operating room thereby reducing potential block time and directly impacting the ability of the surgeons to perform procedures in a setting that is more convenient to them and their patients while also being more cost effective for these patients. Higher volume is correlated with higher quality of care for many procedures and conditions. (1) NESC will continue to monitor the quality of care and health outcomes of its patients over time using a variety of metrics including but not limited to, patient satisfaction, clinical outcomes, and functional assessment.

ASCs must conduct regular, comprehensive assessments of the quality of care they provide their patients as required for certification by CMS and AAAHC. NESC's patient satisfaction surveys, show scores consistently greater than 95% for "Overall Quality" and "Willingness to Recommend". (Table of results in previous factor) Reduced risk for hospital-acquired infections is another reason many patients prefer to have procedures in an outpatient setting. NESC has provided 100% surgical site infection free results between 2011 and 2019. This will continue to be a measure of performance and maintaining this high level of performance is the goal.

The applicant is required to benchmark through Medicare's Ambulatory Surgical Center Quality Reporting (ASCQR) Program and these claims-based measures impact the annual reimbursements levels. Quality data codes (QDCs) outcomes for 2016-2018 NESC also benchmarks complication risks and adverse events quarterly. The benchmarks are consistently at 0% (patient burns, falls, and wrong site/side/patient/procedure.) All cause hospital transfers were 1.28% in 2016, 0% in 2017 and 0% in 2018. All cause inpatient admissions following surgery within 24 hours ranges from .17% in FY2017 to .22% in FY2018. [4]

Cost per case will continue to be monitored and compared to the financial projections for the proposed project. As more procedures are moved from inpatient to outpatient, these procedures will be evaluated for cost effectiveness as NESC continues to provide affordable, quality care while continuing to contribute to the Commonwealth's goals for cost containment, improved health outcomes and delivery system transformation.

The Applicant has undertaken a program to proliferate a culture that endorses safety for all who are cared for as well as those who provide care. The program focuses on methods of communication that encourage open-minded contacts so that the coordination of all services ensure patients are the center of attention regardless of age, race, ethnic background, financial status or disabilities

[4] CMS ASCQR program 2018 mid-year status report

During the pre-procedure screening assessments if a patient needs further clinical evaluation, efforts are coordinated with the patient/family/PCP/surgeon as well as with the identified clinical service such as Cardiology, Neurology, etc.

Patients are informed of the need for them to participate in their care and post-operative recovery. They are taught about skin care and surgical site infection prevention as well as hand hygiene. They are instructed on the use of an inspiration spirometry, breathing and circulation exercise and about early ambulation as well as safety in the home.

The Applicant will continue to maintain a proactive approach to monitoring and improving health outcomes.

(1) Morche J, Mathes T, Pieper D. Relationship between surgeon volume and outcomes: a systematic review of systematic reviews. *Syst Rev*. 2016;5(1):204. Published 2016 Nov 29. doi:10.1186/s13643-016-0376-4)

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.

Although the addition of an operating room at NESC does not directly address an inequity, NESC values diversity and strives to improve the health status and quality of life for those in its community.

Communicating with our patients is a priority to help us understand their needs and facilitate their care journey. It is standard practice to determine ahead of time whether patients will need a translator while accessing services. If a translator is needed for pre- and post-operative visits and phone calls, phone and video interpretive services are provided by CyraCom. Pre- and post-op documents are routinely available in Spanish and can be translated into other languages as needed. To help ensure timely services, a video remote device and dual handset phone are stationed in the surgical area for easy access.

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, which providing reasonable assurances of health equity.

Through the addition of one operating room, two additional pre-op/post-op beds and one enclosed recovery bay, the Applicant will continue to provide access to high-quality, cost-effective care to patients in their service area. The site offers easy access to free parking, in a hassle-free environment helping to minimize patient stress, which is beneficial from both a health outcome and a patient experience perspective.

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.

As the Applicant is an outpatient surgery center, many of the activities related to continuity and coordination of care occur outside NESC, at the surgeon's offices.

All patients go through a standardized pre-operative process. Patients are required to complete pre-op questionnaires that include a number of questions centered around the patient's state of health, previous illnesses and treatments, who will drive them home and who will stay with them at home. Among these questions are their experience with previous surgeries (e.g. bleeding issue, reactions to anesthesia). The patient is also asked to include their primary care physician information and information on any specialists they may be seen by. These questionnaires are reviewed by the pre-op nurse and anesthesia. If during review, there are responses that require follow-up, the primary care

physician is contacted. All patients are required to have a pre-op history and physical completed no more than 30 days prior to surgery and they must have clinical clearance. This is either completed at the surgeon's office or the office of the primary care physician. After dictation and review, copies of operative notes are sent to the office of the surgeon and the primary care physicians offices.

The day after surgery, each patient is called by a nurse to assess their level of pain, mobility (if they had a fall at home), nausea and vomiting, bleeding, and satisfaction with their treatment prior to and after their surgery. For most patients, recovery goes smoothly. If there is a concern, the patient is directed to contact their surgeon's office.

The addition of the operating room and pre-op and post-op beds will not cause any change in these current efficient and well-coordinated care processes. It will allow for the continued success of the patient-focused care delivery team to provide well-coordinated care processes.

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 has communicated with following departments/personnel within the State; Samuel Louis (DPH Office of Health Equity), Nora J. Mann (prior to her exit), Lynn Conover (DoN), Ben Wood (DPH Community Health Planning and Engagement).

After approval, the project will require the Department of Public Health review and approval of architectural plans. In addition, the project will require a building permit from the City of Beverly, which will be obtained by the contractor. As a fit-out inside the existing building footprint and consistent with the approved zoning use of the building, the Proposed Project requires no local zoning approvals.

After completion of the building, NESC will obtain a Certificate of Occupancy from the City of Beverly, a Certificate of Inspection from the Beverly Fire Department and a Certificate of Inspection from the Department of Public Safety. The surgery center will then request a survey by DPH and approval to utilize the facility.

As a free-standing surgery center accredited by the Accreditation Association of Ambulatory Health Care via a Medicare Deemed status survey the Applicant will be required to apply for a re-certification survey.

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 determined the need for the Proposed Project by reviewing trends in the number of patients currently seeking care at the site and the forecasted increase in the number of patients with underlying conditions requiring surgical interventions. The recruitment of a 4-surgeon general surgery

group and continued growth of the current orthopedic and ENT groups support the growth the Applicant is anticipating.

As noted earlier, the project does not specifically address a health disparity or inequity. However, the Applicant will continue to offer a robust Interpreter Services Program for all patients receiving care in the proposed operating room. The Applicant is committed to continuing to have an infection free environment and will continue to monitor quality measures in the proposed operating room.

In addition, the Applicant and participating surgeons held two informational sessions more fully described in Section F1.e.ii . These presentations were planned to inform community members about what an ASC is and the benefits of having surgical procedures in a more convenient and cost-effective setting. Also explained was what a Free-Standing Ambulatory Center is, the advantages of having surgery in one and who the partners of the ASC are. The community was given the opportunity to view the ASC as it is now and to view a copy of the proposed retro fit of the adjacent space.

F1.e.ii Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".

To ensure community engagement throughout the proposed project, two open houses were held to allow the community the opportunity to view the ASC as it is now and to view a copy of the proposed expansion. (Tuesday, November 5, 2019 and Monday, November 11, 2019.) The open houses were advertised via flyers to the surrounding area, posting in the surgeon's offices, bulletin boards in the Cummings Center, where the ASC is located, on the ASC Facebook page and website.

To date, the Applicant and its Participating Physicians have conducted the following engagement activities:

- NESC held an informational session to inform patient on the proposed project Tuesday, November 5, 2019
- NESC held an information session to inform patients on the proposed project Monday, November 11, 2019.

Detailed information on these activities, including the invitation and presentation material, are attachment 3a & 3b.

Factor 2- Health Priorities

Address 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, improved public health outcomes, and delivery system transformation.

Ambulatory Surgery Centers provide a lower cost alternative to more expensive hospital outpatient surgery while maintaining the highest quality. Studies show a $40.3 billion, one-year savings in health care spending created by patients choosing ASCs as an alternative to hospital-based surgery. Medicare patients saved $1.5 billion in 4 years.[5] Similarly, Medicaid, other insurers and patients benefit from lower prices for services performed in the ASC given the lower reimbursement and coinsurance payments. The table below, demonstrates the disparity in price between local ASC's and HOPD payments.

Procedure	ASC	HOPD
Arthroscopic Rotator Cuff Repair (29827)	$2,273	$5,699
ESWL (50590)	$1,134	$2,926
Implantation of Neurostimulator Electrode Array (63650)	$4,449	$5,979
Septoplasty (30520)	$803	$2,231
Cystoscopy with Biopsy (52204)	$651	$1,391

Although the Project involves only a modest expansion of services, given the growth in movement of surgical procedures from inpatient to outpatient settings, the Project will contribute to meeting the increased demand. This increased availability of lower cost services will assist the Commonwealth in achieving its cost containment goals. At the same time, patients will have increased access to experienced surgeons and clinical staff in a safer and more comfortable setting, reviewed regularly to ensure safety and quality.

F2.b Public Health Outcomes:

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

Providing access to expedited, expert surgical care in the patient's own community will improve the patient experience. The Proposed Project will provide the patient with convenient access to the facility, ample parking and expedited scheduling of procedures in their own community. With most of the surgeons associated with the ASC having offices in the same office park, patients are familiar with the

[5] ASC Association web site, August, 2019

area and prefer the ease of use this provides. The ASC provides patient centered technology such as a pre-registration system. This system allows them to pre-register in the comfort of their own home and also provides them with either telephone or text reminders. When patients receive timely care in the appropriate setting both the patient and healthcare market benefit.

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 incorporated into care planning.

As a free-standing ambulatory surgery center, we provide day surgery to high-acuity patients. As such, we are not directly aligned with social services and community-based experts. However, patients are followed post-surgery by their surgeons and primary care physicians.

As noted in Section F1.c, the patient questionnaire used prior to surgery contains a number of questions needed to evaluate the social service needs. Requested information includes information identifying the person who will be escorting the patient home, who will be with the patient once they are home, if they feel safe at home and if their primary language is English. Patient safety is a priority at the ASC and if abuse is indicated, we direct them to contact Safelink, the MA statewide domestic violence hotline. When English is not the patient's primary language or there is hearing or visual impairment, CyraCom, our translation company, is contacted by telephone or via video on an iPad. Where we previously had to call interpreters and set up appointments, we can now have someone available in just a few minutes. This has provided a very cost affective, patient satisfying option.

Factor 5: Relative Merit

F5.a.i Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence based strategies and public health interventions.

Proposal:

To add one additional OR, equipment storage and office space to the already existing Free-Standing Multi-Specialty Surgery Center at 900 Cummings Center, Suite 122U, Beverly, MA

Quality:

The ASC strives and commits to giving high-quality care and safety with a personal touch to all patients, with outcomes that are equal to or better than HOPD surgical departments for the same procedures.

Efficiency:

ASCs in the United States provide identical services to HOPD but are able to perform these surgeries much more efficiently than HOPDs, which will achieve cost savings. Unlike large-scale institutions, ASCs serve fewer patients and are highly specialized in what they do, allowing them to be more responsive to individual patient needs. Clinical efficiencies will be achieved through the use of highly trained staff and the ability to maintain a more uniform schedule, allowing for high quality patient outcomes.

Capital Expense:

The addition of one OR utilizing general anesthesia, two additional post-op beds along with one enclosed pediatric room for both pre-op/post-op usage, a new enlarged central sterile area, equipment storage and office space will result in a one-time capital expense of $1,587,646.

Operating Costs:

The incremental operating expenses anticipated for the first full year of operation post addition, are expected to be $125,000.

List alternative options for the Proposed Project:

Alternative Proposal:

One alternative would be to continuing operations within the existing configuration of procedure capacity. This alternative proposal would not allow an additional OR and would allow no further growth of the cost saving ASC services. Cases would be turned away to higher cost HOPD.

Alternative Quality:

The alternative would not allow the patient panel's increased access to lower cost and high-quality outpatient surgical services. And would result in higher reliance on higher cost HOPD's. Navigating a HOPD is challenging, especially for those within the 65+ age cohort. The ASC will provide a more manageable setting.

Alternative Efficiency:

The lack of an additional general anesthesia OR will result in continued clinical and operational inefficiencies due to the limitation in providing on-time surgical services in a hospital setting.

Alternative Capital Expense:

There would not be a change to the initial Capital expenses for the additional OR unless a new piece of equipment was needed at a future date.

Alternative Operating Costs:

Not adding the additional OR to the ASC, would move the cases to the HOPD, increase cost to the patients, Medicaid and other insurers,

F5.a. ii Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating cost of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

The Applicant determined the need for the Proposed Project by reviewing trends in the number of patients currently seeking care at the site and the forecasted increase in the number of patients with underlying conditions requiring surgical interventions. The recruitment of a 4-surgeon general surgery group and continued growth of the current orthopedic and ENT groups support the growth the Applicant is anticipating.

The addition of the one OR would create a one-time Capital cost, included in the cost of the project and operating costs would see a low increase, in response to the reimbursements for the increased case load.

As previously noted in Factor 2, Ambulatory Surgery Centers provide a lower cost alternative to more expensive hospital outpatient surgery while maintaining the highest quality. Studies show a $40.3 billion, one-year savings in health care spending created by patients choosing ASCs as an alternative to hospital-based surgery. Medicare patients saved $1.5 billion in 4 years.[6] Similarly, Medicaid, other insurers and patients benefit from lower prices for services performed in the ASC given the lower reimbursement and coinsurance payments.

Although the Project involves only a modest expansion of services, given the growth in movement of surgical procedures from inpatient to outpatient settings, the Project will contribute to meeting the increased demand. This increased availability of lower cost services will assist the Commonwealth in achieving its cost containment goals. At the same time, patients will have increased access to experienced surgeons and clinical staff in a safer and more comfortable setting, reviewed regularly to ensure safety and quality.

[6] ASC Association web site, August, 2019

Private physician ownership and an increase in the capability of Freestanding ASCs will continue to provide many convenient benefits to patients undergoing outpatient surgery. ASCs offer transparency on cost — if they need to have a surgery done in a surgery center, it's easy to tell a patient what their benefit is, what their share of the cost will be — there shouldn't be any surprises when they go to a surgery center. It's a much simpler place to understand what their expenses will be.[7]

[7] Becker's ASC Review January, 2020

NBM, Inc.
24 Terry Ave
Burlington, MA 01803

Service Call Summary

Customer	NBR332 New England Surgery Center	**Work Order**	WO167219
Address	900 Cummings Ctr #122u Beverly, MA 01915	**Call**	SC200879
Requested By	Norma Bacon -- 978-922-4670 -- nbacon@ne-surgerycenter.org	**Technician**	Stephen Keniston
Request Received	7/2/2020 11:41 AM	**Call Type**	MFP INSTALL
Due	7/28/2020 8:00 AM	**Equipment**	69901
Contract		**Serial**	9F005438
PO Number		**Item**	MX-B376W
		Make/Model	Sharp/MX-B376W
		Installed Location	New England Surgery Center 900 Cummings Ctr #122u Beverly, MA 01915
Problem Description	Network Install 8-10 (2 Units) Contact: Norma Bacon Replacing B402SC Existing Customer	**Location Remarks**	
		Equipment contact	
		Contact phone	
		Contact fax	
Sales Rep			

Labor

Technician	Dispatch	Arrival	Departure	Travel hours	Standard hours	Overtime hours
Stephen Keniston	7/28/2020 6:52 AM	7/28/2020 8:03 AM	7/28/2020 9:59 AM	1.18	1.93	0

Meter Readings

Meter	Display	Remarks
B\W	96	

Signature

No signal **7/28/2020 9:59 AM**

Remarks

Setup print and scan. Instruct customer on updating address book with fax destinations. Train on all features ok

Attachment
2

New England Surgery Center
Patient Panel by City of Residence

Community	County	2017 #	2017 %	2018 #	2018 %	2019 #	2019 %	Change 2017-2019
BEVERLY (01915)	Essex	200	14%	167	13%	144	13%	-28%
GLOUCESTER (01930)	Essex	151	11%	147	11%	126	11%	-17%
LYNN (01901-07)	Essex	198	14%	104	8%	89	8%	-55%
PEABODY (01960)	Essex	123	9%	123	9%	84	7%	-32%
DANVERS (01923)	Essex	100	7%	80	6%	76	7%	-24%
SALEM (01970)	Essex	96	7%	78	6%	70	6%	-27%
WILMINGTON (01887)	Middlesex	5	0%	13	1%	70	6%	1300%
MARBLEHEAD (01945)	Essex	43	3%	27	2%	38	3%	-12%
IPSWICH (01938)	Essex	52	4%	45	3%	36	3%	-31%
MANCHESTER (01944)	Essex	33	2%	23	2%	31	3%	-6%
ROCKPORT (01966)	Essex	34	2%	28	2%	28	2%	-18%
SWAMPSCOTT (01907)	Essex	6	0%	25	2%	24	2%	300%
MIDDLETON (01949)	Essex	34	2%	24	2%	24	2%	-29%
TOPSFIELD (01983)	Essex	13	1%	20	2%	18	2%	38%
NORTH ANDOVER (01845)	Essex	11	1%	9	1%	18	2%	64%
GEORGETOWN (01833)	Essex	12	1%	22	2%	15	1%	25%
SOUTH HAMILTON (01982)	Essex	17	1%	26	2%	14	1%	-18%
BOXFORD (01921)	Essex	14	1%	20	2%	14	1%	0%
ESSEX (01929)	Essex	12	1%	18	1%	14	1%	17%
WENHAM (01984)	Essex	19	1%	14	1%	13	1%	-32%
LYNNFIELD (01940)	Essex	0	0%	14	1%	10	1%	N/A
NEWBURYPORT (01950)	Essex	10	1%	14	1%	10	1%	0%
ROWLEY (01969)	Essex	12	1%	10	1%	10	1%	-17%
SAUGUS (01906)	Essex	0	0%	0	0%	10	1%	N/A
AMESBURY (01913)	Essex	7	0%	7	1%	9	1%	29%
WAKEFIELD (01880)	Middlesex	11	1%	10	1%	9	1%	-18%
NORTH READING (01864)	Middlesex	9	1%	8	1%	9	1%	0%
METHUEN (01844)	Essex	4	0%	7	1%	6	1%	50%
WOBURN (01801-01815)	Middlesex	4	0%	13	1%	6	1%	50%
READING (01867)	Middlesex	3	0%	3	0%	6	1%	100%
GROVELAND (01834)	Essex	9	1%	7	1%	5	0%	-44%
HAVERHILL (01832)	Essex	18	1%	13	1%	4	0%	-78%
SALISBURY (01952)	Essex	4	0%	10	1%	4	0%	0%
HAMILTON (01936)	Essex	5	0%	0	0%	4	0%	-20%
MALDEN (02148)	Middlesex	6	0%	7	1%	4	0%	-33%
STONEHAM (02180)	Middlesex	0	0%	2	0%	4	0%	N/A
LAWRENCE (01940)	Essex	4	0%	6	0%	3	0%	-25%
NAHANT (01908)	Essex	0	0%	5	0%	3	0%	N/A
TEWKSBURY (01876)	Middlesex	6	0%	7	1%	3	0%	-50%
BILLERICA (01821)	Middlesex	6	0%	4	0%	3	0%	-50%
DRACUT (01826)	Middlesex	0	0%	3	0%	3	0%	N/A
CAMBRIDGE (02141)	Middlesex	0	0%	0	0%	3	0%	N/A

New England Surgery Center
Patient Panel by City of Residence

Community	County	2017 #	2017 %	2018 #	2018 %	2019 #	2019 %	Change 2017-2019
REVERE (02151)	Suffolk	4	0%	3	0%	3	0%	-25%
BRADFORD (01835)	Essex	0	0%	0	0%	2	0%	N/A
NEWBURY (01951)	Essex	5	0%	0	0%	2	0%	-60%
BURLINGTON (01803)	Middlesex	2	0%	2	0%	2	0%	0%
EVERETT (02149)	Middlesex	2	0%	0	0%	2	0%	0%
MEDFORD (02153)	Middlesex	0	0%	0	0%	2	0%	N/A
HAMPSTEAD, NH (03841)	Rockingham NH	0	0%	2	0%	2	0%	N/A
PRIDES CROSSING (01965)	Essex	4	0%	0	0%	1	0%	-75%
CHELSEA (02150)	Suffolk	8	1%	0	0%	1	0%	-88%
BOSTON (02201-02298)	Suffolk	0	0%	0	0%	1	0%	N/A
MERRIMAC (01860)	Essex	3	0%	7	1%	0	0%	N/A
ANDOVER (01810)	Essex	2	0%	3	0%	0	0%	N/A
BYFIELD (01922)	Essex	6	0%	3	0%	0	0%	N/A
HAWTHORNE (01937)	Essex	0	0%	0	0%	0	0%	N/A
WEST NEWBURY	Essex	3	0%	0	0%	0	0%	N/A
LUDLOW (01056)	Hampden	0	0%	0	0%	0	0%	N/A
LOWELL (01850)	Middlesex	12	1%	7	1%	0	0%	N/A
SOMERVILLE (02143)	Middlesex	0	0%	4	0%	0	0%	N/A
CHELMSFORD (01824)	Middlesex	0	0%	3	0%	0	0%	N/A
WINCHESTER (01890)	Middlesex	0	0%	3	0%	0	0%	N/A
MELROSE (02176)	Middlesex	4	0%	3	0%	0	0%	N/A
NATICK (01760)	Middlesex	0	0%	2	0%	0	0%	N/A
WALTHAM (02452)	Middlesex	0	0%	2	0%	0	0%	N/A
ARLINGTON (02474)	Middlesex	4	0%	2	0%	0	0%	N/A
WINTHROP (02152)	Suffolk	0	0%	2	0%	0	0%	N/A
NASHUA, NH (03060)	Hillsborough NH	0	0%	5	0%	0	0%	N/A
LONDERRY, NH (03053)	Rockingham NH	0	0%	3	0%	0	0%	N/A
EXETER, NH (03833)	Rockingham NH	0	0%	3	0%	0	0%	N/A
SEABROOK (03874)	Rockingham NH	0	0%	2	0%	0	0%	N/A
PLAISTOW, NH (03865)	Rockingham NH	4	0%	0	0%	0	0%	N/A
Addition 1 case town		73	5%	75	6%	46	4%	-37%
Total		1,427	100%	1,301	100%	1,138	100%	-20%

New England Surgery Center Patient Panel

Patients by Gender	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
Female	748	52%	677	52%	516	50%	-31%
Male	679	48%	624	48%	508	50%	-25%
Total	1,427	100%	1,301	100%	1,024	100%	-28%

Patients by Age Cohort	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
0-17	134	9%	100	8%	96	9%	-28%
18-64	746	52%	679	52%	598	58%	-20%
65+	547	38%	522	40%	330	32%	-40%
Total	1,427	100%	1,301	100%	1,024	100%	-28%

Patients by Race or Ethnicity	2017		2018		2019		3-Year
Self-Reported Race	#	%	#	%	#	%	Change
White	515	89%	637	88%	691	90%	34%
Spanish/Hispanic/Latino	19	3%	35	5%	33	4%	74%
Other	23	4%	8	1%	4	1%	-83%
Multiracial	3	1%	12	2%	15	2%	400%
Asian	5	1%	12	2%	10	1%	100%
Not Specified	7	1%	17	2%	0	0%	-100%
Black/African American	3	1%	5	1%	15	2%	400%
Native	1	-	0	0%	0	0%	-100%
Total Respondents	576	100%	726	100%	768	100%	33%

New England Surgery Center Patient Panel

Primary Language*							
Self-Reported Primary Language	2017		2018		2019		3 Year
	#	%	#	%	#	%	Change
English	1,162	98%	1,073	98%	1,004	97%	-14%
Spanish	9	1%	16	1%	14	1%	56%
Portugese	3	0%	1	0%	6	1%	100%
Russian	2	0%	1	0%	3	0%	50%
Arab	3	0%	0	0%	1	0%	-67%
Italian	2	0%	1	0%	0	0%	-100%
Greek	0	0%	2	0%	0	0%	0%
Cantonese	0	0%	1	0%	0	0%	0%
German	1	0%	0	0%	0	0%	-100%
Crotian	1	0%	0	0%	0	0%	-100%
Hatian/Creole	0	0%	0	0%	0	0%	0%
Albanian	0	0%	0	0%	0	0%	0%
Asian	0	0%	0	0%	0	0%	0%
Other	1	0%	5	0%	3	0%	200%
Total Respondents	1,184	100%	1,100	100%	1,031	100%	-13%

*Not all patients responded

New England Surgery Center Patient Panel

Patients by Payment Source							
Payment Source	2017		2018		2019		3-Year
	#	%	#	%	#	%	Change
Medicare	566	40%	545	42%	306	30%	-46%
MassMedicaid	197	14%	125	10%	118	12%	-40%
BCBS	272	19%	248	19%	285	28%	5%
Tufts	71	5%	111	9%	75	7%	6%
Harvard Pilgrim	79	6%	70	5%	52	5%	-34%
United Health	43	3%	33	3%	47	5%	9%
Cigna	25	2%	27	2%	17	2%	-32%
Aetna	19	1%	1	0%	16	2%	-16%
Other Commercial	75	5%	58	4%	27	3%	-64%
Workmen's Comp	66	5%	64	5%	65	6%	-2%
Self Pay	14	1%	19	1%	16	2%	14%
Total	1,427	100%	1,301	100%	1,024	100%	-28%

New England Surgery Center Patient Panel

TOTAL PATIENT PANEL							
Specialty	2017		2018		2019		3 Year Change
	#	%	#	%	#	%	
Otolaryngology	425	30%	329	25%	294	29%	-31%
Urology	334	23%	355	27%	209	20%	-37%
Ophthalmology	237	16%	275	21%	207	20%	-13%
Pain Management	274	19%	153	12%	125	12%	-54%
Orthopedics	131	9%	147	11%	138	13%	5%
Podiatry	28	2%	43	3%	26	3%	-7%
Anesthesia	7	0%	20	2%	0	0%	-100%
Plastics	1	0%	2	0%	18	2%	1700%
General	0	0%	0	0%	6	1%	N/A
Unclassified	0	0%	0	0%	1	0%	N/A
Total	1,437	100%	1,324	100%	1,024	100%	-29%

New England Surgery Center
Patient Panel Information
Top Diagnoses by Year

CODE	DESCRIPTION	2017
	Ophthalmology	
H02.831	Dermatochalasis of right upper eyelid	88
H02.423	Myogenic ptosis of bilateral eyelids	17
H02.132	Senile ectropion of right lower eyelid	11
H02.135	Senile ectropion of left lower eyelid	11
H02.413	Mechanical ptosis of bilateral eyelids	10
C44.119	Basal cell carcinoma of skin of left eyelid, including canthus	8
C44.112	Basal cell carcinoma of skin of right eyelid, including canthus	7
H02.422	Myogenic ptosis of left eyelid	7
H02.035	Senile entropion of left lower eyelid	6
H02.032	Senile entropion of right lower eyelid	5
	Orthopedics	
M75.121	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic	57
M75.122	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic	33
M24.811	Other specific joint derangements of right shoulder, not elsewhere classified	4
S83.232A	Complex tear of medial meniscus, current injury, left knee, initial encounter	4
S43.432D	Superior glenoid labrum lesion of left shoulder, subsequent encounter	3
S83.241D	Other tear of medial meniscus, current injury, right knee, subsequent encounter	3
S83.242D	Other tear of medial meniscus, current injury, left knee, subsequent encounter	3
G56.01	Carpal tunnel syndrome, right upper limb	2
G56.02	Carpal tunnel syndrome, left upper limb	2
M19.012	Primary osteoarthritis, left shoulder	2
	Otolaryngology	
J34.2	Septal Deviation	99
J34.3	Hypertrophy of nasal turbinates	0
J35.3	Hypertrophy of tonsils with hypertrophy of adenoids	38
J03.90	Acute tonsillitis, unspecified	32
S02.2xxA	Fracture of nasal bones, initial encounter for closed fracture	31
J35.01	Chronic tonsillitis	22
J32.9	Chronic sinusitis, unspecified	17
J35.2	Hypertrophy of adenoids	14
J34.3	Hypertrophy of nasal turbinates	12
H65.23	Chronic serous otitis media, bilateral	11
H69.83	Other specified disorders of Eustachian tube, bilateral	8

New England Surgery Center
Patient Panel Information
Top Diagnoses by Year

CODE	DESCRIPTION	2017
H65.93	Unspecified nonsuppurative otitis media, bilateral	0
	Pain Management	
M54.16	Radiculopathy, lumbar region	92
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region	29
M96.1	Postlaminectomy syndrome, not elsewhere classified	29
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region	20
M54.17	Radiculopathy, lumbosacral region	19
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region	15
M54.12	Radiculopathy, cervical region	15
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region	9
M46.1	Sacroiliitis, not elsewhere classified	6
M48.06	Spinal stenosis, lumbar region	5
	Podiatry	
L60.0	Ingrowing nail	4
M20.11	Hallux valgus (acquired), right foot	3
B07.0	Plantar wart	2
M20.21	Hallux rigidus, right foot	2
M20.41	Other hammer toe(s) (acquired), right foot	2
M20.42	Other hammer toe(s) (acquired), left foot	2
M67.40	Ganglion, unspecified site	2
L03.115	Cellulitis of right lower limb	1
M1A.0721	Idiopathic chronic gout, left ankle and foot, with tophus (tophi)	1
M20.12	Hallux valgus (acquired), left foot	1
	Urology	
N20.0	Calculus of Kidney	165
N40.1	Enlarged prostate with lower urinary tract symptoms	44
R39.15	Urgency of urination	15
N39.41	Urge incontinence	10
N39.3	Stress incontinence (female) (male)	8
N13.30	Unspecified hydronephrosis	6
N43.3	Hydrocele, unspecified	5
N32.81	Overactive bladder	4
N40.0	Enlarged prostate without lower urinary tract symptoms	4
R31.0	Gross hematuria	4

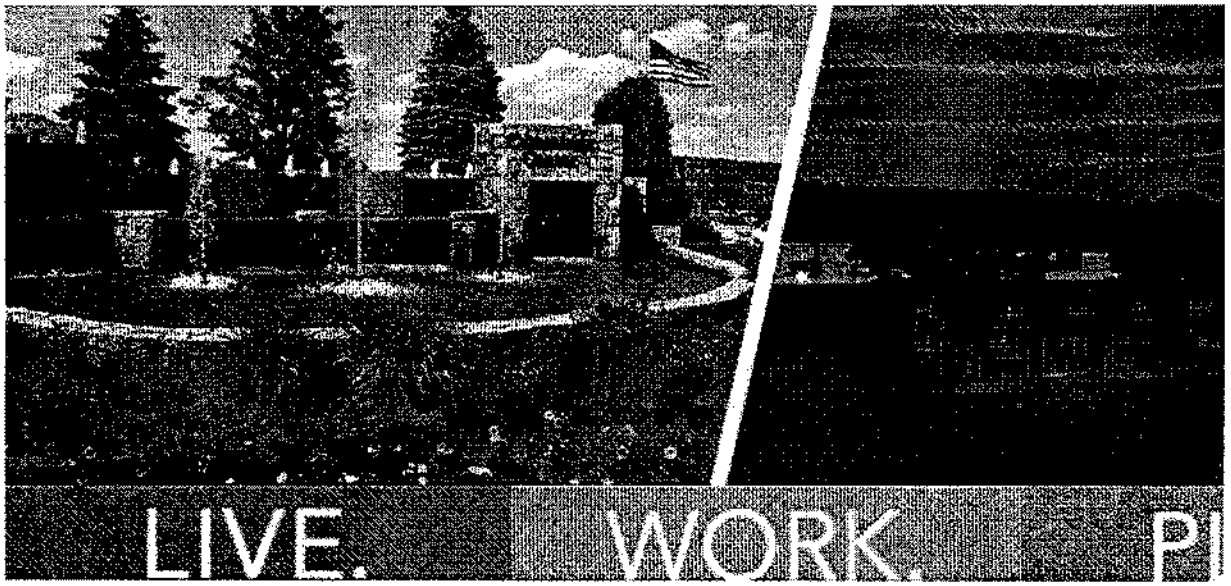
CODE	DESCRIPTION	2018	CODE	DESCRIPTION	2019
	Ophthalmology			**Ophthalmology**	
H02.831	Dermatochalasis of right upper eyelid	98	H02.831	Dermatochalasis of right upper eyelid	102
H02.423	Myogenic ptosis of bilateral eyelids	24	H02.423	Myogenic ptosis of bilateral eyelids	29
H02.135	Senile ectropion of left lower eyelid	15	H02.132	Senile ectropion of right lower eyelid	14
H02.839	Dermatochalasis of unspecified eye, unspecified eyelid	15	H02.422	Myogenic ptosis of left eyelid	5
H02.132	Senile ectropion of right lower eyelid	14	H02.413	Mechanical ptosis of bilateral eyelids	11
H02.429	Myogenic ptosis of unspecified eyelid	10	H02.59	Other disorders affecting eyelid function	7
C44.112	Basal cell carcinoma of skin of right eyelid, including canthus	6	C44.112	Basal cell carcinoma of skin of right eyelid, including canthus	5
H02.109	Unspecified ectropion of unspecified eye, unspecified eyelid	6	H02.032	Senile entropion of right lower eyelid	7
H02.421	Myogenic ptosis of right eyelid	6	C44.119	Basal cell carcinoma of skin of left eyelid, including canthus	3
H02.403	Unspecified ptosis of bilateral eyelids	5	H02.135	Senile ectropion of left lower eyelid	5
	Orthopedics			**Orthopedics**	
M75.121	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic	55	M75.121	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic	30
M75.122	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic	23	M75.122	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic	26
S83.232A	Complex tear of medial meniscus, current injury, left knee, initial encounter	9	G56.02	Carpal tunnel syndrome, left upper limb	5
M25.311	Other instability, right shoulder	6	M25.312	Other instability, left shoulder	10
S83.231A	Complex tear of medial meniscus, current injury, right knee, initial encounter	5	M25.311	Other instability, right shoulder	8
M25.312	Other instability, left shoulder	4	S83.242A	Other tear of medial meniscus, current injury, left knee, initial encounter	8
S83.241A	Other tear of medial meniscus, current injury, right knee, initial encounter	4	S83.241A	Other tear of medial meniscus, current injury, right knee, initial encounter	5
S83.242A	Other tear of medial meniscus, current injury, left knee, initial encounter	4	G56.01	Carpal tunnel syndrome, right upper limb	8
M67.431	Ganglion, right wrist	2	G56.20	Lesion of ulnar nerve, unspecified upper limb	4
S52.501A	Unspecified fracture of the lower end of right radius, initial encounter for closed fracture	2	M20.019	Mallet finger of unspecified finger(s)	1
	Otolaryngology			**Otolaryngology**	
J34.2	Septal Deviation	79	J34.2	Septal Deviation	65
J34.3	Hypertrophy of nasal turbinates	0	J34.3	Hypertrophy of nasal turbinates	35
J38.3	Other diseases of vocal cords	22	J03.90	Acute tonsillitis, unspecified	24
J03.90	Acute tonsillitis, unspecified	17	J35.3	Hypertrophy of tonsils with hypertrophy of adenoids	24
S02.2xxA	Fracture of nasal bones, initial encounter for closed fracture	17	J32.9	Chronic sinusitis, unspecified	8
J03.91	Acute recurrent tonsillitis, unspecified	13	S02.2xxA	Fracture of nasal bones, initial encounter for closed fracture	17
J34.3	Hypertrophy of nasal turbinates	12	J31.0	Chronic rhinitis	8
J35.01	Chronic tonsillitis	11	J35.01	Chronic tonsillitis	8
J35.2	Hypertrophy of adenoids	10	J35.2	Hypertrophy of adenoids	16
H69.83	Other specified disorders of Eustachian tube, bilateral	8	H69.83	Other specified disorders of Eustachian tube, bilateral	8
H90.0	Conductive hearing loss, bilateral	8	M95.0	Acquired deformity of nose	8

CODE	DESCRIPTION	2018	CODE	DESCRIPTION	2019
H65.93	Unspecified nonsuppurative otitis media, bilateral	0	H65.93	Unspecified nonsuppurative otitis media, bilateral	8
	Pain Management			**Pain Management**	
M48.062	Spinal stenosis, lumbar region with neurogenic claudication	36	M48.062	Spinal stenosis, lumbar region with neurogenic claudication	26
M54.16	Radiculopathy, lumbar region	27	M96.1	Postlaminectomy syndrome, not elsewhere classified	18
M96.1	Postlaminectomy syndrome, not elsewhere classified	23	M54.16	Radiculopathy, lumbar region	13
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region	9	E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified	2
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region	6	G90.522	Complex regional pain syndrome I of left lower limb	3
T85.193D	Other mechanical complication of implanted electronic neurostimulator, generator Subsequent Encounter	6	G57.01	Lesion of sciatic nerve, right lower limb	1
T85.193S	SEQUELA -- Other mechanical complication of implanted electronic neurostimulator, generator	6	G57.72	Causalgia of left lower limb	1
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region	5	G58.8	Complex regional pain syndrome I, unspecified	1
M46.1	Sacroiliitis, not elsewhere classified	4	G89.29	Other chronic pain	1
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region	4	G90.50	Complex regional pain syndrome I, unspecified	1
	Podiatry			**Podiatry**	
M20.41	Other hammer toe(s) (acquired), right foot	6	S90.852A	Superficial foreign body, left foot, initial encounter	2
L60.0	Ingrowing nail	3	B07.0	Plantar wart	1
M20.11	Hallux valgus (acquired), right foot	3	G57.62	Lesion of plantar nerve, left lower limb	1
M20.12	Hallux valgus (acquired), left foot	3	L60.0	Ingrowing nail	1
L03.031	Cellulitis of right toe	2	L72.0	Follicular cyst of the skin and subcutaneous tissue, unspecified	4
M19.90	Unspecified osteoarthritis, unspecified site	2	L72.9	Follicular cyst of the skin and subcutaneous tissue, unspecified	1
M79.9	Soft tissue disorder, unspecified	2	M20.11	Hallux valgus (acquired), right foot	2
S82.61xA	Displaced fracture of lateral malleolus of right fibula, initial encounter for closed fracture	2	M20.42	Other hammer toe(s) (acquired), left foot	2
S82.62xA	Displaced fracture of lateral malleolus of left fibula, initial encounter for closed fracture	2	M21.621	BUNIONETTE RIGHT FOOT	1
S82.832A	Other fracture of upper and lower end of left fibula, initial encounter for closed fracture	2	M67.471	Ganglion, right ankle and foot	1
	Urology			**Urology**	
N20.0	Calculus of Kidney	194	N20.0	Calculus of Kidney	79
N40.1	Enlarged prostate with lower urinary tract symptoms	52	N40.1	Enlarged prostate with lower urinary tract symptoms	31
N39.41	Urge incontinence	12	C61	Malignant neoplasm of prostate	5
R31.1	Benign essential microscopic hematuria	9	N13.2	Hydronephrosis with renal and ureteral calculous obstruction	5
N13.2	Hydronephrosis with renal and ureteral calculous obstruction	8	R39.15	Urgency of urination	8
R39.15	Urgency of urination	6	C67.0	Malignant neoplasm of trigone of bladder	2
N30.10	Interstitial cystitis (chronic) without hematuria	5	N39.41	Urge incontinence	5
N13.30	Unspecified hydronephrosis	4	N47.1	Phimosis	5
N39.3	Stress incontinence (female) (male)	4	R31.2	Other microscopic hematuria	4
N43.3	Hydrocele, unspecified	4	D30.3	Benign neoplasm of bladder	6

Attachment 2(a)

Norma Bacon

From: Cummings Properties <keri@cummings.ccsend.com> on behalf of Cummings Properties <tmw@cummings.com>
Sent: Tuesday, November 5, 2019 4:18 PM
To: nbacon@ne-surgerycenter.org
Subject: Cummings North Shore News



November 5, 2019

Quick Links

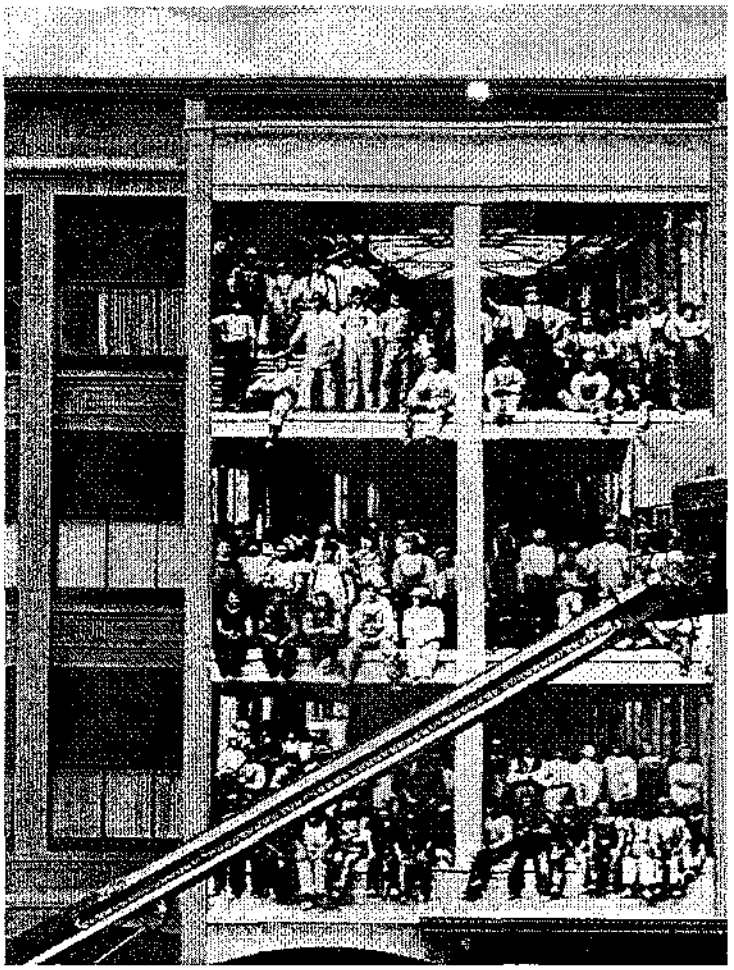
Client Directory

Cummings Properties

Service Call Request

Executive Office Suites

Submit Your News
To be included in a future edition, please email newsbrief@cummings.com.



Cummings Center pays tribute to its history with a tableau depicting workers during the construction of United Shoe Machinery Corporation. Stop by the exterior staircases at the 100 building to view this larger-than-life scene.

Survey Says....

We Appreciate Your Feedback! Thank you to the hundreds of clients who completed our recent survey. We are reviewing the results and the valuable suggestions you have shared. Congratulations to our five randomly selected client survey raffle winners: **Scott B.** from Benefit Strategy Partners, **Stacey R.** from 7AC Tech, **Chris H.** from Plummer Youth Promise, **Denise P.** from Agri-Mark, and **Greg Z.** from SEEM Collaborative will each receive a $100 gift certificate.

Upcoming Events

New England Surgery Cen

New England Surgery Center, 900 Cummings Center, Suite 122-U, is hosting open house events on **Tuesday, November 5 from 5:00 to 6:00 PM** and **Monday, November 11 from 8:00 to 9:00 AM.** The purpose of these public events is to petition the Massachusetts Department of Public Health for an additional operating room at the current facility. For more information, contact 978-922-4670.

JOIN US FOR COFFEE AND CONVERSATION

NEW ENGLAND SURGERY CENTER

900 CUMMINGS CENTER

SUITE 122U

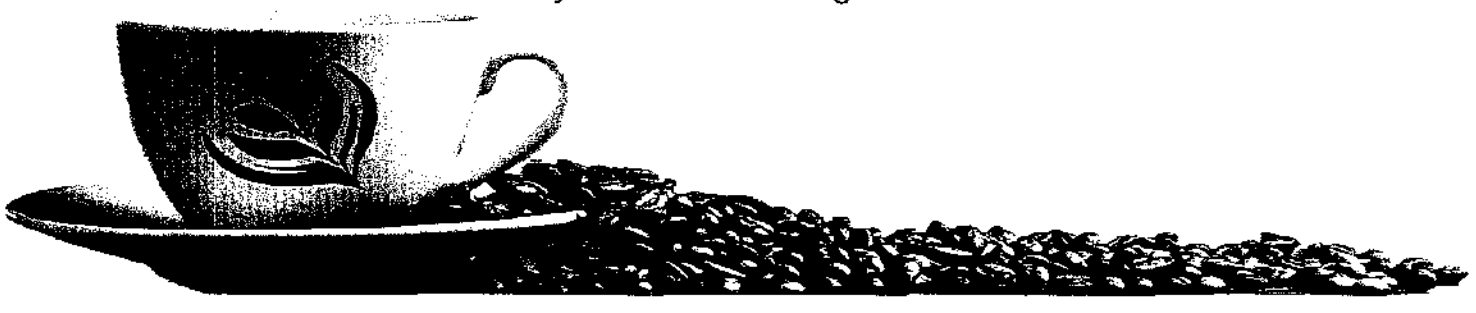
Beverly, MA

TUESDAY, NOVEMBER 5TH 5:00-6:00 P.M.

OR

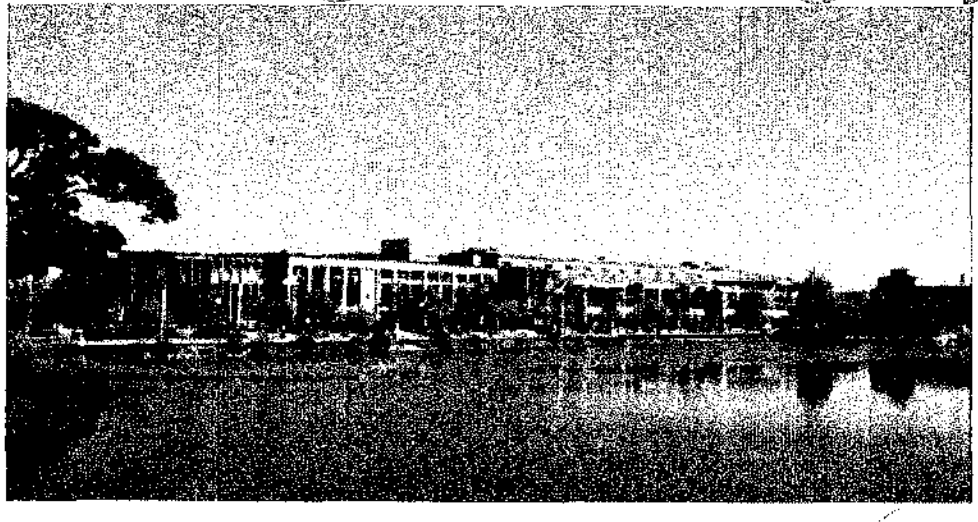
MONDAY, NOVEMBER 11TH 8:00 -9:00 A.M.

We're hosting an open forum for our patients to discuss the addition of one operating room to the ambulatory surgical services we have brought to the Town of Beverly and surrounding communities.



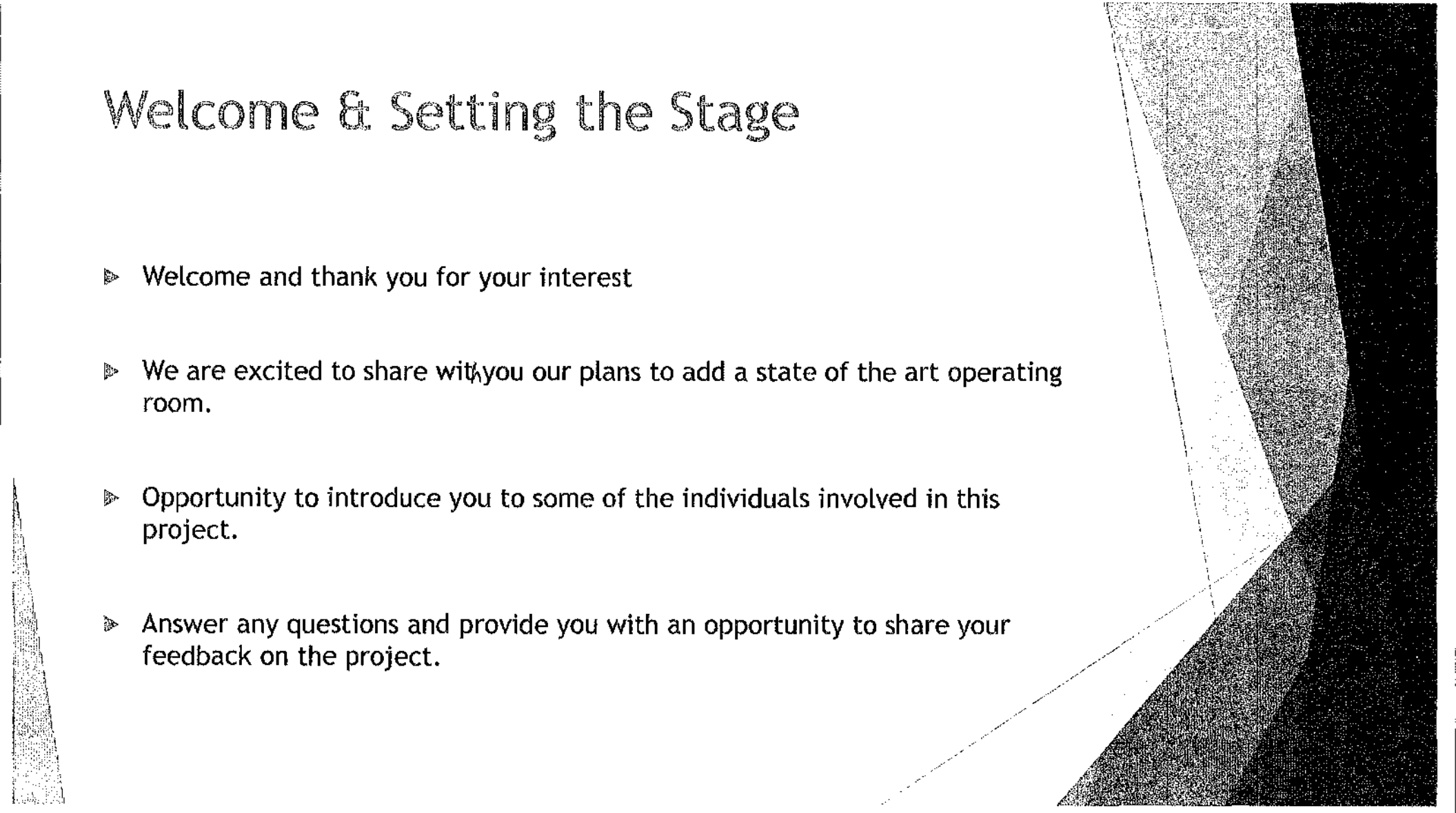
Attachment 2(a)

New England Surgery



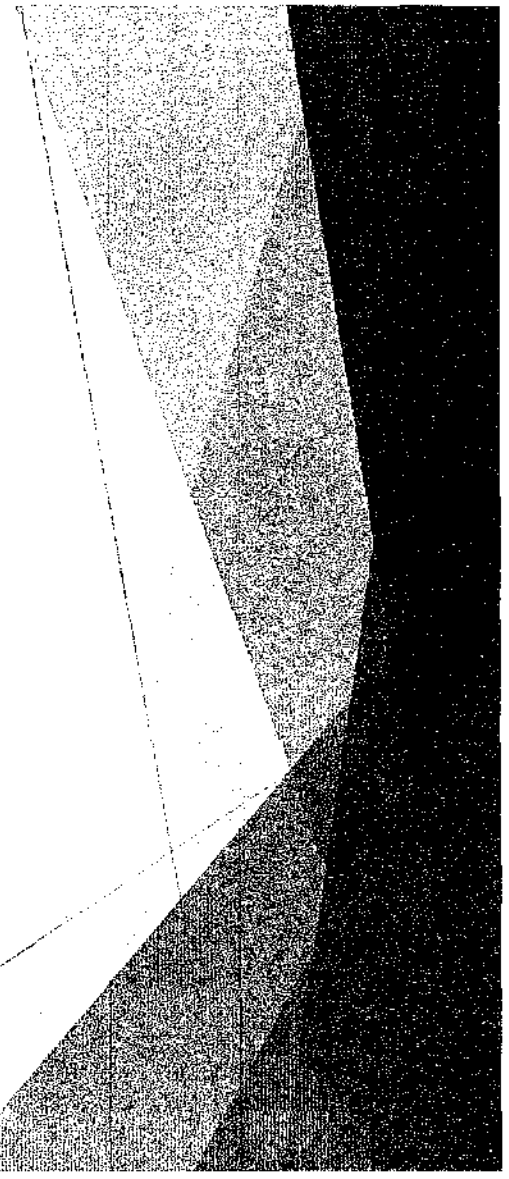
Welcome & Setting the Stage

- Welcome and thank you for your interest
- We are excited to share with you our plans to add a state of the art operating room.
- Opportunity to introduce you to some of the individuals involved in this project.
- Answer any questions and provide you with an opportunity to share your feedback on the project.



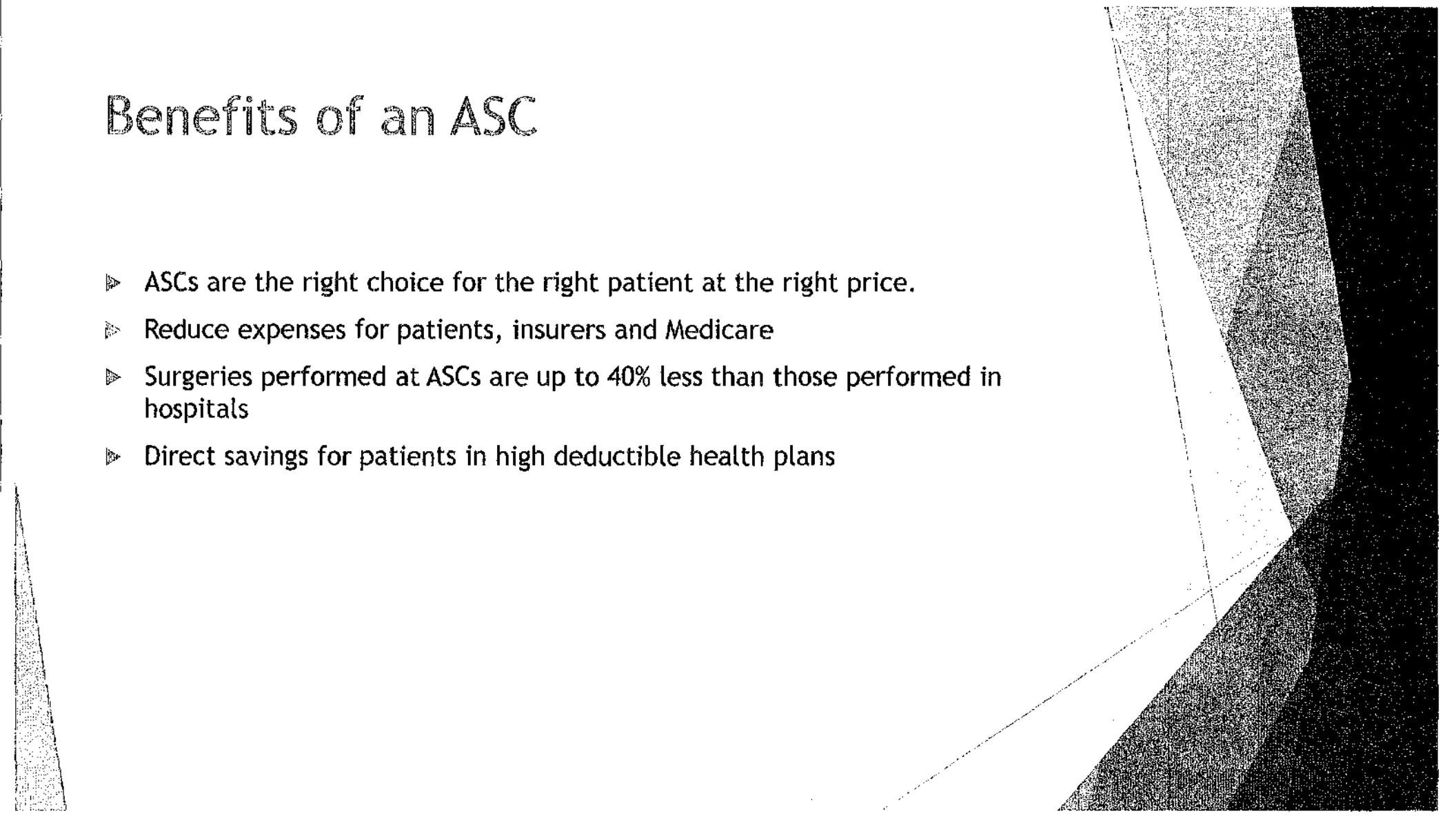
What is an ambulatory surgical center (ASC)?

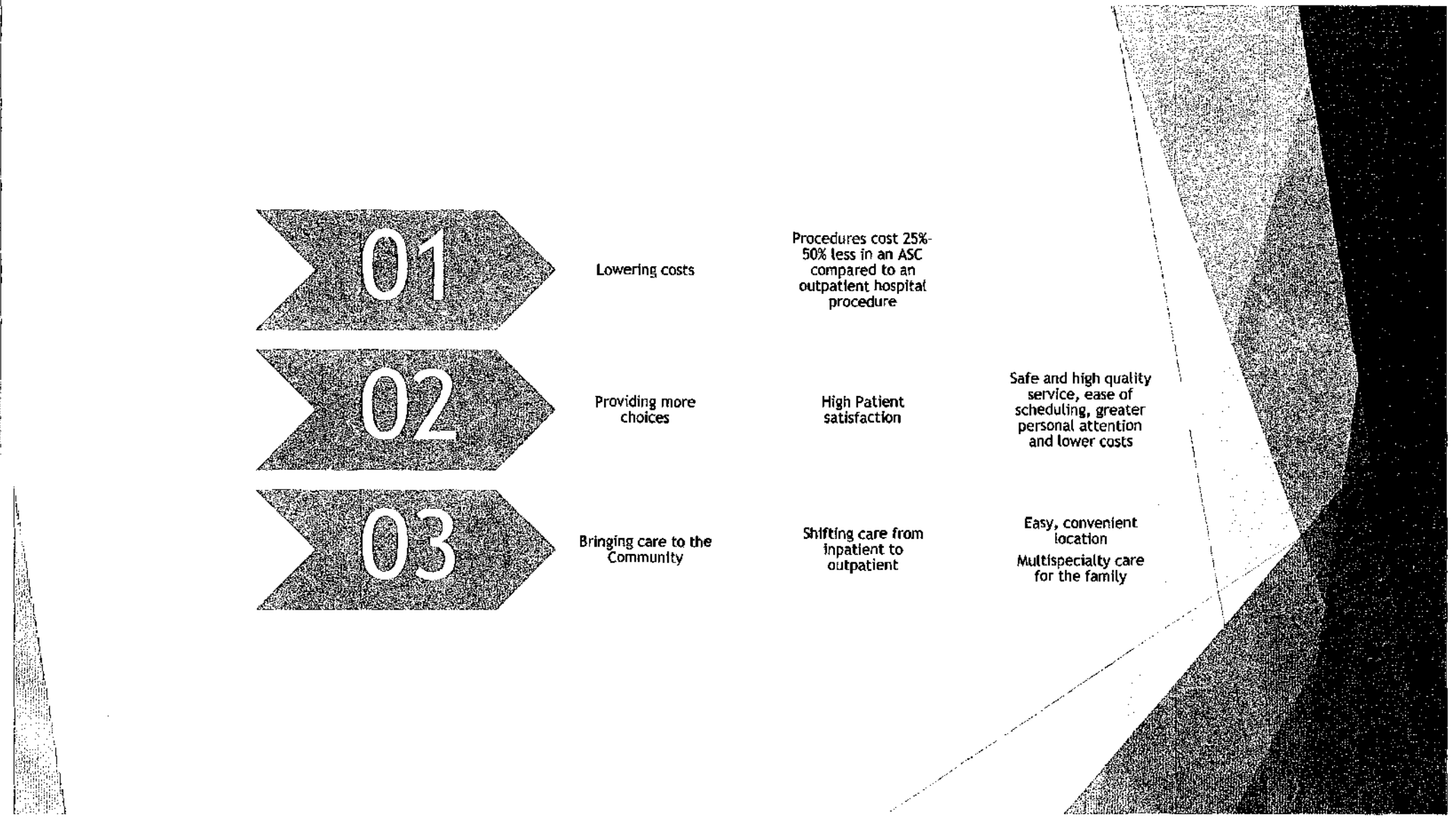
- A highly regulated health care facility to provide outpatient or "day-surgery" procedures
- Provides patients with the convenience of having a non-complex surgery locally, where they live and work
- Research demonstrates exceptional outcomes in ASC's and in fact, patients are less likely to be admitted to the hospital for post-surgery complications.
- Patients report a 92% satisfaction rage for surgeries performed at ASCs



Benefits of an ASC

- ASCs are the right choice for the right patient at the right price.
- Reduce expenses for patients, insurers and Medicare
- Surgeries performed at ASCs are up to 40% less than those performed in hospitals
- Direct savings for patients in high deductible health plans



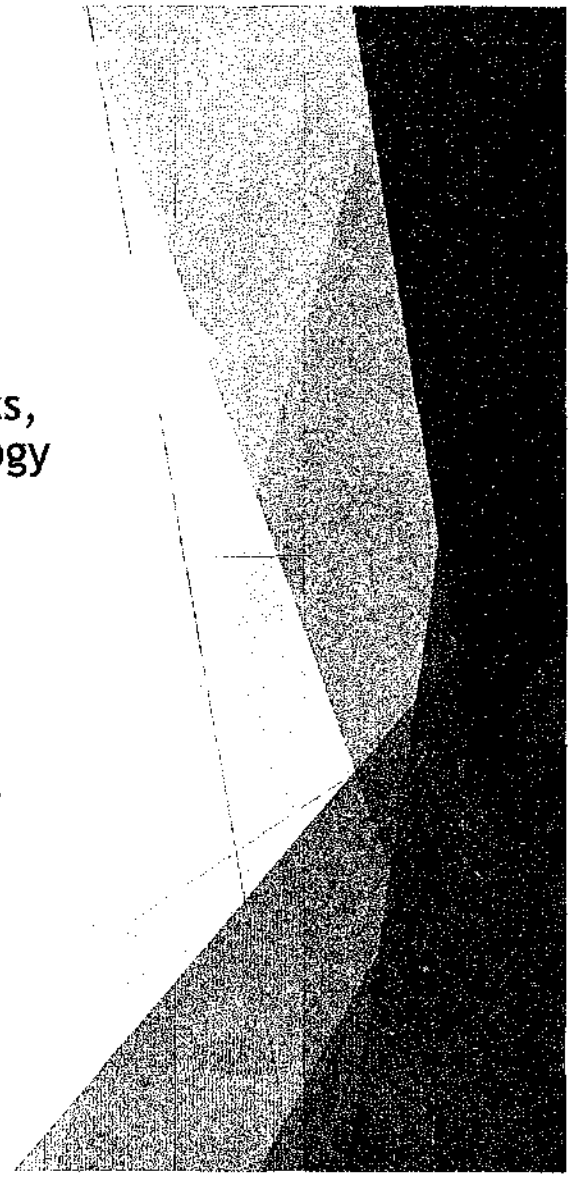

01
Lowering costs
Procedures cost 25%-50% less in an ASC compared to an outpatient hospital procedure
02
Providing more choices
High Patient satisfaction
Safe and high quality service, ease of scheduling, greater personal attention and lower costs
03
Bringing care to the Community
Shifting care from inpatient to outpatient
Easy, convenient location
Multispecialty care for the family

Services

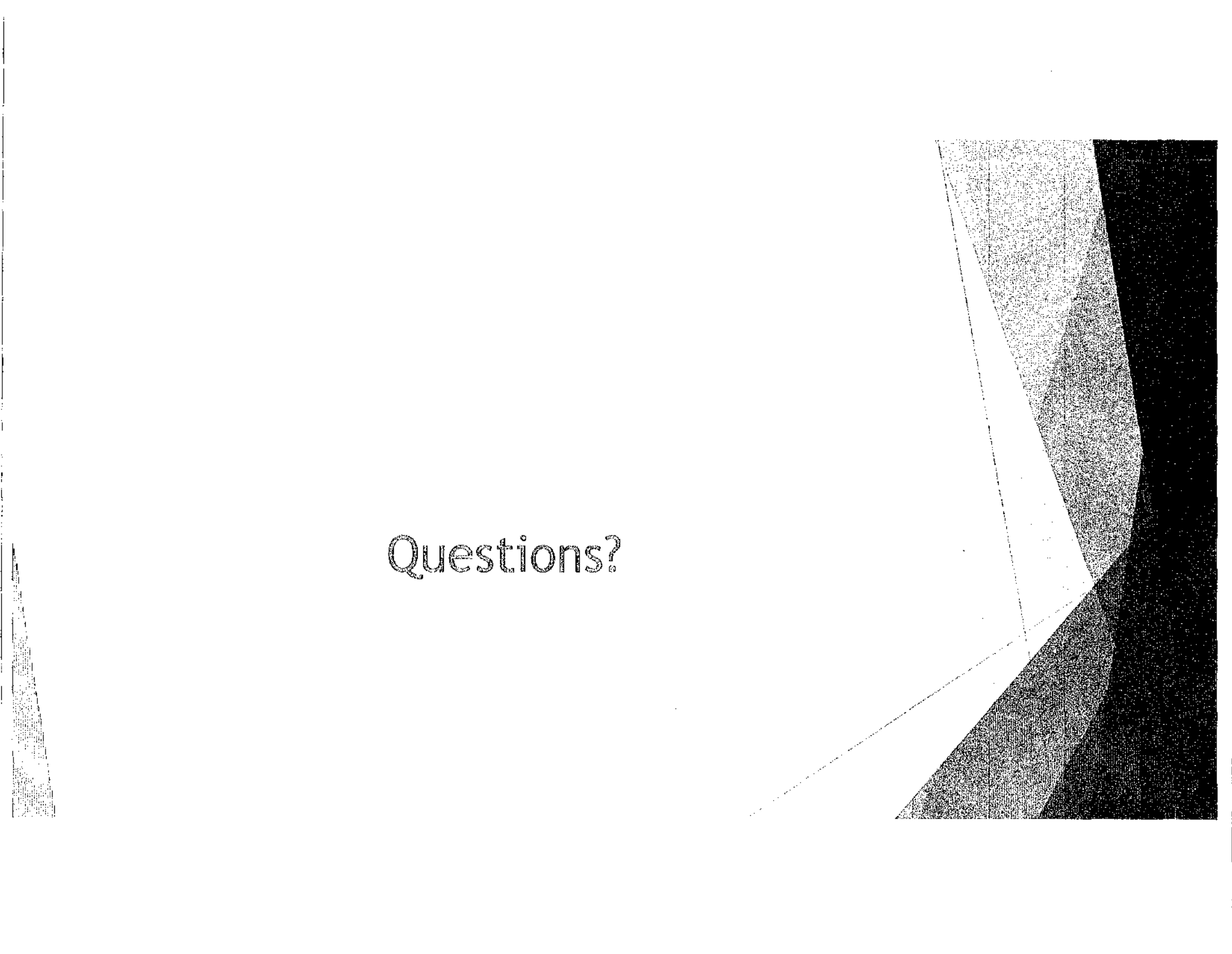
- 2 Operating rooms, 1 procedure room
- General, Pain Management, Plastics, Podiatry, Ophthalmology, Orthopedics, Otolaryngology (ENT), Urology

Facility

- 5,190 square feet of newly renovated space
- 900 Cummings Center, Suite 122U, Beverly, MA



Questions?



Attachment 3

Attachment 4: Community Health Initiative Monies

In compliance with the Department of Public Health's (Department sub-regulatory guidelines and guidance provide by staff (specifically, Mr. Ben Wood), the Applicant is not required to carry out a CHI given its for-profit status, rather the organization is required to contribute directly to the CHI statewide Fund. Consequently, the Applicant will be making a payment of $79,382.30 to the Community Health Initiative (CHI) Statewide Fund upon approval of the Determination of Need from the Public Health Council.

Attachment 4

Massachusetts Public Notices
Powered by MyPublicNotices.com

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE

PUBLIC ANNOUNCEMENT CONCERNING A PROPOSED HEALTH CARE PROJECT New England Surgery Center, LLC ("Applicant"), Freestanding Ambulatory Surgery Center, with a principal place of business at 900 Cummings Center, Suite 122U, Beverly, MA 01915, intends to file an application for a Notice of Determination of Need for the addition of one operating room, with support area through the renovation of existing space at its current location at 900 Cummings Center, Suite 122U, Beverly, MA 01915. The total value of the project based on the maximum capital expenditure is $1,587,646. The Applicant does not anticipate any price or service impacts on its Patient Panel as a result of the project. Any ten Taxpayers of Massachusetts may register in connection with the intended Application by no later than **9/12/20** or 30 days from the Filing Date of the Application, whichever is later, by contacting the Department of Public Health, Determination of Need Program, 250 Washington Street, 6th Floor, Boston, MA 02108. SN - 7/30/20

Appeared in: ***The Salem News*** on Thursday, 07/30/2020

Printer-friendly version E-mail to a friend

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Appeared in: ***The Salem News*** on Thursday, 07/30/2020

Back

Attachment 6

The Commonwealth of Massachusetts

Secretary of the Commonwealth

State House, Boston, Massachusetts 02133

William Francis Galvin
Secretary of the
Commonwealth

Date: July 28, 2020

To Whom It May Concern :

I hereby certify that a certificate of organization of Limited Liability Company was filed in this office by

NEW ENGLAND SURGERY CENTER, LLC

in accordance with the provisions of Massachusetts General Laws, Chapter 156C, on

May 10, 2007.

I further certify that said Limited Liability Company has not filed a Certificate of Cancellation; that said Limited Liability Company has not been administratively dissolved; and that, so far as appears of record, said Limited Liability Company has legal existence.

In testimony of which,
I have hereunto affixed the
Great Seal of the Commonwealth
on the date first above written.

William Francis Galvin

Secretary of the Commonwealth

Certificate Number: 20070553810

Verify this Certificate at: http://corp.sec.state.ma.us/CorpWeb/Certificates/Verify.aspx

Processed by: bod