New England Surgery Center, LLC

Applicant Questions for DoN #20072809-AS

1) Provide the Payer mix and APM contract percentage for New England Surgery Center (NESC) using the table provided below. Provide a year for the data.

New England Surgery Center is a free-standing ambulatory surgery center and not affiliated with any ACO or APM program. There are no Primary Care Physician affiliations. (NESC software does not break payer mix by PPO/HMO/Indemnity)

APM Contract Percentages (for any system-affiliated Primary Care Physicians)				Payer Mix-Lists Percentages (Must = 100%)			
	FY17	FY18	FY19		FY17	FY18	FY18
AXC and APM Contracts	N/A	N/A	N/A	Commercial MassHealth Managed Medicaid	35.0% 2.3% 13.5%	38.8% 2.7% 8.7%	40.0% 2.1% 11.4%
Non-ACO and Non-APM Contracts	N/A	N/A	N/A	Commercial Medicare Medicare FFS All Other	6.4% 34.7% 8.1%	6.0% 35.8% 8.0%	6.3% 32.8% 7.4%

Factor 1 requires the Applicant to demonstrate Patient Panel Need for the Proposed Project

2) The application states that the surgery center is performing more complex procedures.
   a. Explain Patient Panel need for these more complex procedures (pg.3)

A key growth area in the ASC setting is the ability to perform more complex surgeries, such as the Vertiflex, MILD, SI Joint stabilization and neurostimulator implantation procedures for pain and the Fusion image guided sinus surgeries. Some of this growth is fueled by Medicare changing numerous procedures from inpatient to outpatient status. In Massachusetts the population, 65 or older, is slightly higher than the U.S. population with a rate of 15%. Lumbar spinal stenosis (LSS) is a common degenerative spinal condition causing significant pain and functional disability, especially in the elderly. The MILD procedure (percutaneous laminotomy/laminectomy) is only performed on patients 65 or older who have not had success with epidural steroid injections (ESI).

Complex Fusion sinus cases allow better visualization of sinus anatomy and sinus disease. With better visualization and understanding of the patient's anatomy, more complete surgery can be carried out at the first attempt, and carried out more safely. It is generally perceived that IGS (image guided surgery) is critical to certain cases for verifying the location of vital structures

surrounding the paranasal sinuses and minimizing the risk of injury. Intuitively, this would result in improved patient-based outcomes and lower complications or revision rates.[1] [2]

Approximately 90% of the population will at some point experience low back pain. Predisposing factors for SI joint pain include leg length discrepancies, older age, osteoarthritis, previous spine surgery and trauma. Sacroiliac joint pain treatments have included physical therapy, chiropractic manipulation, injections, prolotherapy, radio frequency lesioning, peripheral nerve stimulation and sacroiliac joint fusion.[3] A minimally invasive technique created by "PainTEQ" has been developed specifically for interventional pain management physicians. This procedure is performed using local anesthesia along with either monitored anesthesia care (MAC) or general anesthesia. Three months post fusion, 60% patients had 100% pain relief while 40% had 50-80% pain relief.[4]

Spinal cord stimulation (SCS), for which electrodes are placed into the dorsal epidural space, is an available treatment of a variety of chronic neuropathic pain conditions such as failed back surgery syndrome and complex regional pain syndrome (CRPS). An estimated 40% to 50% of CRPS subjects achieved clinically meaningful pain relief with SCS.

i) What data informed the decision to shift to more complex surgeries?

The applicant has a Medicare base of approximately 40%. With the aging population comes more complex medical issues. The above average incidence and prevalence of these specific complex conditions, compounded by the increase in the populations that tend to have them, has resulted in a decrease in NESC's operating room availability. As the OR demand for these complex cases continues, available OR time will continue to decline resulting in the vital need for expanded surgical capacity for NESC's Patient Panel (primarily comprised of Essex County residents with these diverse and serious health conditions).

ii) Can you provide evidence to demonstrate the benefit of these procedures, including improved outcomes and quality of life for patients?

Evidence of the benefits of the MILD procedure were documented in the MiDAS ENCORE Study, Cleveland Clinic Study and Jain Paper. Historically, definitive treatment of spinal stenosis has been decompressive surgery, which exposes patients to complications, extensive recovery periods and an economic healthcare burden. All patients who have had the procedure show evidence of significant improvement in function, mobility and pain improvement and typically resume normal activity within 24 hours.[5]

BurstDR™ stimulation is a physician-designed form of spinal cord stimulation (SCS) clinically proven to provide superior outcomes for patients with chronic pain over traditional SCS

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[3] Expert Rev Neurotherapy. 2013 Jan; 13(1):99-116. Doi:10.1586/em.12.148. Sacroiliac joint pain: a comprehensive review of epidemiology, diagnosis and treatment. Cohen SP1, Chen Y, Neufeld NJ

[4] Sacroiliac (si) Joint Pain Marc Rad – https//www.ncbi.nlm.nih.gov/books/NBK470299

[5] Regional Anesthesia and Pain Medicine • Volume 00, Number 00, Month 2018

therapy. The brain receives information in two ways: neurons travel through the central nervous system at steady, singular intervals (known as tonic waves) or in clustered "burst" waves BurstDR stimulation was evaluated in a large-scale clinical trial known as the SUNBURST study. The study enrolled 100 patients in 20 centers across the U.S., and found BurstDR delivered:

* **Superior pain relief:** Patients receiving BurstDR stimulation achieved superior pain relief and greater treatment success when compared to traditional tonic SCS.

* **Patient preference:** A majority of patients preferred BurstDR stimulation to traditional tonic SCS for the treatment of their chronic pain.[6]

The use of image-guided surgery (IGS) has played an important and expanding role in endoscopic sinus surgery (ESS) over the past 2 decades. IGS is critical, in certain cases, for verifying the location of vital structures surrounding the paranasal sinuses and minimizing the risk of injury. It may also provide additional information to assist in complete clearance of pathology while maintaining safety. This will result in improved patient-based outcomes and lower complications or revision rates. We are trying to provide care to patients with more extensive disease to avoid referring them to an academic center in town, causing the patients inconvenience and the additional cost from having the procedure performed there.[7]

iii) What percentage of current surgeries do these complex procedures represent? Do you expect this to change after project implementation?

The percentage of current surgeries that these more complex procedures represent is 97% of all pain procedures are complex. Currently, the four surgeons performing pain procedures share one full day per week. As the two newer pain surgeons have indicated that they could utilize an additional day.
12% of all otolaryngology cases are complex. The four surgeons who perform these procedures originally had nine full OR days. OR availability has been reduced to five days in order to accommodate additional in orthopedics and urology. The additional OR capacity would allow otolaryngology to return to 9 full days to accommodate demand.

b. The application notes the recent addition of four general surgeons and three orthopedic surgeons.

i) How will the addition of these surgeons impact the volume and range of surgical services offered at NESC?

When we first began our application process there were three orthopedic surgeons and four general surgeons. We now have four orthopedic surgeons. Previously, our orthopedic cases consisted of shoulder and knee arthroscopies. The addition of these four surgeons increases our surgical services by adding foot, ankle and hand procedures that include open reduction

[6] St. Jude Medical™ Proclaim™ Neurostimulation System Clinician's Manual. Plano, TX. 2016.

[7] American Academy of Otolaryngology—Head and Neck Surgery. Intra-operative use of computer aided surgery. http://www.entnet.org/Practice/policyIntraOperativeSurgery.cfm.Accessed December 24, 2012.

of fractures to foot, ankle and hand, endoscopic and open carpal tunnel and an increased number of knee and shoulder arthroscopies. The majority of these cases require general anesthesia only available in our one OR. These surgeons have indicated that they plan to bring 5-10 cases more per week. The complexity of ankle or wrist open reductions and shoulder arthroscopies take approximately two hours.

The four general surgeons bring a multitude of different procedures that include, excision of malignant lesions, umbilical hernia repair and removal of soft tissue tumors. All general surgery cases are performed under general anesthesia. The volume of cases is reliant on OR time available and length of case, most taking approximately one hour.

Additionally, since the application was submitted, we have credentialed two additional urologists. They have increased our urology cases requiring general anesthesia by 20 cases per month. These cases include TURP (transurethral resection of the prostate), Pyronie disease repair and kidney stone removal. Due to increased procedure complexity the total operative time per procedure has increased from 71.01 minutes in 2017 to 76.83 minutes in 2019.

ii) The application and HCC Factor 4 report note national trends on conditions more prevalent in the age 65 and over population driving demand for surgical services.
   (1) Is there regional data that you can share to understand how that manifests locally?
   (2) Explain how the increase in certain conditions is tied to the need for expanded surgical capacity for the Patient Panel.

Older adults are high utilizers of health care services.[8] Local demand for the services provided by NESC is projected to increase in the near future, primarily as a result of changing trends in demographic characteristics and health indicators in Essex County, MA (NESC's primary market service area). Each of these trends are discussed further below.

The number of Essex County residents over the age of 65 is expected to increase from 142,934 in 2020 to 167,520 in 2025 (an increase of 17.2%).[9] This projected increase in the elderly population will increase demand for a variety of the healthcare services offered by NESC, as the elderly spend disproportionately more on healthcare expenses than the rest of the population.[10]

In addition to increased demand for NESC services stemming from growth of the over-age-65 population, the prevalence of chronic disease among the elder in Essex County has increased from 37% in 2007 to 39% in 2015, and has consistently remained above that of the peer counties (see Table 1, Line 7), Massachusetts and the U.S.[11] The increase of both: (1) the over-age-65 population and (2) the prevalence of chronic disease among the elderly in Essex County, indicates the increased need for surgical services in NESC's market service

[8] US Health Spending Trends by Age and Gender: Selected years 2002-10, David Lassman, Micah Hartman, Benjamin Washington, Kimberly Andrews, and Aaron Catlin, Health Affairs 2014 33:5, 815-822

[9] "Pop-Facts Demographics, By Age, Race, and Sex: Essex County, MA" Spotlight, Environics Analytics, 2020

[10] "US Health Spending Trends By Age and Gender: Selected Years 2002-10" By David Lassman et al., Health Affairs, Vol. 33, No. 5 (2014), p. 820.

[11] "Chronic Diseases Among Older Adults," Impact Essex County, https://impactessexcounty.org/health/chronic-disease-among-older-adults (Accessed 10/20/22).

area. In particular, there is expected to be an increase in the demand for urological, orthopedic, and ophthalmologic surgical services (i.e., the primary surgical cases performed at NESC), as these are the most commonly-utilized surgical services by the over-age-65 population.[12]

In addition to the elderly, those individuals with certain health determinants require more healthcare services than the rest of the population. For example, the percentage of the Essex County adult population considered to be obese has increased from 19% in 2004 to 25% in 2016 (see Table 1).[13] Individuals with obesity are more likely to require surgical services relative to individuals who are not overweight.[14] Specifically, individuals with obesity are 20 times more likely to need a knee replacement than individuals who are not overweight.[15] The increased obesity in Essex County indicates that there will be an increase in the need for orthopedic surgical procedures at NESC in the future.

Finally, as compared to Massachusetts and the U.S., Essex County has a higher age-adjusted incidence rate per 100,000 population for all cases of cancer.[16] The cancers with the highest incidence in Essex County are breast, lung & bronchus, prostate, colon & rectum, and bladder (see Table 2).[17] The high incidence rates of cancer in Essex County result in the increasing demand for the multi-specialty surgical services offered by NESC.

The above average incidence and prevalence of these specific conditions, compounded by the increase in the populations that tend to have these conditions, have resulted in a decrease in NESC's operating room availability, which is projected to decrease further, resulting in the vital need for expanded surgical capacity for NESC's Patient Panel (primarily comprised of Essex County residents with these diverse and serious health conditions).

c. Describe the criteria used to determine need for the addition of one enclosed pediatric room, and two additional post-op beds.

The addition of requested post-op beds is required by the departments plan review State Compliance Checklist. When the center was originally built in 2010, we were required to have 1.5 post-op beds per OR. The new 12/2018 requirements are one patient care station for each operating room. The expansion would require one current post-op bed to be removed to allow for access to the expansion area. The new area would include the bed lost and the required

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12 "Patterns of Surgical Care and Complications in Elderly Adults," By Stacie Deiner, Benjamin Westlake, and Richard Dutton, Journal of the American Geriatrics Society, Vol. 62, No. 5, May 2014, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4024102/pdf/nihms568357.pdf (Accessed 10/22/20).

13 "Health Outcomes – Essex County," County Health Rankings, https://www.countyhealthrankings.org/app/massachusetts/2020/rankings/essex/county/outcomes/overall/snapshot (Accessed 10/22/20).

14 "The Impact of Obesity on Bone and Joint Health," American Academy of Orthopaedic Surgeons (AAOS), March 2015, https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1184-the-impact-of-obesity-on-bone-and-joint-health1.pdf (Accessed 10/22/20).

15 "The Impact of Obesity on Bone and Joint Health," American Academy of Orthopaedic Surgeons (AAOS), March 2015, https://www.aaos.org/contentassets/1cd7f41417ec4dd4b5c4c48532183b96/1184-the-impact-of-obesity-on-bone-and-joint-health1.pdf (Accessed 10/22/20).

16 "Incidence Rate Report for Massachusetts by County, 2013-2017," State Cancer Profiles, National Cancer Institute, https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=25&areatype=county&cancer=001&race=00&sex=0&age=001&type=incd&sortVariableName=rate&sortOrder=default&output=0#results (Accessed 10/22/20).

17 "Incidence Rate Report for Massachusetts by County, 2013-2017," State Cancer Profiles, National Cancer Institute, https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=25&areatype=county&cancer=001&race=00&sex=0&age=001&type=incd&sortVariableName=rate&sortOrder=default&output=0#results (Accessed 10/22/20).

additional bed. We currently have seven pre/post-procedure beds. After expansion the center would have nine pre/post-procedure and one enclosed pediatric room.

Pediatric cases performed most often are tonsils and adenoids. The surgeons require the patient to remain for two to three hours, to ensure there are no post-op complications. Children do not recover from anesthesia as easily as adults and spend a significant amount of time crying. Because the center performs cases on such a diverse group of patients, the crying child can be stressful to an older patient. The enclosed room would help to prevent this. With only one OR for general anesthesia, no OR time is available for a day with just pediatric cases.

d. The application states that without the Proposed Project, cases would be turned away to higher cost HOPDs. However, the HCC Factor 4 report identified six potential NESC competitors in the market service area. Explain why a higher cost HOPD is the only alternative for the Patient Panel.

Of the six potential NESC competitors in our area, there are no multi-specialty free standing ambulatory surgery centers to provide the lower cost cases. Peabody Surgery Center was opened by a plastic surgeon and closed. It is now North Shore Plastics and performs office procedures. Two centers Mass General/North Shore and Lahey Outpatient Danvers are hospital outpatient facilities and bill HOPD rates leading to a higher cost to patients and insurers. Lahey Medical Center Peabody is an urgent care facility, where no surgery is performed, and also has primary care physicians' offices, lab and x-ray. New England Pain Care only provides pain care treatments (e.g. injections, massage, physical therapy) and a minimal number of pain procedures. Lastly, Orthopedic Surgery Center of the North Shore is a limited multi-specialty facility. It was licensed for Orthopedics and has added pain and GI specialties in the past 10 years.

3) In the application, it states that because of the additional volume from new surgeons, the operating room will meet or exceed its capacity.

a. The OR is currently seeing reserved time usage of 58-62%. How are you defining maximum capacity?

The applicant utilizes individual and group block scheduling for OR time. OR time is figured as 9.5 hrs/day x 5 days = 47.5 hrs/wk. This allows 2,470 OR hours per year (not allowing for holidays). Optimal OR usage would be 75-80%, utilization higher than 85% to 90% leads to patient delays and staff overtime.[18] Over the past three years (2017-2019) OR block utilization has increased from 60.3% to 63.5%. Other time indicators used in the OR are anesthesia which takes 45% and time to prepare the OR. The ideal OR preparation time between one operation and another can be classified as of high performance if up to 25 minutes, NESC exceeds this with 15-20-minute turnovers.

[18] Anesthesia & Analgesia, May 2003, 96(4):1114-21, Pub Med

b. Explain the referring origin of current (and anticipated) NESC surgical patients.

As a free-standing ambulatory surgery center, without ACO affiliation, we do not receive referrals directly. The surgeons that perform cases at the center receive referrals from primary care physicians in Essex County and surrounding areas.

Factor 1 requires us to consider "evidence of sound community engagement and consultation throughout the development of the Proposed Project."

4) List how many people attended the information sessions on November 5th and November 11th (other than staff or clinicians employed or working at NESC.)

Information was highly publicized in the Essex County and surrounding areas, but there were only two total attendees. These were staff members of North Shore Medical Group that is located in the same building as our center. They came to the open house on November 5th as they were leaving work.

a. Provide any feedback received from participants engaged during the development of the Proposed Project.

All feedback to date has been enthusiastic and positive. Surgeons are voicing approval and hoping they will be able to move more cases to the center. Patients who were made aware of the project, by the information posted in the lobby, gave their "thumbs up" and were happy to see us growing and would recommend our facility to anyone needing surgery.

In order to understand how the Proposed Project will improve health outcomes and quality of life:

5) Describe the current wait times for surgeries for NESC patients and how they will be impacted by the proposed Project.

Wait times vary by specialty. Due to a reduction in block time for otolaryngology, patient wait times are 5-10 days. The proposed project would bring the number of hours allotted to this group back to the original nine. Due to pain management cases all being performed in one day, shared by four surgeons, patients wait time is also 5-10 days. Orthopedics has three half days to allow four surgeons to book their cases, many of which require two hours plus for complicated ORIF of wrists or ankles. They can only get two cases completed in one half day. The project would allow additional OR time for these four surgeons.

6) The application describes a correlation between surgeon volume and quality of care (pg.14). Explain the implications for the Proposed Project and the Patient Panel's quality of care and health outcomes?

As noted in the narrative, higher volume is correlated with higher quality of care and health outcomes. Surgeons can perform their procedures in a more convenient setting without delay due to trauma or urgent surgeries. ASCs can expedite the scheduling process and allow patients

to receive treatment in a timelier manner. Longer wait times result in decreased patient satisfaction,[19]and are associated with higher rates of medical complications. The patients look forward to a quicker return to work, life or sports.

7) The quality of care measures you site focus on adverse events (pg. 14). In order to demonstrate how the Proposed Project will add measurable public health value, provide quality and outcome measures that are most appropriate to the patients impacted by the services provided through the Proposed Project.

The applicant provides a streamlined patient satisfaction survey both online and by paper to each patient seen at the facility. This survey measures quality indicators related to patient satisfaction and quality of care. There are 6 key elements of these surveys: (1) before patient procedure, (2) about the facility and staff (3) communications about patients' procedure (4) patient recovery (5) overall rating of facility and (6) recommendation of facility. .

On the survey, patients are asked if they were able to discuss financial arrangements prior to their surgery. Due to replies to this question, the applicant added a staff member to the billing office who is responsible for checking all patient benefits and contacts the patient with information on deductibles, copays and coinsurances. No patient receives a surprise bill.

Patients are asked if all their contact with the center pre- and post-surgery was provided in a clear and concise manner and if all of their questions and concerns were addressed. With the changes required due to the pandemic, patient's family or caregiver cannot wait in the facility. Prior to anesthesia, all patients are provided with post-surgery training in the pre-op area and when discharged, walked to their transportation and post-surgery information. Patients and family have been comfortable and understanding about this change.

In addition to the satisfaction survey, patients receive a call from one of the post-surgery nurses 24 hours after their surgery. They are questioned about adequate discharge instructions, pain, nausea and vomiting, signs or symptoms of infection or falls. Results of these calls are addressed during the call and reviewed by the Quality Improvement Committee.

As previously mentioned, the applicant will continue to provide patients with improved quality of care, improved health outcomes in a more cost-effective way. Patients out-of-pocket expenses are greatly reduced by having their surgery at the ASC.

With respect to health equity, we understand that NESC provides language access.

8) Describe what else NESC is doing around CLAS. Refer to the guide on CLASS https://www.mass.gov/lists/making-clas-happen-six-areas-for-action - if needed.

NESC has embraced and appreciates the wealth of diversity reflected in its patients, employees and the community it serves. This allows us to be a more compassionate organization. In order to provide quality care and positive outcomes for all patients, the facility does not discriminate based

[19] hhttps://www.ncbi.nlm.nih.gov/pmc/araticles/PMC5513615

on race, education, health literacy, age, sexual orientation, ethnicity, religion, physical or mental disability, language, gender, gender expression, identity, income, or class (National Partnership for Action to End Health Disparities, 2011). All individuals have the right to be free of discrimination while accessing care or services. For the past 10+ years, the applicant has created a culture that does not tolerate bias by providing annual diversity training for all staff, surgeons and new hires, through HealthStream. This training is reviewed yearly and adjustments made in order to keep training topics relevant. Training on sexual harassment is provided through Paychex and surgeons are provided this information via written material. The Governing Board reviews all of the training yearly.

9) Provide the number of physicians performing procedures at the surgery center and the current percentage participating as Mass Health Providers

   There are currently 24 surgeons performing procedures at the surgery center and 90% are participating Mass Health Providers, but not to all products.

   a. Describe any efforts underway to increase the percentage of MassHealth in the payer mix?

      MassHealth is the 3rd highest volume of payers for the applicant's facility (Table 1) NESC contracts with all MassHealth products. The administrator works closely with Davina Maddox, provider representative at MassHealth, and was instrumental in providing case information that lead to an increase in the rate of payment ASC's received, the first since 2010. With this increase, we have been in contact with all surgeons' offices providing them with information on our ability to now perform most cases. The administrator has previously provided written testimony to the Massachusetts Health Policy Commission (HPC) regarding healthcare cost trends and how to assist the state in meeting its benchmark. Surgery centers are the cost-effective way to do this.

We understand that many of the activities related to continuity and care coordination occur at the surgeon's office and/or PCP.

10) Explain how patient records are shared between NESC, the surgeons' offices and patient's primary care physician.

    It is typically the surgeon's office, rather than NESC staff, that shares information with the patient's primary care physician. However, if there are responses during review of the pre-op questionnaire, that staff determine require follow-up, the primary care physician or specialist is contacted by phone or fax. Staff also have viewing access to Lahey Epic to review test results. The center provides copies of the operative notes to the primary care physician and surgeon. A nurse contacts the patient the day after surgery and patients are asked about pain, mobility, medication, nausea and vomiting, signs of infection or if any falls have occurred. Any questions or concerns are addressed and if necessary, the patient is instructed to contact their surgeon or other specialist. The nurse making the post-op call will contact the surgeon's office as necessary.

a. Are there electronic interfaces to ensure interoperability?

The HITECH Act providing incentives for physicians and hospitals that implement an EHR, does not include ASCs, thus the center would have to bear the full cost of purchasing and installing an EHR. NESC does not have an EHR and the only form of interface is the ability to access Epic for patient test results, which has been provided by the local hospital.

11) How are services coordinated for patients requiring assistance with registration/pre-operative questionnaire?

Assistance for patients starts when their procedure is booked by a surgeon's office. Booking sheets list special needs or equipment that will be needed for an upcoming date. If the patient is vision or hearing impaired or a patient has limited English, the preop nurse will contact CyraCom. CyraCom provides us with phone and video interpretation for all communication needs. Occasionally, we do need to contact the Massachusetts Commission for the Deaf and if they have an interpreter available, we use them. If questions regarding the patient's health occur during review of the questionnaire, the primary care physician or another specialist is contacted.

a. Describe the social needs that are identified by the questionnaire and how are they addressed.

As a free-standing ambulatory surgery center, physician owned and not affiliated with any ACO, we provide day surgery to high-acuity patients. As such, we are not directly aligned with social services and community-based experts. However, during their pre-op call a patient will be asked if they require assistance to ambulate, and if needed, wheelchairs are available. Ensuring the patient is safe at home is a priority of NESC so the patient is asked to identify the person who will be providing transportation to and from the appointment and who will be with them at home for the first 24 hours. They are asked if they feel safe at home, and if abuse is indicated, we provide contact information for the MA Statewide Domestic Violence Hotline.

b. Describe how the Applicant communicates with referring physicians' post-procedure.

Surgical and OR notes and results are forwarded to surgeons and primary care providers for follow-up post-surgery either by mail or fax. If the patients have experienced a problem post-surgery and this is found during a post-surgery call, the nurse will contact the surgeon's office by phone to provide this additional information to the surgeon who would share with the primary care physician.

TABLES

Table 1: Summary of Essex County Characteristics

	Characteristic	Geographic Region	Number	% of Population
1	Population Ages 65+: 2020	Essex County	142,934	18%
2	Population Ages 65+: 2025	Essex County	167,520	20%
3	Population Ages 65+ With a Chronic Disease: 2007[20]	Essex County	38,881	37%
4	Population Ages 65+ With a Chronic Disease: 2015[21]	Essex County	55,744	39%
5		Massachusetts	459,089	38%
6		United States	20,886,696	38%
7		Peer Counties[22]	379,861	36%
8	Adult Population With Obesity: 2004[23]	Essex County	108,503	19%
9	Adult Population With Obesity: 2016[24]	Essex County	157,644	25%

Table 2: Summary of Cancer Incidence

	Geographic Region	Cancer Site	Age-Adjusted Incidence Rate (Cases per 100,000)	Average Annual Count
1	Massachusetts	All Sites	452.7	37,030
2	United States		448.7	1,673,102
3	Essex County		462.4	4,439
4	Essex County	Breast	138.3	700
5		Lung & Bronchus	61	599
6		Prostate	107.4	509
7		Colon & Rectum	33.3	316
8		Bladder	25.2	245

20 Population Size was estimated using 2010 population data. "Pop-Facts Demographics, By Age, Race, and Sex: Essex County, MA" Spotlight, Environics Analytics, 2020

21 Population Size was estimated using 2020 population data. "Pop-Facts Demographics, By Age, Race, and Sex: Essex County, MA" Spotlight, Environics Analytics, 2020; "Pop-Facts Demographics, By Age, Race, and Sex: Massachusetts" Spotlight, Environics Analytics, 2020; "Pop-Facts Demographics, By Age, Race, and Sex: United States" Spotlight, Environics Analytics, 2020.

22 Peer County % and Population Size was calculated by taking an average of the reported % and estimated population size for the provided peer counties (Lake County, IL, Middlesex County, MA, and Westchester County, NY). Peer counties were identified by Impact Essex County.

23 Population Size was estimated using 2010 population data. "Pop-Facts Demographics, By Age, Race, and Sex: Essex County, MA" Spotlight, Environics Analytics, 2020

24 Population Size was estimated using 2020 population data. "Pop-Facts Demographics, By Age, Race, and Sex: Essex County, MA" Spotlight, Environics Analytics, 2020; "Pop-Facts Demographics, By Age, Race, and Sex: Massachusetts" Spotlight, Environics Analytics, 2020; "Pop-Facts Demographics, By Age, Race, and Sex: United States" Spotlight, Environics Analytics, 2020.

Table 3

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%

APPLICANT QUESTIONS

Responses should be sent to DoN staff at DPH.DON@State.MA.US

1. In the DoN application and responses to DoN questions, the Applicant stated NESC added four general surgeons, four orthopedic surgeons, and two urologists.
    a. Explain why NESC chose to add new surgeons and increase its surgical services.

New England Surgery Center is a multi-specialty, AAAHC/Medicare certified facility whose mission is to provide comprehensive, compassionate and cost-effective care to patients that require specialized and general outpatient center surgical services. As we indicated in the Application, recent reimbursement trends, involving both Medicare and other payers, together with clinical advances have resulted in changes in the locations for a number of procedures to outpatient settings. Moreover, freestanding ASCs offer a more cost-effective high-quality alternative to Hospital Outpatient Departments (HOPDs). Increasingly, surgeons have experienced difficulty in scheduling patients at HOPDs. NESC's Governing Board, after reviewing OR block time utilization, concluded that there was capacity for the addition of new surgeons and general surgery OR block times can be one hour for one case to a full day (7:00-4:30) for one surgeon or one group.

BLOCK TIME UTILIZTION

2017	60.3%
2018	62.2%
2019	63.5%

The business plan of the center is to reflect market trends and projected increased demand to achieve growth over a period of time by adding high performing surgeons. Orthopedics and urology are founding specialties of the center and have grown as additional surgeons have approached owners of the center requesting privileges. General surgery was added September, 2019, in response to surgeon's requests to be credentialed and anticipated demand. The Department was notified that general surgery would be performed at NESC.

2. The Applicant indicated complex procedures represent 97% of all pain procedures and 12% of all otolaryngology cases.
    a. From which year are these data from?

Collection of data for complex pain procedures began in 2016 after CMS changed payment rationale for interventional pain management. (Table below.) More complex interventional techniques are being performed in lieu of prescription opioids[1] and as CMS has approved more complex procedures to be moved to the outpatient fee schedule.

YEAR	INJECTION	COMPLEX CASES
2017	82%	18%
2018	40%	60%
2019	17%	83%
2020 thru 10/31/20	3%	97%

[1] Pain Physician 2018; 21:415-432 • ISSN 1533-3159

Collection of data for otolaryngology cases began in May, 2018 (table below) after the surgeon that performed most pediatric cases left his group and a new surgeon joined the group and specialized in sinus surgery.

YEAR	CASES	%SINUS SURGERY
2018	310	8%
2019	319	12%
2020 (as of 10/31/20)	169	14%

b. Is the shift to complex procedures occurring in other specialties? If so, provide the percentage of complex procedures by specialty.

At this time there are no other specialties moving to more complex procedures.

3. What percentage of FY19 case volume was complex procedures?

Complex procedures make up 13% of the 2019 case volume.

4. How do you determine which patients will derive the most benefit from complex procedures?

Determining which patient would benefit from a more complex procedure is not the decision of the applicant but rests solely on the expertise and knowledge of the surgeon that will perform the procedure. The surgeon obtains authorization from payors after they undergo clinical review.

5. The Applicant described a shift to more complex procedures resulting from Medicare approval of the procedures in the outpatient setting.
   a. During what time frame did these Medicare changes occur?

As previously mentioned in Question 2, pain management began to shift to more complex procedures in 2016 when Medicare changed its payment rationale and began to work toward alternatives to opioid treatments, evidenced in the above table. The Otolaryngology case shift began in 2018 date.

6. The Applicant stated OR days available for the four surgeons performing otolaryngology cases were reduced from nine full days to five days.
   a. The OR schedule is five days over what period of time?

The equivalent of 5 days available to otolaryngology is a total of half days and full days over a period of one month.

b. Which year did the reduction in OR days occur?

Otolaryngology's reduction in OR days began in 2019 as there became a need for more OR time by other physicians. The applicant worked with this group and encouraged them to move from one surgeon per day to two surgeons sharing.

7. List all the social needs that you screen for in the pre-operative questionnaire.

   When our patients are screened, they are asked about their smoking habits, if they use alcohol or drugs, whether they feel safe at home or suffer abuse and their level of physical activity. If a patient doesn't feel safe at home or suffers abuse, we provide information on the Massachusetts Statewide Domestic Hotline.

   As a free-standing ambulatory surgery center not affiliated with a hospital, the applicant is not able to meet all of the social needs of our patients. That does not deter us from giving high-quality low-cost care.

8. The Applicant mentioned working closely with a provider representative at MassHealth in a process that led to an increase in the rate of payment ASC's received, which has increased the facility's ability to perform most cases.
   a. Explain how the rate increase from MassHealth increased the facility's surgical services?

      Prior to the MassHealth rate increase, procedures that cost the facility more than was reimbursed could not be accommodated and had to be performed at HOPDs. This was true for most cases not only those more complex. The complex cases are more costly due to the length of time they take and/or implants used (e.g. invoice for a spinal cord stimulator is $15,500 facility reimbursement was $12,728.) With the rate increase we are able to not only cover all of our costs (fixed and staff) but see a small profit, while still providing a lower cost option to HOPDs.

   b. How does the rate increase impact the Applicant's ability to provide lower-cost surgical services?

      Historically, ASCs have always provided lower cost surgical services. With the reimbursements at 50% of those paid to HOPDs, the rate increases will allow us to accommodate more MassHealth product cases and continue to provide more cost effective, safe, high-quality care.[2]

   c. Explain why the surgeons participating as MassHealth Providers do not participate in all MassHealth products.

      Participation in all MassHealth products is not possible for the facility or the surgeons. Some plans are for emergency services only and specifically state they won't pay outside of these guidelines (e.g. MassHealth Buy In and Family Assistance – listed as not covered in an ASC; MassHealth Limited - emergency services only.)

9. Explain how the increase in total operative time per procedure (71.01 minutes in 2017 to 76.83 minutes in 2019) is reducing OR availability?

   The increase in total operative time per procedure reduces the time available per day to a lower number of cases. A full OR day would be 8 cases including turnaround time. As the operative time per procedure has increased, we are now down to 7 cases. When

[2] Steward Angie, "HOPD vs. ASCs: 5 insights on the Reimbursement Gap," Becker's ASC Review, 4/6/2018.

more complex cases are scheduled, at approximately 120 minutes per case, we are then reduced to 4-5 cases per day.

APPLICANT QUESTIONS

Responses should be sent to DoN staff at DPH.DON@State.MA.US

While you may submit each answer as available, please

- List question number and question for each answer you provide
- Submit responses as a separate word document, using the above application title and number as a running header and page numbers in the footer
- When providing the answer to the final question, submit all questions and answers in one final document
- Submit responses in WORD or EXCEL; only use PDF's if absolutely necessary. If "cutting and pasting" charts, provide them in a PDF so they can be clearly seen

1. In the DON application and responses to DoN questions, the applicant states optimal OR utilization is 75-80%, and that utilization higher than 85% to 90% leads to patient delays and staff overtime. The OR at NESC is currently seeing usage of 58-62%, and over the past three years (2017-2019) OR block utilization increased from 60.3% to 63.5%.
   a. Explain the need for additional OR capacity when current OR utilization is less than the optimal OR utilization.

      The application process for additional OR space was started after review of the continued growth pattern over the past three years and the projection of future OR needs with the addition of orthopedic and general surgeons. The increased case load projections were previously supplied in F1.a.i. As of October 31, 2020, the OR utilization increased to 65.7%, even though we had a partial close due to the Covid pandemic. November OR utilization was 73.7%.

      Also, CMS is finalizing its proposal to transition codes off the inpatient-only list, indicating in the final rule that the list will be eliminated by 2024. CMS is starting with approximately 300 services for removal from the inpatient-only list in 2021. These procedures are primarily musculoskeletal[1] and are within the surgical specialty areas provided by the Applicant. As more codes are moved to the outpatient list, the center continues to believe our projections for a second OR are correct.

   b. How will the addition of a second OR improve OR utilization and increase access to NESC's services?

      The addition of a second OR will allow the center to provide more optimum OR time and less wait time to patients who require the more complex cases. Since the complex cases taking approximately two hours, we are only able to accommodate four cases per day. An additional OR would allow us to provide access to four additional patients requiring the more complex cases.

      Due to the pandemic, the time between cases has had to be increased to provide for adequate air exchanges. With this additional time and as previously mentioned, the addition of cases approved by CMS to be added to the outpatient list, the second OR will be necessary to improve OR utilization and provide more patients access to NESC's services.

[1] Ambulatory Surgery Center Association; Elimination of Inpatient-only List by 2024; December 2, 2020

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Massachusetts Health Policy Commission, in collaboration with the Office of the Attorney General and the Center for Health Information and Analysis, will hold a public hearing on health care cost trends. The Hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled Hearing dates and location:

Monday, October 17, 2016, 9:00 AM
Tuesday, October 18, 2016, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on Tuesday, October 18. Any person who wishes to testify may sign up on a first-come, first-served basis when the Hearing commences on October 17.

Members of the public may also submit written testimony. Written comments will be accepted until October 21, 2016, and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 21, 2016, to the Massachusetts Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02109, attention Lois H. Johnson, General Counsel.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the Hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at Suffolk, but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this Hearing, please contact Kelly Mercer at (617) 979-1420 or by email Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the Hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the Hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us.

You may expect to receive the questions and exhibits as an attachment from HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

We encourage you to refer to and build upon your organization's 2013, 2014, and/or 2015 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. **If a question is not applicable to your organization, please indicate so in your response.**

The testimony must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any difficulty with the Microsoft Word template, did not receive the email, or have any other questions regarding the Pre-Filed Testimony process or the questions, please contact HPC staff at HPC-Testimony@state.ma.us or (617) 979-1400. For inquires related to questions required by the Office of the Attorney General in Exhibit C, please contact Assistant Attorney General Emily Gabrault at Emily.gabrault@state.ma.us or (617) 963-2636.

On or before the close of business on **September 2, 2016**, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. Please complete relevant responses in the provided template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in Microsoft Excel or Access format. If there is a point that is relevant to more than one question, please state it only once and make an internal reference.

If a question is not applicable to your organization, please indicate so in your response.

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

* Drug costs are increasing and we continue to deal with shortages
* Expenses per procedure have increased more than revenue per procedure from 2010 to present.
* The increase in high deductible health plans requiring more out of pocket expense for the patient.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

*Remove the current Department of Public Health moratorium on Free Standing Ambulatory Surgery Centers and allow growth without being affiliated with an acute care hospital. These Centers provide high quality patient care in a much less expensive setting.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Does NOT Apply to my Organization

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Does NOT Apply to my Organization

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Does NOT Apply to my Organization

iv. Establishing internal formularies for prescribing of high-cost drugs

Does NOT Apply to my Organization

v. Implementing programs or strategies to improve medication adherence/compliance
Does NOT Apply to my Organization

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending
Does NOT Apply to my Organization

vii. Other: Insert Text Here
Click Here

viii. Other: Insert Text Here
Click Here

ix. Other: Insert Text Here
Click Here

3. **Strategies to Integrate Behavioral Health Care.**
Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)
N/A

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)
N/A

4. **Strategies to Recognize and Address Social Determinants of Health.**
There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

* As a Free Standing Ambulatory Surgery Center, we only provide day surgery therefore our patient interaction is limited. As part of our screening process patients are asked if they feel safe in their environment. We have available, information on the Mass Statewide Domestic Violence Hotline. We also required that patients go home with a responsible adult.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

* Because we see these patients on a one-time basis, lack of time spent is the biggest barrier.

5. **Strategies to Encourage High-Value Referrals**.
In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

N/A

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   Click here to enter text.

   ii. If no, why not?
   We do not have an electronic health record system.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?
No

   i. If yes, please describe what information is included.
   Click here to enter text.

   ii. If no, why not?
   Same as b.ii.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?
No

   i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
   Click here to enter text.

   ii. If no, why not?
   We do not have an electronic health record system but we can retrieve information through Epic with special permission from our local hospital.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

   *Our center has tried to work on bundled payments for self-insured companies and for self-pay patients but this process has been slow to implement.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)

* The largest barrier for free standing ambulatory surgery centers is the rate at which they are paid (approx 52% of what an HOPD is paid.) Trying to work within the confines APMs would be almost impossible.

c. Are behavioral health services included in your APM contracts with payers?
No
   i. If no, why not?
   Day surgery only

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.
   a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

   * Lack of alignment statewide would add another level of stress to already overburdened administration, staff and physicians. We currently do required quality reporting to CMS. If each health plan required reporting, the amount of time spent would be greater than the time needed for patient care. It is important that any statewide alignment not add to the already overburdened administrative staff but possibly work with the national reporting already in effect.

   b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

   *It is suggested that the state not add any additional quality measures to the list already required nationally.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

9.

*It is high recommended that the proposed revision of 105 CMR 100.000: Determination of Need not be considered. The proposed restrictions will not aid the state in reducing Health Care Cost Growth but contribute to the unnecessary increases. Free Standing Ambulatory Surgery Centers are able to provide much less expensive, but high quality care to patients already overwhelmed by being forced to change to health plans with increased costs and higher deductibles.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.
   Click here to enter text.

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.
   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

   *Whenever a patient inquires about prices for procedures or what their responsibility would be, we look at their insurance plan and its corresponding fee schedule and give them an approximate amount. Patients are always told that this is an estimate and may change as clinically needed.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

   *We do not monitor the timeliness of our response as the requested information is given at the time of the initial call. Patients are told during the call that this is solely an estimate and may change due to the many variables that can occur during their procedure.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

   *We have found no issues with responding to inquiries. The only issues that occasionally arise are the surgeon modifying or changing the procedure as clinical needs occur.

Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

    Our facility has seen a continuing decrease in reimbursement for Pain Management procedures. We have seen an increase in utilization due to the addition of a number of new surgeons and the increase in the number of cases other surgeons have added. Surgeons can do four or five cases at an HOPD versus ten or eleven cases at the center due to the turnover time. The center works with two group purchasing organizations and our materials manager works with supplier representatives on a consignment plan for some of the supplies, all in an effort to keep supply costs down. The center has increased the staff health insurance deductible to minimize the centers contribution. All of these efforts to control costs are accomplished with ASC being paid only 58% of what the HOPD's are paid, and still saving the patient, payers and the State.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

    The center has talked with payors in an effort to move more procedures to the ASC from the HOPD. This would help in controlling health care spending due to ASC being paid only 58% of what the HOPD's are paid but allowing patients to still receive the high quality health care.

    c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

    Our center has embraced price transparency by providing patients with high deductibles or no insurance, the opportunity to bundle surgeon/facility/anesthesia into one price.

    d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

    - The facility could operate more efficiently if less time was spent providing duplicate data to multiple organizations under one department.
    - ASC's should not continue to be lumped in with hospitals and required to provide data on patient types we do not see in a same day surgery setting.
    - Produce legislation that prohibits exclusive referral arrangements. All physicians should be allowed to access the lower cost service of an ASC that maintains equal or greater quality service to that of the HOPD.

- Remove the Determination of Need guidelines enabling existing ASC growth.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?
    - Barriers preventing adoption of alternative payment methods is the continued inequity of fee schedules between ASC's and HOPD's.
    - HOPD's should be paid at the same rate as ASC's.
    - Payors should not be afraid to anger the hospitals by allowing more procedures to be done in the ASC's.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.
        1. ASC's day surgery does not require post-acute care
        2. N/A surgery center
        3. Only doing cases appropriate for day surgery reduces emergency department use
        4. N/A not done at ASC

    b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.
        The ASC will continue to pre-op screen patients and only do those appropriate for day surgery

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?
        There is no acceptable reason for prices to vary across providers. The exact same procedure done in a more expensive and less efficient hospital outpatient facility can be accomplished at a free standing ambulatory surgery center for a fraction of the cost.

b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.
Price variation, as is, could lead to Massachusetts' never meeting the benchmark. The continuation of the hospitals pressure on physicians to refer only to affiliates prevents ASC's from continuing to grow. The discrepancy in fees paid to ASC's by different payors could cause these excellent facilities, that provide service at a much lower cost to no longer be viable. If ASC's are no longer viable and available to the community that would leave the HOPD's to become a monopoly, causing the state to pay only the higher prices.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
   a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.
   N/A this does not pertain to free standing ambulatory surgery centers

   b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these patients and to avoid unnecessary utilization of emergency room departments and inpatient care.
   N/A as above

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?
   N/A as above as the ASC's are not involved with home care or ACO's

APPLICANT QUESTIONS

Responses should be sent to DoN staff at DPH.DON@State.MA.US

While you may submit each answer as available, please

- List question number and question for each answer you provide
- Submit responses as a separate word document, using the above application title and number as a running header and page numbers in the footer
- When providing the answer to the final question, submit all questions and answers in one final document
- Submit responses in WORD or EXCEL; only use PDF's if absolutely necessary. If "cutting and pasting" charts, provide them in a PDF so they can be clearly seen

Interpretation and Translation Services

1. How are patients receiving NESC services made aware of the interpretation and language access and assistive services that are offered?
   Patients who receive services at NESC can find information on interpretation and language services in the non-discrimination section of our website. Our preop website also requests the patient provide primary language and if they require assistants.

2. Do you track the provision of language interpreter services provided by in-person, video and phone?
   Services provided at the center are tracked by reviewing monthly billing by CyraCom and patient self-reporting language spoken in the One Medical Passport preop questionnaire. As reported in F1.a.i of the application, nearly all patients of the NESC speak English.

   a. Which languages are requested and what is the percentage of live vs. video/telephone interpretation provided over the past 24 months?
      As reported in F1.a.i of the application, nearly all patients of the NESC speak English. Attachments 2, of the application has patient panel self-reporting information on primary language for 2019. The languages requested were Spanish, Portuguese, Russian and Arabic. 2020 interpretation services to date also show Spanish, Portuguese, Russian and Arabic.

      As a free-standing ambulatory surgery center, live interpretation was previously provided but was cost prohibitive. An interpreter would arrive at the time the patient checked in and stay until the patient was discharged. Their actual time spent with the patient was minimal but the cost was not. We investigated what was being offered for these services from the local hospitals and found that CyraCom had become the preferred method, was extremely cost effective and easily available for use with patients. 100% of interpretive services, including patients who are hearing impaired, are provided by video or telephone.

   b. What is the percentage of live vs video/telephone interpretation anticipated?
      The applicant anticipates continued use of video/telephone interpretation to be 100%

3. What strategies/approaches are you using to accommodate for people with disabilities?
   The applicant's accommodations for patients with disabilities starts during our preop calls where we ask if they will need any special accommodations, (e.g.do they need assistance getting around, do they use a walker/wheelchair or are they hearing or visually impaired.) We have wheelchairs if patients do not and assistance is provided, when requested, bringing the patients into the center and upon discharge. The center is ADA compliant, starting in our parking lot where handicapped spaces are available at the front door and there is no parking fee. The doors into the building are fitted with automatic openers and once in the center everything is built to ADA specifications. Toilets, sinks and hand sanitizers are at required accessible heights.

4. Have you made any operational or service provision adjustments to your interpretation and translation services due to COVID-19?
   Based on our experience, the only operational or service adjustments the center has made due to COVID-19 is the posting and availability of COVID-19 intake and care posters in the languages most used. Our interpretation and translation services have always been off sight and continue to be the safest and most effective for our patients who receive these services.

APPLICANT QUESTIONS

Responses should be sent to DoN staff at DPH.DON@State.MA.US

1. In the DoN Application, you provide CMS's Medicare Procedure Price Lookup information for common procedures performed at the ASC. Provide the price information for the complex pain management (MILD and Vertiflex) and otolaryngology procedures (complex fusion sinus) that are mentioned in the application.

   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 Medicare Fee for Service prices and copays sample of the more complex pain and otolaryngology procedures.[1] T 8wo of the pain procedures reflect a higher patient responsibility if performed in an ASC vs HOPD. This is due to APC pricing.

Medicare Local Payments 2020 without 2% Sequester

Procedure	Ambulatory Surgery Center (Average)			Hospital Outpatient Department (Average)		
	Total	Medicare Payment	Copay	Total	Medicare Payment	Copay
Percutaneous Laminectomy for decompression of neural elements (MILD)	$2,947	$2,358	$589	$6,816	$5,453	$1,363
Percutaneous fusion stabilization of sacroiliac joint	$13,648	$10,918	$2,730	$18,169	$16,483	$1,686*
Insertion of Interlaminar/interspinous process stabilization device (Vertiflex)	$10,380	$8,304	$2,076	$13,560	$11,874	$1,686*
Nasal sinus endoscopy frontal tissue removal	$1,993	$1,594	$399	$6,199	$4,959	$1,240
Repair of nasal septum (Septoplasty)	$1,109	$887	$222	$2,985	$2,388	$597
Repair of shoulder rotator cuff using endoscope	$2,947	$2,358	$589	$6,816	$5,453	$1,363
Arthroscopy, knee, surgical (medial or lateral)	$1,352	$1,082	$270	$3,119	$2,495	$624
Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any	$4,521	$3,617	$904	$6,816	$5,453	$1,363

[1] Medicare.gov website. Local average prices are based on 2020 Medicare payments and copayments, and do not include physician fees. Payment rates for each covered surgical procedure after adjustments for regional wage variations and wage indices.

method						
Suture of quadriceps or hamstring muscle rupture; primary	$2,947	$2,358	$589	$6,816	$5,453	$1,363
Removal of deep bone implant	$1,045	$836	$209	$2,642	$2,114	$528
Fragmenting of kidney stone (ESWL)	$1,045	$1,158	$289	$3,439	$2,751	$688
Cystoscopy with biopsy	$830	$664	$166	$2,018	$1,614	$404

* C-APC (other APCs package into J1 except for status indicators F, G, H, L, and U)

APC- **How It Works**

For a single patient visit, the hospital can receive several separate APC payments. Anything used during a procedure is a billable expense, and it is up to the hospital's team of coding specialists to determine which APC codes are appropriate. In addition to the procedures provided by the hospital, APC codes are chosen by criteria like the size of the facility and the complexity of service. Reimbursement is not fixed on a nationwide scale, payment is regulated in every state.

APCs were created to transfer some of the financial risk for provision of outpatient services from the Federal government to the individual hospitals, thereby achieving potential cost-savings for the Medicare program. By transferring financial risk to hospitals, APCs incentivize hospitals to provide outpatient services economically, efficiently and profitably.[2] Thus, the HOPD is paid at a higher rate than an ASC which allows for the lower patient responsibility.

[2] 2020 American College of Emergency Physicians