

STAFF REPORT TO THE PUBLIC HEALTH COUNCIL FOR A DETERMINATION OF NEED	
Applicant Name	Emerson Endoscopy and Digestive Health Center, LLC
Applicant Address	310 Baker Avenue Concord, MA 01742
Filing Date	May 30, 2025
Type of DoN Application	Substantial Change in Service – Ambulatory Surgery
Total Value	\$484,856.00
Project Number	EDHC-25021711-AS
Ten Taxpayer Groups	None formed
Community Health Initiative (CHI)	\$24,242.80
Staff Recommendation	Approval with Conditions
Public Health Council Meeting	October 8, 2025
<p style="text-align: center;"><u>Project Summary and Regulatory Review</u></p> <p>Emerson Endoscopy and Digestive Health Center, LLC (Applicant or EDHC) filed a Determination of Need (DoN) application to expand its existing ambulatory surgery center (ASC), located at 310 Baker Avenue, Concord, MA. The Applicant is proposing to increase the number of procedure rooms from two to three and to increase the number of pre/post operative bays from six to nine (Proposed Project). The total value for the Proposed Project is \$484,856. The Community Health Initiative (CHI) contribution to the Statewide Initiative Fund is \$24,242.80.</p> <p>Review of Applications for Ambulatory Surgery is under the DoN regulation 105 CMR 100.000. The Department must determine that need exists for a Proposed Project, on the basis of material in the record, where the Applicant makes a clear and convincing demonstration that the Proposed Project meets each Determination of Need Factor set forth within 105 CMR 100.210. This staff report addresses each of the six factors set forth in the regulation.</p> <p>The Department did not receive any public comments on this DoN application, nor did any Ten Taxpayer Groups (TTGs) form in connection with this DoN application.</p>	

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## Background: Emerson Endoscopy and Digestive Health Center, LLC; and Application Overview

Emerson Endoscopy and Digestive Health Center, LLC (Applicant or EDHC) is a freestanding single-specialty endoscopy ambulatory surgery center (ASC) located in Concord, MA. The Applicant received Determination of Need (DoN) approval in February 2021 to construct its existing ASC, herein referred to as “the Center”, with two procedure rooms and six pre/post operative bays to provide endoscopy services to Emerson Hospital patients and the surrounding communities. The Center is in the primary service area (PSA) of an independent community hospital, Emerson Hospital, and in compliance with 105 CMR 100.715(B)(2)(b)(2)(a), the Center is a joint venture between Emerson Hospital (75% ownership interest), in Concord, MA and Physicians Endoscopy, LLC (25% ownership interest), a national development and management company for gastroenterology medicine. Emerson Hospital is part of Emerson Health, a regional health system delivering primary and specialty care throughout the region. Emerson Health includes Emerson Hospital, Radiation Oncology Center Mgt. Co. LLC, Shields Imaging Management at Emerson Hospital, LLC, Shields PET-CT at Emerson Hospital, LLC, Emerson Endoscopy and Digestive Health Center, LLC, and Emerson Physician Hospital Organization, a 50/50 joint venture with Emerson Independent Physician Associates (IPA). The Center opened in April 2022 and is licensed by the Department of Public Health (Department) and certified by the Centers for Medicare and Medicaid Services (CMS). The Center is a participating MassHealth provider, and a member of Mass General Brigham’s Accountable Care Organization.

### Application Overview

The Applicant is proposing to expand the number of procedure rooms and pre/post operative bays at the Center to “ensure the Center has adequate capacity to provide the Patient Panel with timely access to endoscopy services” in the most appropriate and accessible care setting. Table 1 provides an overview of the Proposed Project.

**Table 1: Overview of Proposed Project at The Center**

	Current	Proposed	Total
Procedure Rooms	2	+1	3
Pre/Post Operative Bays <sup>1</sup>	6	+3	9

The Applicant states that Patient Panel need for endoscopy services is increasing as a result of a number of factors that include: the recent closure of Nashoba Valley Medical Center (NVMC) in Ayer; current colorectal cancer (CRC) screening recommendations and higher incidence of CRC among adults under age 50; new referrals from Atrius Health, Emerson Hospital’s clinical affiliate; and projected population growth in the Center’s service area, specifically among the aged 45 to 75 population. The Applicant asserts that the Proposed Project supports adequate capacity to provide timely access to preventative care in the community allowing for early diagnosis and treatment.

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<sup>1</sup> The Applicant states that the bays are used interchangeably for pre- and post-operative care.

## Patient Panel<sup>2</sup>

Table 2 includes three calendar years (CYs), 2022 to 2024, of the Applicant's Patient Panel.<sup>3</sup> The Applicant's Patient Panel increased by 197% from 2022, the first year of operation, to 2024. The Applicant states that 90.1% or 4,354 patients seen at the Center in 2024, were patients of Emerson Hospital.

**Table 2: EDHC Patient Panel, 2022 to 2024**

	2022	2023	2024	% Change 2022 to 2024
Unique Patients	1,610	3,210	4,790	197%

The Applicant states that historically, self-reporting of race and ethnicity was optional for patients of the Center, and that most patients chose not to self-report. Therefore, the Applicant does not have race and ethnicity data to provide on the Patient Panel for this Application. The Applicant states further that as of April 29, 2025, the Center collects race and ethnicity data from patients during check-in at which time patients are asked to provide their race and ethnicity via a written screening form. Patient responses are then recorded in the Center's Patient Accounting System.

The Emerson Hospital 2024 Community Health Needs Assessment (CHNA), states that Emerson Hospital's primary and secondary service areas are "less racially and ethnically diverse than the state and Middlesex County," and notes that "diversity has increased over time," based on demographic data.<sup>a,4,5</sup>

Table 3 shows the age and gender makeup of the Applicant's Patient Panel. The Applicant notes the following about the data in Table 3:

- The percent of patients aged 18 to 49 in the Applicant's Patient Panel increased from 27% of patient volume in 2022 to 38% of patient volume in 2024.
- The percent of males in the Applicant's Patient Panel increased from 35% in 2022 to 44% in 2024.

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<sup>2</sup> As defined in 105 CMR 100.100, Patient Panel is the total of the individual patients regardless of payer, including those patients seen within an emergency department(s) if applicable, seen over the course of the most recent complete 36-month period by the Applicant or Holder. Patient Panel also means: (1) If the Applicant or Holder has no Patient Panel itself, the Patient Panel includes the Patient Panel of the health care facilities affiliated with the Applicant; or (2) If the Proposed Project is for a new facility and there is no existing Patient Panel, Patient Panel means the anticipated patients; or (3) In the case of a Transfer of Ownership, Patient Panel also includes the Patient Panel of the Entity to be acquired.

<sup>3</sup> The Center's fiscal year is the Calendar Year.

<sup>4</sup> In the Emerson Hospital 2024 CHNA on the hospital's service area is comprised of 21 towns in Massachusetts. The primary service area of the hospital is comprised of 14 communities: Acton, Bedford, Bolton, Boxborough, Carlisle, Concord, Harvard, Hudson, Lincoln, Littleton, Maynard, Stow, Sudbury, and Westford. The secondary service area is comprised of seven communities: Ayer, Devens, Groton, Hanscom, Pepperell, Shirley, and Townsend.

<sup>5</sup> Primary Service Area: 76.9% White, non-Hispanic in 2018 to 2022; compared to 78.9% in 2015 to 2019 and Secondary Service Area: 80.8% White in 2018 to 2022 compared to 86.0% in 2015 to 2019.

**Table 3: EDHC Patient Panel Age and Gender Makeup, 2022 to 2024**

	<b>2022 Count</b>	<b>2022 Percent</b>	<b>2023 Count</b>	<b>2023 Percent</b>	<b>2024 Count</b>	<b>2024 Percent</b>
<b>Gender: Female</b>	1,042	64.7%	1,883	58.7%	2,697	56.3%
<b>Gender: Male</b>	568	35.3%	1,327	41.3%	2,093	43.7%
<b>Total</b>	1,610	100.0%	3,210	100.0%	4,790	100.0%
<b>Age: 18-49</b>	441	27.4%	1,030	32.1%	1,810	37.8%
<b>Age: 50-69</b>	861	53.5%	1,723	53.7%	2,439	50.9%
<b>Age: 70+</b>	308	19.1%	457	14.2%	541	11.3%
<b>Total</b>	1,610	100.0%	3,210	100.0%	4,790	100.0%

Table 4 summarizes patient origin data for the Applicant's Patient Panel. The category "All Other" includes cities and towns represented in the Applicant's Patient Panel with a count less than 11. The Applicant states its PSA comprises 20 cities and towns in Northeastern MA, and that the geographic origin of the Center's patients remained consistent from 2022 to 2024. The Applicant also notes that the Center serves a number of cities and towns that were also served by NVMC, including Acton, Westford, Littleton, Groton, Harvard, Leominster, Ayer, Lunenburg, and Pepperell. These cities and towns are highlighted yellow in Table 4.

**Table 4: EDHC PSA, 2022 to 2024**

<b>Geographic Origin</b>	<b>2022 Count</b>	<b>2022 Percent</b>	<b>2023 Count</b>	<b>2023 Percent</b>	<b>2024 Count</b>	<b>2024 Percent</b>
Concord	134	8.3%	310	9.7%	379	7.9%
Acton	123	7.6%	275	8.6%	383	8.0%
Sudbury	100	6.2%	200	6.2%	269	5.6%
Westford	96	6.0%	184	5.7%	237	4.9%
Bedford	75	4.7%	118	3.7%	162	3.4%
Maynard	66	4.1%	150	4.7%	209	4.4%
Littleton	58	3.6%	110	3.4%	177	3.7%
Groton	54	3.4%	111	3.5%	225	4.7%
Stow	52	3.2%	102	3.2%	118	2.5%
Hudson	44	2.7%	68	2.1%	89	1.9%
Carlisle	36	2.2%	48	1.5%	98	2.0%
Chelmsford	35	2.2%	63	2.0%	129	2.7%
Boxborough	34	2.1%	58	1.8%	110	2.3%
Harvard	34	2.1%	62	1.9%	97	2.0%
Leominster	33	2.0%	63	2.0%	91	1.9%
Ayer	30	1.9%	55	1.7%	91	1.9%
Marlborough	29	1.8%	71	2.2%	70	1.5%
Lexington	27	1.7%	70	2.2%	87	1.8%
Lunenburg	26	1.6%	43	1.3%	66	1.4%
Pepperell	26	1.6%	53	1.7%	74	1.5%

All Other <sup>6</sup>	498	30.9%	996	31.0%	1,629	34.0%
Total	1,610	100.0%	3,210	100.0%	4,790	100.0%

Table 5 summarizes the Applicant's payer mix data and Table 6 shows the percent of the Center's patients covered under an alternative payment method (APM). The Applicant notes that in 2024, commercial payers comprised 81% of the Center's payer mix, and in 2024, approximately 19% of the Center's patients were insured through a government payer. The Applicant attributes the high percentage of commercial payers in the Center's payer mix to the age and socioeconomic demographics of the Applicant's service area. Staff confirmed that in the majority of the cities and towns in the Applicant's service area, the median household income is higher than the state average and the percent living below the poverty level is below the state average, but staff could not confirm the percentage MassHealth enrollment in each of the cities and towns in the Applicant's service area. The Applicant also attributes the increase in commercial payers and decrease in government payers between 2022 and 2024 to the change in CRC screening guidelines which led to a change in the age composition of the Applicant's Patient Panel and in turn, the Applicant's payer mix. This is discussed in greater detail in Factor 1b: Public Health Value.

**Table 5: EDHC Patient Panel Payer Mix, 2022 to 2024**

	2022	2023	2024
Commercial (PPO/Indemnity and HMO/POS)	60.0%	72.6%	80.73%
Medicare FFS	20.0%	15.0%	12.17%
Commercial Medicare (Private Medicare/ Medicare Advantage)	11.0%	11.0%	4.78%
Managed Medicaid (Private Medicaid/Medicaid MCOs)	4.0%	0%	0.34%
MassHealth	4.0%	1.4%	1.56%
Other	1.0%	0.5%	0.36%
Total	100.0%	100.0%	100.0%

**Table 6: EDHC APM Contracts, 2022 to 2024**

	2022	2023	2024
ACO and APM Contracts	0%	0%	0%
Non-ACO and APM Contracts	100%	100%	100%
Total	100%	100%	100%

Table 7 shows the payer mix for Emerson Hospital patients and for Emerson Hospital endoscopy patients for the most recent year available. In 2024, The Center had a higher percentage of commercially insured patients in its payer mix, and a lower percentage of Medicare FFS patients as compared to Emerson Hospital endoscopy patients, and the Center's MassHealth percentage in its payer mix was almost half that of the MassHealth percentage of Emerson Hospital's endoscopy patients.

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<sup>6</sup> Additional towns that represent 75% of the Center's patients for CY2024 include Lincoln, Framingham, Bolton, Townsend, Shirley, Billerica, and Lancaster.

**Table 7: Emerson Hospital and Emerson Hospital Endoscopy Patients Payer Mix, 2024**

	Emerson Hospital	Emerson Hospital Endoscopy
Commercial (PPO/Indemnity and HMO/POS)	33.0%	57.4%
Medicare FFS	11.9%	27.5%
Commercial Medicare (Private Medicare/ Medicare Advantage)	47.6%	8.6%
Managed Medicaid	3.0%	1.4%
Medicaid	1.8%	2.8%
All Other <sup>7</sup>	2.7%	2.3%
Total	100%	100%

**Factor 1: a) Patient Panel Need**

In this section, staff assesses if the Applicant has sufficiently demonstrated need for the Proposed Project components by the Applicant's Patient Panel. The Applicant attributes Patient Panel need for an additional procedure room and three pre/post operative bays at the Center to the following factors:

- Closure of Nashoba Valley Medical Center (NVMC) and unmet need in the region
- Increase in referrals from the Applicant's clinical affiliate Atrius Health
- Population Projections in the Applicant's Services Area and Colorectal Cancer (CRC) Screening Guidelines
- Increasing Cancer Rates in Massachusetts

*Background: Historical Utilization*

The Applicant states that the Center "has experienced steady volume growth since opening" in 2022. Table 8 shows the Center's historical case volume. The number of cases per year increased by 173% between 2022 and 2024.

**Table 8: The Center's Annual Cases, 2022 to 2024**

	CY2022	CY2023	CY2024	% Change 2022-2024
Cases	1,782	3,583	4,873	173%

Table 9 shows year-over-year change in the Center's case volume.

**Table 9: Year-over-year change in The Center's Case Volume**

	CY2022 to CY2023	CY2023 to CY2024
Cases	101%	36%

<sup>7</sup> Other includes Tricare/VA, self-pay, and worker's compensation.

The Center experienced a 101% increase in case volume from CY22 to CY23. The Applicant attributes this increase to the Center becoming operational and ramping up volume in CY22 and in CY23. The Center opened in April 2022, and therefore CY22 patient volume does not represent a full calendar year.

Table 10 shows a breakdown of the Center's case volume by upper and lower endoscopy for CY22 to CY24. Lower endoscopy made up more than 75% of the Center's case volume from 2022 to 2024.

**Table 10: The Center's Case Volume by Upper and Lower Endoscopy, 2022 to 2024**

	CY2022	% of CY2022 Total	CY2023	% of CY2023 Total	CY2024	% of CY2024 Total
Upper	433	24%	759	21%	951	20%
Lower	1,349	76%	2,824	79%	3,922	80%
Total Cases	1,782	100%	3,583	100%	4,873	100%

The Applicant states that the most common procedures performed at the Center include colonoscopy screenings for high-risk patients and standard patients, colonoscopies to conduct biopsies or remove polyps, and esophagogastroduodenoscopies (EGD) to perform biopsies. The Applicant states further that in some cases the patient returns to the Center because a procedure requires further investigation, leading to approximately 21 recalls per month for further testing at the Center. The most common diagnoses for the Center's patients are colon cancer, colon polyps, gastrointestinal cancer, epigastric pain, and melena.

The Center operates from 7a.m. to 5p.m., Monday through Friday. The Applicant states the following about the Center's procedure capacity:

- Each case is scheduled for a **30-minute** slot with **10 minutes** of turnover time between each case, which allows for a maximum of **14 cases** per room per day.
- Because the Center is closed for 10 holidays each year, each procedure room can accommodate a maximum of **3,500 cases** per year.<sup>8</sup>

The Applicant states that the optimal operating capacity for the Center is 75% to 85%. Table 11 shows the Center's operating capacity from 2022 to 2024. As of April and May of 2025, the Center's operating capacity was 75%, which the Applicant states is optimal operating capacity to allow for add-on cases. As of July 2025, operating capacity at the Center is 80%. It has been previously reported that a 70% to 80% range is optimal for utilization depending on the type of ASC, with single-specialty ASCs in the higher range and multi-specialty ASCs towards the lower end.<sup>b</sup>

**Table 11 Center's Operating Capacity, 2022 to 2025**

Calendar Year	Cases per Room	Case Capacity Per Room	Operating Capacity
2022 <sup>9</sup>	891	3,500	25%

<sup>8</sup> The Applicant used the following calculation: ((52 weeks per year x 5 days per week) – 10 holidays) X 14 slots = 3,500 cases.

<sup>9</sup> The Center opened in April 2022.



2023	1,791	3,500	51%
2024	2,436	3,500	69%
2025 (Annualized) <sup>10</sup>	(2,628)	3,500	75%

The Original DoN stated that the ASC would address Patient Panel need for endoscopy services by shifting clinically appropriate cases from Emerson Hospital to the Center. Table 12 from the Original DoN, shows projected endoscopy case volume at the Center and Emerson Hospital. In the Original DoN, EDHC stated that the projections were based on historical utilization with modest growth over time. In the Original DoN, EDHC projected that overall cases would increase, but at Emerson Hospital, they were expected to decrease over time as case volume at the Center increased.

The Applicant provided data to show that the Center has effectively shifted clinically appropriate (routine) cases from Emerson Hospital to the ASC setting based on available capacity at the Center. When the Center first opened the majority of cases were performed at Emerson Hospital, and presently, the majority of cases are performed at the Center. This is shown in Table 13.

**Table 12: Projected Endoscopy Procedures by Site from the Original DoN, 2022 to 2026**

Location	2022 Count	2022 Percent	2023 Count	2023 Percent	2024 Count	2024 Percent	2025 Count	2025 Percent	2026 Count	2026 Percent
The Center	3,416	81%	4,290	84%	4,719	85%	4,813	85%	4,910	86%
Emerson Hospital	816	19%	819	16%	822	15%	825	14%	828	14%
Total	4,232	100%	5,109	100%	5,541	100%	5,638	100%	5,738	100%

**Table 13: Endoscopy Cases at Emerson Hospital and The Center, 2022 to 2024**

Location	2022 Count	2022 Percent	2023 Count	2023 Percent	2024 Count	2024 Percent
The Center	1,970	31%	3,273	50%	4,873	57%
Emerson Hospital	4,363	69%	3,258	50%	3,633	43%
Total (Routine)	6,333	100%	6,531	100%	8,506	100%

As shown in Tables 12 and 13, the Center's case volume initially fell below its projections in 2022 and 2023, but began to outpace projections in 2024. The Center's 2024 actual utilization exceeded the projected volume for 2025 and nearly met the projected volume for 2026.

The Applicant states that the Center's case volume is surpassing projections due to the following:

- The CRC screening guidelines lowered the starting age of screening from 50 to 45, making more patients eligible for screening;
- The closure of NVMC's endoscopy service; and
- The hiring of two physicians by Emerson GI, and one GI physician by Atrius Health.

As discussed above, by 2024 the actual volume at the Center exceeded projected volume. However, actual volume at Emerson Hospital outpaced projected volume, as well. Across the two sites, endoscopy cases exceeded total projections by 2,101 cases (50%) in 2022, 1,422 cases (28%) in 2023, and 2,965 (54%) in 2024. The 2024 total actual volume also exceeded the projected total

<sup>10</sup> The Applicant states that Annualized volume/capacity is based on April and May cases to account for low volume in earlier months due to a provider's leave of absence.

volume for 2025 and 2026. The Applicant states the actual case volumes indicate a need for endoscopy in the region greater than what the projected volume relied on in the Original DoN. As described above, the majority of cases are performed at the Center, however, actual percentage of cases falls short of the projected percentages with 57% of cases performed at the Center and 43% at Emerson Hospital in 2024. In its Original DoN, the Applicant projected 85% of cases in 2024 would be performed at the Center and 15% performed at the Hospital. Consequently, the Applicant anticipates that continued timely access to endoscopy services requires an additional procedure room.

### **1. Closure of NVMC**

The Applicant states the recent closure of NVMC is a significant driver of the need for the Proposed Project. NVMC's closure occurred on August 31, 2024 and the NVMC service area overlapped with the Center's, including the towns/cities of Acton, Westford, Littleton, Groton, Harvard, Leominster, Ayer, Lunenburg, and Pepperell. The Applicant asserts that NVMC's closure has "resulted in unmet demand for endoscopy" within the Center's service area.

The Applicant states that many NVMC patients are making Emerson Hospital their medical home, resulting in increasing need for the Center's endoscopy services.<sup>11</sup> Additionally, the Applicant clarifies there is only one other ASC providing endoscopy procedures within the service area shared by the former NVMC and the Center. In the year prior to its closure, NVMC performed 3,500 endoscopy procedures. The Applicant asserts this number exceeds the amount of procedures that one facility can absorb and Emerson Health has experienced an increase in demand for testing and screening services, including colonoscopies systemwide. The Applicant states that it expects 15% to 30% of NVMC's historical endoscopy procedure volume to shift to the Center, and notes that in addition to reflecting the increases resulting from the Emerson Hospital referrals to the Center, this shift will be further supported by Emerson Health's hiring of additional PCPs from NVMC and Emerson Health's partnerships with PCPs in the service area.<sup>12</sup> Emerson Health's hiring of additional PCPs within the NVMC service area is anticipated to lead to more endoscopy cases at the Center because PCPs are a significant referral source for endoscopy.

To prepare for the expected increase in patients resulting from the closure of NVMC, the Applicant states that the Center internally monitored provider utilization, nurse/technician staffing ratios, and tracked supplies. The Applicant states that it also began preparing to expand the Center's procedure room capacity to prepare for the closure. The Applicant states that the Center has experienced an increase in procedures since the closure of NVMC, based on actual and scheduled procedures in July 2025. The Center has experienced a 15% increase in utilization from 435 cases in July 2024 to 501 cases in July 2025. As of July 2025, the Center is operating at 80% capacity, which the Applicant states leaves limited capacity at the Center to increase procedure volume, while maintaining optimal utilization of 75% to 85%.

Staff reviewed the Final Report of The Nashoba Valley Health Planning Working Group, a group that was convened by Governor Healey in 2024 to examine the rising health care needs associated with

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<sup>11</sup> The Applicant states that the data received by the Center via the booking sheet does not provide the historical information that would indicate if a patient was a former NVMC patient.

<sup>12</sup> The Applicant states that leading up to the closure of NVMC, Emerson Health prepared for the closure and expected increase in patient demand, by hiring additional staff, including hiring 14 primary care providers (PCPs) for the NVMC service area; increasing operating hours at some of its sites; and opening an observation unit at Emerson Hospital.

the closure of NVMC. The Final Report, issued March 2025, states, “Closure of NVMC presented significant challenges for the region, impacting access to emergency and inpatient care, straining nearby healthcare facilities, and requiring residents to travel farther for certain medical services.”<sup>c</sup> The Final Report discusses Emerson Health’s response to the closure of NVMC<sup>13</sup> to increase access to services for former NVMC patients.<sup>d</sup> In the Final Report, the Emergency, Outpatient, and Healthcare Services Subcommittee recommended “re-establishment of essential services in a tiered approach as soon as possible, to reduce overall and long-lasting negative health impacts in this region” with a Tier 1 recommendation to re-establish Endoscopy, with a GI physician on call 24/7 and an additional recommendation to establish a satellite emergency facility (SEF) with complementary services such as endoscopy. Distance to and shortage of access to specialty care were also cited as concerns in the Final Report by the Upstream Efforts and Public Health Subcommittee.

## **2. Increase in Referrals from Atrius Health**

Emerson Hospital, a joint owner of the Center, has a clinical affiliation with Atrius Health, a nonprofit multi-specialty physician group serving adult and pediatric patients in eastern Massachusetts. Emerson Hospital’s clinical affiliation with Atrius began in December 2022. Atrius Health has 28 practice locations in Eastern Massachusetts and the Applicant states that one of those locations is within the same plaza as the Center.<sup>e,14</sup> The Applicant states that through Emerson Hospital and Atrius Health’s affiliation agreement, the Center provides preventive and diagnostic endoscopy services for patients of Atrius Health’s PCPs and gastroenterologists. The Applicant states that there are two referral pathways that Atrius patients have to the Center: 1) Atrius patients are referred to Emerson Health Gastroenterologists (GIs) to receive care at the Center by the Emerson Health GI provider; and 2) the Atrius patient is scheduled at the Center to be seen by an Atrius GI provider that is credentialed to perform cases at the Center. The Applicant states that 45 cases per month at the Center are a result of the clinical affiliation between Emerson Hospital and Atrius Health. The Applicant expects the number of cases per month at the Center that are the result of the clinical affiliation to increase to 75 in 2025. The Applicant states that Atrius hired an additional provider who began requesting block time at the Center in August 2025, and this has led to the increase in Atrius cases from 45 per month to the expected 75 per month in 2025. The Applicant projects this affiliation and the recent changes, including additional providers and the request for block time, will result in an increase in the number of Atrius cases referred to the Center.

## **3. Population Projections in Applicant’s Services Area and CRC Screening Guidelines**

The Applicant states that based on UMass Donahue Population Projections, by 2030 the combined projection for the 45 to 49 age group and the 50 to 74 age group is expected to be more than 39,000 residents in the top five towns in the Applicant’s service area.<sup>f</sup> This is shown in Table 14. The Applicant states that based on screening guidelines for this age group, a minimum of 3,900 residents will require CRC screening each year, and those with a higher risk of CRC will require more frequent screening.

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<sup>13</sup> The Final Report states that nine communities were selected as the focus communities: Ayer, Devens Enterprise Zone, Groton, Harvard, Littleton, Lunenburg, Pepperell, Shirley, and Townsend.

<sup>14</sup> The Atrius Health Concord practice of which Emerson Hospital is a preferred hospital partner.

<https://www.atriushealth.org/locations/concord>

**Table 14: Age 45 to 74 Population Projections for Top Five Towns in the Applicant's Service Area**

Municipality	County	Age Group	2010	2020	2025	2030
Acton	Middlesex	45-74	8,644	9,814	9,713	9,803
Concord	Middlesex	45-74	7,473	7,827	7,661	7,544
Groton	Middlesex	45-74	4,385	4,848	4,683	4,548
Sudbury	Middlesex	45-74	7,095	7,778	7,622	7,533
Westford	Middlesex	45-74	8,873	10,139	10,129	10,284
Total 1-5	Middlesex	45-74	36,470	40,406	39,808	39,712

The American Cancer Society's CRC screening guidelines recommend that adults with average risk of CRC begin screening at age 45, and continue screening every 10 years through age 75, with more frequent screening recommended for adults at higher risk.<sup>g</sup> The 2021 U.S. Preventative Service Taskforce (USPSTF) screening recommendations for colon cancer are as follows:

- Grade A (substantial net benefit): Screening is recommended for colorectal cancer in all adults aged 50 to 75 years.
- Grade B (moderate net benefit): Screening is recommended for colorectal cancer in adults aged 45 to 49 years.
- Grade C (small net benefit): Recommends selectively offering screening for colorectal cancer in adults aged 76 to 85 years.<sup>h</sup>

The Applicant states that need for endoscopy services, and specifically colonoscopy services, will continue to increase as the population ages.<sup>i</sup> Staff notes that the American Cancer Society's National Colorectal Cancer Roundtable, established in 1997 in partnership with the Centers for Disease Control and Prevention (CDC), set a target for CRC screening rates in the United States at 80%.<sup>j,15</sup> In 2022, 70.9% of adults ages 45 to 75 received at least one recommended CRC screening test in Massachusetts.<sup>k</sup> The Applicant argues that the Proposed Project is anticipated to provide endoscopy services to segments of the population outside of the Center and Emerson Hospital's historical endoscopy utilization patient population and states increased access aligns with efforts to achieve the 80% CRC screening goal in every community.

#### **4. Increasing Cancer Rates in Massachusetts**

The Applicant states that ASCs in Massachusetts will "play a pivotal role in early detection and improving health outcomes" in response to increasing cancer rates in Massachusetts. The Applicant cited the following reports on rising cancer rates:

- The Massachusetts Cancer Registry states that, between 2016 to 2020, there were 196,399 new cancer cases in Massachusetts, an average of 39,280 cases per year.<sup>l</sup>
- The American Cancer Society estimated 44,000 new cancer cases in Massachusetts in 2025, with 2,770 of those cases being cancer of the colon and rectum.<sup>m</sup>
- The American Cancer Society reported that adults aged 50 were the only group to experience an increase in overall cancer incidence between 1995 and 2020, and CRC cases among adults younger than age 50 are increasing.<sup>n</sup>
- CRC, once the fourth leading cause of cancer death among men and women in the 1990s, is now the leading cause of cancer death in men younger than 50 and the second leading cause

<sup>15</sup> The National Colorectal Cancer Roundtable, one of the American Cancer Society's seven mission-critical national roundtables, is a coalition of more than 180 member organizations, with a shared mission to increase the use of proven colorectal cancer screening tests among the entire population for whom screening is appropriate.

- of cancer death in women younger than 50.<sup>o</sup>
- By 2030, it is estimated that colon cancer will be the leading cause of cancer-related deaths in the 20 to 49 age group.<sup>p</sup>

The Applicant states that increasing cancer incidence among adults younger than age 50 will increase need for endoscopy services, and for colonoscopy in particular.

### **Need Methodology**

When determining the number of procedure rooms needed to address Patient Panel need for the Center's endoscopy services, the Applicant considered the Center's operating capacity (current and projected), anticipated increases in patient volume and cases, and wait times. The Applicant maintains that need for an additional procedure room is also supported by the evidence of the benefits of access to timely screening and diagnosis of CRC. Colonoscopy is considered the "gold standard" for CRC screening, with the ability to both screen for and prevent CRC through identifying and removing precancerous polyps. The Applicant points to the effectiveness of CRC screening in reducing CRC incidence and CRC mortality, as well as the rise in CRC among younger adults. The Applicant states that the Center already has available space to build out a third procedure room, allowing the Applicant to increase access to the Center's services in a cost-effective manner.

The Applicant states that it is starting to see wait times at the Center increase, and that wait times will continue to increase without the addition of another procedure room. At the Center, wait times are one month for Emerson Health GI patients, and a minimum of three months for Atrius patients. The Applicant's stated goal is to address Patient Panel need for the Center's endoscopy services before wait-times surpass six months, and patient health outcomes begin to be negatively impacted. The Applicant states that the Center's wait times will increase alongside the Center's increasing case volume and due to the addition of a new Atrius GI physician. The Applicant states further that Atrius has a backlog of cases, and Atrius providers have requested additional procedural block time at the Center to address it, but the Center does not have additional block time to offer to Atrius providers at this time due to the Center's current operating capacity.

The Applicant expects that the Center's wait times for diagnostic procedures will remain under two months after implementation of the Proposed Project, which the Applicant states is consistent with the only standard that currently exists. The Applicant states further that the United States has not developed a wait time measure, and points to the Canadian Association of Gastroenterology's guidelines which recommend a maximal wait time of two months for diagnostic colonoscopy and six months for screening colonoscopy.<sup>q</sup> Other studies have remarked on the lack of consensus on colonoscopy guidelines in the United States. A 2024 study on colonoscopy and underinsured patients stated "Given the lack of guidelines on acceptable colonoscopy wait times in the United States, we referred to the Canadian Association of Gastroenterology expert consensus statement on suggested wait times for colonoscopy based on the acuity category."<sup>r</sup> Another 2017 study looking at time to colonoscopy following a positive fecal occult blood test stated "Guidelines for colonoscopy follow-up vary and lack supporting data", citing differences and challenges with the 2006 Canadian consensus group recommendation of diagnostic colonoscopy within two months of an abnormal, or positive fecal immunochemical test (FIT) result, the 2007 Veteran's Health Administration directive that a diagnostic colonoscopy be performed within 60 days, and the 2012 European guidelines recommending diagnostic colonoscopy after positive screening within 31 days.<sup>s</sup> The Applicant states that adding additional capacity to the Center at this time will prevent a backlog of patients from developing, which would delay access to endoscopy services for the Applicant's

Patient Panel. The Applicant maintains that it “is taking a proactive approach to address this known public health need for timely access in the community to colorectal screening and treatment.” As described above, the Applicant projects higher case volume in the coming years, due in part from the closure of NVMC, and states that the addition of a procedure room will allow the Center to accommodate 9,000 patients annually, which will in turn allow the Applicant to maintain and reduce current wait times for all patients.

Studies have also mentioned factors similar to those cited by the Applicant, as contributing to a growing need for endoscopy services. A 2022 study comparing adverse outcomes after outpatient GI endoscopy procedures (EDG and colonoscopy) performed in ASCs and HOPDs, stated that “Outpatient GI endoscopies are increasingly being performed in ambulatory surgery centers (ASCs)” and that “Technologic advancements, provider preference, and consumer demand” have all contributed to the increased volumes in ASCs.”<sup>t</sup> A 2024 review on establishing a freestanding GI endoscopy surgical center in the United States, examined need and site selection for endoscopy focused ASCs, and cited an aging population, current CRC screening guidelines requiring screening begin at age 45, and an increase in the prevalence of gastrointestinal disorders, including in younger patients, as creating need for endoscopic procedures and in turn, endoscopy centers.<sup>u</sup> For example Gastrointestinal Reflux Disease (GERD), is predominant among older populations, but has been increasing in younger populations, particularly the 30 to 39 age group over the last ten years.<sup>v</sup>

### **Projected Volume**

The Applicant is proposing to increase procedure room capacity at the Center to anticipate increases to utilization and support continued timely access to endoscopy services in the community and to meet projected need for endoscopy services before patients begin experiencing challenges accessing the Center as a result of longer wait times.

Table 15 shows the projected volume at the Center from 2027 to 2031. The Applicant anticipates during this time period, between 500 to 1,000 cases annually will be the result of the NVMC closure, and an additional 2,000 referrals annually will come from Atrius Health. The Applicant expects volume at the Center to increase by 67% during the projection period. The Applicant also expects to maintain a utilization rate below 90% during the projection period, which the Applicant states will not negatively impact wait times.

**Table 15: Projected Volume at The Center, 2027 to 2031**

	2027	2028	2029	2030	2031	% Change 2027-2031
Total Cases	5,564	6,564	7,564	8,564	9,314	67%

Table 16 shows projected operating capacity at the Center from 2025 to 2030.

**Table 16: Projected Operating Capacity at The Center, 2026 to 2030**

Calendar Year	Projected Cases per Room	Projected Operating Capacity
2026	1,855	53%

2027	2,188	63%
2028	2,521	72%
2029	2,855	82%
2030	3,105	89%

Table 17 shows a breakdown of the Center’s projected case volume by upper and lower endoscopy for CY22 to CY24.

**Table 17: The Center’s Projected Case Volume by Upper and Lower Endoscopy, 2027 to 2031**

Projected Volume	2027	2028	2029	2030	2031
Upper	1,169	1,378	1,589	1,798	1,956
Lower	4,395	5,186	5,975	6,766	7,358
Total Projected Cases	5,564	6,564	7,564	8,564	9,314

### Staffing

The Center does not employ physicians. Rather, the Center provides block time to physicians with privileges at the Center. There are currently nine physicians with privileges at the Center: six Emerson Health providers and three Atrius providers. Table 18 shows existing block time for Atrius providers and for Emerson Health providers.

**Table 18: Block time at The Center**

Operating Day	Room 1	Room 2
Monday	Emerson	Emerson
Tuesday	Emerson	Atrius: 1 <sup>st</sup> and 3 <sup>rd</sup> ; Emerson: 2 <sup>nd</sup> , 4 <sup>th</sup> , and 5 <sup>th</sup>
Wednesday	Emerson	Atrius
Thursday	Emerson	Emerson
Friday	Emerson	Emerson

The Applicant states that physician practices affiliated with the Center recently hired physicians who have requested operating room time for their patients: Emerson Health’s GI Group hired one physician and Atrius hired two physicians, for a total of three recently hired physicians. However, because of the Center’s current utilization, additional block time is not available, and this is contributing to a backlog of cases.

The Applicant states that two Registered Nurses and 1.5 Endoscopy Technicians will be needed to implement the Proposed Project, and that the Center will recruit for the new positions through job postings on its internal websites (SCA Surgery and Emerson Health) and through external job boards such as Indeed.

### Analysis

Staff finds that the Applicant has demonstrated increasing need for the Center’s endoscopy services through data showing an increase in patient volume and case volume, and through projected increasing need for the Center’s services over the next five years. The Proposed Project will address

growing need for high-quality, cost-effective, ambulatory endoscopy services, including need for such care resulting from the closure of NVMC. As a result, Staff finds that the Proposed Project meets the requirements of Factor 1a.

### **Factor 1: b) Public health value, improved health outcomes and quality of life; assurances of health equity**

For this element of Factor 1, the Applicant must demonstrate that the Proposed Project adds public health value in terms of improved health outcomes and quality of life for the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

#### **Public Health Value: Improved Outcomes and Quality of Life**

To demonstrate that the Proposed Project will contribute to improved health outcomes, the Applicant cited published studies and reports on the use and benefits of endoscopy as a screening, diagnostic and treatment tool. The Applicant provided more detailed explanation of the clinical advantages of common routine endoscopy procedures including upper endoscopy for Esophagogastroduodenoscopy (EDG)<sup>16</sup>, lower endoscopy for Colonoscopy<sup>17</sup>, and Sigmoidoscopy<sup>18</sup>. The Applicant also cited a study that reported an increase in screening participation and subsequent decreases in CRC incidence and mortality resulting from organized CRC screenings within a community-based population.<sup>w,19</sup>

The Applicant asserts the Proposed Project will support access to high-quality care and improve patient experience and quality of life for several reasons, including:

- 1) The Applicant's ongoing process improvement initiatives such as its participation in national quality programs that include reviewing quality of care outcomes, identifying best practices, and implementing performance improvement initiatives. The Applicant states that the Center submits Adenoma Detection Rate (ADR) data to the GI Quality Improvement Consortium, Inc. (GIQuIC).<sup>20</sup> The ADR, the rate of an endoscopist's ability to find adenomas or precancerous polyps, is a key quality indicator that when improved, can improve quality of care. The Applicant states that the Center's physicians review ADR data quarterly so that they can make improvements in the quality of care. The Applicant also reports metrics as part of CMS' Ambulatory Surgical Center Quality Reporting

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<sup>16</sup> Esophagogastroduodenoscopy (EGD) is a medical procedure where a thin, flexible, lighted tube called an endoscope is used to visualize the esophagus, stomach, and the first part of the small intestine (duodenum).

<sup>17</sup> Colonoscopy is a medical procedure used to examine the inside of the large intestine (colon). Colonoscopy is considered the "gold standard" for CRC screening compared to other screening methods.

<sup>18</sup> Sigmoidoscopy is a medical procedure used to examine the lower part of the colon (the sigmoid colon) and rectum.

<sup>19</sup> The replacement of an opportunistic CRC screening program based primarily on sigmoidoscopy and gFOBT, with an organized screening program of annual FIT combined with opportunistic colonoscopy doubled the percentage of patients screening up-to-date, from almost 40% to >80%. The increase in screening was associated with an immediate increase in CRC incidence, particularly early-stage disease, followed by a substantial 25.5% decline in cancer incidence and a 52.4% decrease in cancer mortality during a 12- to 16-year period.

<sup>20</sup> A national endoscopic registry and clinical benchmarking tool for gastroenterologists that is jointly managed by the American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE).



(ASCQR) Program.<sup>21</sup> The Applicant states that the data submitted through ASCQR is reported publicly, allowing patients to use the information to make informed decisions about their care.

- 2) The Center's targeted focus on GI-related endoscopy services supports efficient scheduling practices to minimize delays, backlogs, and rescheduling.

Per section 140.305: Emergency Transfer of the Department's regulations governing Clinic Licensure (105 CMR 140.000), the Center maintains a transfer agreement with Emerson Hospital, located 1.2 miles from the Center, and in the case of an emergency, 911 is called and emergency services are requested.<sup>22</sup>

To further demonstrate the improved health outcomes and patient experience that will result from the Proposed Project, the Applicant cited several articles and reports on the benefits of performing the Center's endoscopy procedures in the ASC setting, as compared to the hospital setting, many resulting from ASCs focus on a limited set of specialties and low-risk procedures. The benefits of performing GI-specific procedures in the ASC setting as compared to the hospital setting include:

- Greater clinical and operational efficiencies
- More efficient use of time
- Cost-savings to payers and patients
- Lower overhead costs, such as staffing, laboratory, medication, and imaging costs
- Reduced wait times, scheduling delays and cancellations

The Applicant maintains that improved access to the Center's services in a non-hospital, lower-cost setting will improve patient adherence to CRC screening recommendations, and will increase CRC screening rates, which will in turn allow for earlier detection and more successful treatment. The American Cancer Society states that the five-year survival rate for CRC is 91% for localized cancer.<sup>23</sup> The Massachusetts Cancer Registry 2020 Data Report on CRC in Massachusetts noted that CRC diagnosed in those aged 50 and less were more likely to be regional or distant<sup>24</sup> compared to those age 50 and older, and that this is an important consideration as CRC rates for this age group continue to increase.<sup>x</sup>

The Applicant proposed specific outcome measures to track the impact of the Proposed Project which staff has reviewed and will become a part of the reporting requirements. These measures are shown in Appendix I.

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<sup>21</sup> Measures reported include Patient Burn (ASC-1); Patient Fall (ASC-2); Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant (ASC-3); All-cause hospital transfer/admission (ASC-4); Appropriate follow-up interval for normal colonoscopy in average risk patients (ASC-9); Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS-CAHPS)(ASC-15); and COVID-19 vaccination coverage among healthcare personnel (ASC-20).

<sup>22</sup> 140.305: Emergency Transfer (A) Each clinic shall have a written policy addressing the procedures for calling 911 for patients who need emergency treatment. A clinic is not precluded from entering into agreements for inter-facility transport in nonemergency situations.

<sup>23</sup> Localized: There is no sign that the cancer has spread outside of the colon or rectum.

<sup>24</sup> Regional: The cancer has spread outside the colon or rectum to nearby structures or lymph nodes.

Distant: The cancer has spread to distant parts of the body, such as the liver, lungs, or distant lymph nodes.

***Analysis: Improved Outcomes and Quality of Life***

Staff finds that increasing access to GI-specific ambulatory surgery in the ASC setting has the potential to improve health outcomes and quality of life of the Patient Panel. A 2015 research article examined the impact of opening an ASC on quality, found “the shift of outpatient surgery from the hospital to the ASC was not associated with higher rates of hospital admission or mortality” and stated further that their findings “suggest that freestanding ASCs can safely achieve their intended effects of outpatient procedure redistribution to a less expensive setting without sacrificing quality, as measured by hospital admission or mortality.”<sup>y</sup> A 2022 article comparing rates of unplanned hospital visits after GI endoscopy (EDG and colonoscopy) performed in ASCs and HOPDs (in Massachusetts from 2014 to 2017) found that “ASC patients consistently had less frequent hospital-based acute care encounters” and “did not observe that the transition of GI endoscopy to ASC settings compromised patient safety in Massachusetts at the time of this study.”<sup>z</sup> The Applicant states that it provides regular reporting to GIQuIC and to CMS’ ASCQR Program. The Applicant will also report annually to the Department on the measured listed in Appendix I. As a result, Staff finds that the Applicant meets the requirements of Public Health Value: Health Outcomes as part of Factor 1b.

***Public Health Value: Health Equity***

The following section outlines the Applicant’s processes in place to support equitable access to the Center.

**Language Access:**

- The Center provides language access services at no cost to patients.
- Patients are screened prior to the procedure to identify those patients with need for interpreter services as well as to identify the level of assistance needed. Interpreter services are always immediately available to patients even if they are not scheduled ahead of time.
- Translation services are provided for all languages through LanguageLine.
- In-person interpreter services are available for patients with hearing impairment.
- For patients with visual impairment, someone is available to read printed materials in a location that protects patient privacy.
- Printed or recorded materials are available upon request.

The Applicant states that it received 44 requests for interpreter services in 2024, and the top languages requested were Mandarin, Spanish, Portuguese, Korean, and Haitian Creole.

**Cultural Competency Training:**

- The Center requires that all staff complete a cultural competency training upon hire and annually thereafter.
- The cultural competency training is provided to staff through UKG Pro Learning. Core courses include “CLN Cultural Competence” and “Affordable Care Act Nondiscrimination and Limited English Proficiency.”
- The core courses in the cultural competency training are intended to promote understanding of the association between clinical outcomes and cultural competence, recognizing key

terms, acknowledging common assumptions across cultures, and best practice for interaction with patients and families.

### Payer Mix

The Applicant states, “The high percentage of commercial payers in the Center’s payer mix reflects the age and socioeconomic demographics of the Applicant’s service area. Overall, the towns within the Applicant’s service area have higher median household incomes and lower poverty rates compared to the overall Massachusetts figures.” With respect to economic stability in the Emerson Hospital service area, the Emerson Hospital CHNA states, “The percent of individuals living below the poverty line is lower in the service areas than the state or Middlesex County overall, but there is a range – in Sudbury just 1.5% of individuals live below the poverty line while it is 8.3% of individuals in Maynard.”<sup>aa</sup> Staff examined the median household income and poverty rate for the cities in towns that make up the Applicant’s PSA. Like the Emerson Hospital service area, there is a range within the service area with respect to median household income and the percentage of the population living below the poverty level, with the top towns in the Applicant’s PSA above the state and county average for median household income, and below the state and county poverty levels. This is shown in Table 19.

**Table 19: Percent Poverty Level and Income by City/Town in EDHC’s PSA, 2024**

Geographic Origin	% of the Center’s PSA 2024	County	Median <sup>bb</sup> Household Income	Median Household Income County	Median Household Income State <sup>cc</sup>	% Below Poverty Level <sup>dd</sup>	% Below Poverty Level County	% Below Poverty Level State <sup>ee</sup>
Concord	7.9%	Middlesex	\$212,315	\$123,705	\$99,858	2.5%	7.7%	10.4%
Acton	8.0%	Middlesex	\$153,338	\$123,705	\$99,858	3.4%	7.7%	10.4%
Sudbury	5.6%	Middlesex	\$234,634	\$123,705	\$99,858	2.6%	7.7%	10.4%
Westford	4.9%	Middlesex	\$181,523	\$123,705	\$99,858	2.4%	7.7%	10.4%
Bedford	3.4%	Middlesex	\$158,964	\$123,705	\$99,858	4.1%	7.7%	10.4%
Maynard	4.4%	Middlesex	\$119,549	\$123,705	\$99,858	7.4%	7.7%	10.4%
Littleton	3.7%	Middlesex	\$146,250	\$123,705	\$99,858	6.0%	7.7%	10.4%
Groton	4.7%	Middlesex	– <sup>25</sup>	\$123,705	\$99,858	7.8%	7.7%	10.4%
Stow	2.5%	Middlesex	\$177,862	\$123,705	\$99,858	5.0%	7.7%	10.4%
Hudson	1.9%	Middlesex	\$96,149	\$123,705	\$99,858	5.7%	7.7%	10.4%
Carlisle	2.0%	Middlesex	\$250,000+ <sup>26</sup>	\$123,705	\$99,858	2.1%	7.7%	10.4%
Chelmsford	2.7%	Middlesex	\$140,519	\$123,705	\$99,858	4.3%	7.7%	10.4%
Boxborough	2.3%	Middlesex	\$151,000	\$123,705	\$99,858	3.6%	7.7%	10.4%
Harvard	2.0%	Worcester	200,688	\$94,099	\$99,858	4.4%	11.0%	10.4%
Leominster	1.9%	Worcester	\$81,566	\$94,099	\$99,858	10.1%	11.0%	10.4%
Ayer	1.9%	Middlesex	\$81,286	\$123,705	\$99,858	9.0%	7.7%	10.4%
Marlborough	1.5%	Middlesex	\$95,047	\$123,705	\$99,858	9.2%	7.7%	10.4%
Lexington	1.8%	Middlesex	\$219,402	\$123,705	\$99,858	4.3%	7.7%	10.4%

<sup>25</sup> The estimate could not be computed because there was an insufficient number of sample observations.

<sup>26</sup> The margin of error could not be computed.

Lunenburg	1.4%	Worcester	\$112,422	\$94,099	\$99,858	3.1%	11.0%	10.4%
Pepperell	1.5%	Middlesex	\$76,196	\$123,705	\$99,858	10.6%	7.7%	10.4%

The Applicant also states that the change in recommended age to begin screening for CRC from age 50 to age 45 in the USPSTF updated screening guidelines, and increased awareness of colorectal cancer among younger adults resulted in an increase in the percent of adults aged 18 to 49 in the Center's Patient Panel from 27% in 2022 to 38% in 2024 and a shift in the Center's payer mix between governmental payors and commercial payers. The Applicant maintains that the update to the CRC screening guidelines is "the largest driver" of the decrease in Medicaid in the Center's payer mix because the majority of patients aged 18 to 49 are commercially insured, so when this age group increased in the Center's patients, it led to an increase in the commercial insurance in the Center's payer mix, and a decrease in patients insured through other payers. As a result, the Medicaid percent in the Center's payer mix decreased from 2022 to 2024.

The Applicant also states that the Medicare payer mix decreased as well from 2022 to 2024 because of the increased volume of patients on their Patient Panel under the age of 65, who are not eligible for Medicare. The Applicant cites increased awareness of colon cancer among younger adults, and increased calls for screening for CRC among younger adults, as leading to a "significant shift in the age of the ASC's patient population." Specifically, between 2022 and 2024, the 18 to 44 age group increased from 13.5% of the Center's population to 18.3%, the 45 to 49 age group increased from 10.2% to 17.9% of the Center's patient population, and the traditional Medicare population of patients 65 and older decreased from 30.9% to 20.8% of the Center's patient population. The Applicant notes that since 2022 the Center has become a participating provider with additional commercial insurers in an effort to increase access to care, and this has resulted in an increase in the commercial portion of the Center's patient population.

The Applicant states that all providers at the Center accept MassHealth, in compliance with provider regulatory requirements. The Applicant states that the Center piloted a partnership with a community primary care practice to allow for quicker access to scheduling CRC screenings at the Center for patients that were due for a colonoscopy screening. The GI practice at Emerson Hospital contacted patients to allow for quicker access to scheduling at the Center. During the pilot period, 188 patients were contacted. The pilot was successful and extended for the next two calendar years. In CY2023, 635 patients were contacted, and in CY2024, 577 patients were contacted. The Applicant states that it is planning to implement an open access referral system to increase the number of MassHealth patients served by the Center. The open access referral system will allow patients to call the Center and request an appointment without a GI referral. The Applicant states that patients will be offered the first available GI provider or will be paired with a provider that matches their preferences. Patients will be screened to determine which ones are eligible for a colonoscopy without a physician's referral. There will be no difference in wait-times for patients that enter through the open access referral system. The Applicant affirms that the open access referral system will "remove barriers to care, in turn improving access to cancer screening." The Applicant states that in an effort to expand access to the Center to MassHealth patients, it is in the process of determining which communities and practices to expand the partnership program to, and where to message its open access scheduling system.

### **Analysis: Health Equity**

The Massachusetts Health Policy Commission (HPC) DataPoints Issue 26 titled *Trends in Ambulatory Surgical Centers in Massachusetts* states “For most procedures, MassHealth patients had a substantially smaller share performed in ASCs than commercial patients.”<sup>ff</sup> The majority of GI/Endoscopy cases are performed in an HOPD versus an ASC for both commercially insured patients, and patients insured through MassHealth. However, 27% of GI/endoscopy procedures performed in the ASC setting in Massachusetts were for commercially insured patients, while 10% were for patients insured through MassHealth.<sup>gg</sup> As noted above, the Center’s payer mix in 2024 was 80.87% commercial, 1.56% MassHealth, and 0.34% Managed Medicaid. The DataPoints Issue notes that “More research is needed to understand and address drivers of this difference.”

In order to ensure that the Proposed Project increases access to care for patients insured by MassHealth, as a Condition of Approval, the Applicant will provide a plan detailing how it will increase MassHealth in the Center’s payer mix. The Applicant will report annually to demonstrate measurable progress. The Applicant will also report annually on patient race and ethnicity. The full text of the Conditions is listed in the “Other Conditions” section of this report. Staff finds that with the “Other Conditions” listed below, the Applicant sufficiently demonstrated reasonable efforts to provide equitable access to the Center’s services. As a result, Staff finds that the Applicant meets the requirements of the Public Health Value: Health Equity part of Factor 1b.

### **Factor 1: c) Efficiency, Continuity of Care, Coordination of Care**

The Applicant states that the Proposed Project will operate efficiently and effectively by furthering the continuity and coordination of care for the Applicant’s Patient Panel. The Applicant states that its care coordination systems support effective communication between providers and connection to other appropriate services outside of the ASC.

#### **Care Coordination:**

- Discharge Planning: All patients or the accompanying adult, receive prescriptions, written instructions for recovery from the procedure and warning signs of complications to be alert for, and contact information for the operating physician, prior to discharge.

#### **Electronic Medical Record (EMR):**

- Copies of each procedure and pathology report are shared with the referring physician via Epic as part of follow-up procedures. The operating physician shares procedure notes with the PCP via Epic. The Applicant states that the physicians and their care teams manage and coordinate all follow-up care. For patients that are self-referred, follow-up communication with the patient occurs through the GI provider performing the procedure, or through the patient’s PCP, if one is identified.

#### **Efficiency:**

The Applicant states that the ASC’s singular focus on GI-related endoscopy services, will “maximize operational efficiencies” due to the ability to limit the range of supplies, equipment, and staff needed to support the procedures at the ASC.

**Follow-up Care:**

- The Applicant states that all follow-up care is conducted at the physician's practice location.

**Analysis**

Staff finds that the Applicant's care coordination will continue to contribute to efficiency, continuity, and coordination of care. The Applicant demonstrated appropriate maintenance and sharing of patient records as well as communication with patients and providers, pre- and post-operatively, to track patient progress and to promote better health outcomes. As a result, Staff finds that the Proposed Project meets the requirements of Factor 1c.

**Factor 1: d) Consultation**

The Applicant has provided evidence of consultation, both prior to and after the Filing Date, with all government agencies that have licensure, certification, or other regulatory oversight, which has been done and will not be addressed further in this report.

**Factor 1: e) Evidence of Sound Community Engagement through the Patient Panel**

The Department's Guideline<sup>dd</sup> for community engagement defines "community" as the Patient Panel, and requires that at minimum, the Applicant must "consult" with groups representative of the Applicant's Patient Panel. Regulations state that efforts in such consultation should consist of engaging "community coalitions statistically representative of the Patient Panel."

To fulfill the community engagement requirement, the Applicant took the actions described below.

**Emerson Hospital Patient and Family Advisory Council (PFAC):** The Center's Administrator and Director of Nursing discussed need for the Proposed Project at Emerson Hospital's PFAC meeting on November 21, 2024. The Applicant states that PFAC members inquired about the relationship between Emerson Hospital and the Center, projected volume at the Center and the Center's staffing plans. The Applicant states further that the PFAC provided positive feedback and was supportive of the Proposed Project because of the associated quality, convenience, and cost. There were 15 attendees including 13 PFAC members and two of the Center's staff members.

**Educational Flyers:** The Applicant states that it posted educational flyers at the Center with information about the Proposed Project, information about the importance of cancer screening, and information on how to ask questions about the Proposed Project and provide feedback on the Proposed Project. The Applicant states that the flyers were intended to inform and engage current patients of the Center. The Applicant did not receive any feedback on the Center's patient education materials. The Applicant notes that the flyers remain posted around the Center.

**Legal Notices:** The Applicant states that it published two legal notices announcing the Proposed

Project in the Boston Herald on February 28, 2025 and also posted a copy of the legal notice on the Center's website.

### ***Analysis***

Staff reviewed the information on the Applicant's community engagement and finds that the Applicant has met the required community engagement standard of Consult in the planning phase of the Proposed Project. As a result, Staff finds that the Proposed Project meets the requirements of Factor 1e.

### **Factor 1: f) Competition on price, total medical expenses (TME), costs and other measures of health care spending**

The Applicant states, "The Proposed Project will compete on the basis of price, TME, provider costs, and health care spending because of the cost savings driven by the provision of outpatient endoscopy at the Center." The Applicant points to the HPC's DataPoints Issue 26 which discusses the supply of ASCs in Massachusetts, to further demonstrate need for additional ASC capacity in Massachusetts, and endoscopy-specific ASC capacity, in particular. DataPoints Issue 26 states that, "Massachusetts has the fourth fewest ASCs per capita in among all states".<sup>hh</sup> The HPC attributes the low number of ASCs in Massachusetts to the "state's regulatory history" which included a change to DoN law in 2008 resulting in a moratorium on the establishment of new ASCs, until 2017 when the DPH amended the DoN regulations and lifted the moratorium, with certain requirements.<sup>ii</sup> Staff concur that increasing the availability of ASCs in Massachusetts could serve to provide alternative, lower-cost sites of care for clinically appropriate patients. Staff note that the HPC's 2023 Cost Trends Report and Recommendations Chartpack states, "In 2021, 66% of endoscopies among commercially-insured patients took place in HOPDs, 29% took place in ASCs, and 5% took place in [physician] offices."<sup>jj</sup> Additionally, the HPC's 2024 Cost Trends Report and Recommendations Chartpack states that in 2022, the price for a colonoscopy with removal of lesions was higher when performed in an HOPD (\$2,390) than in an ASC (\$1,521), and that 62% of procedures were performed in an HOPD as compared to 33% in an ASC and 5% in a physician's office.<sup>kk</sup>

The DataPoints Issue states that the low supply of ASCs in Massachusetts translates to **23** ASC operating rooms per one million residents in the Commonwealth compared to the national average of **56**.<sup>ll</sup> Additionally, Massachusetts' ASC supply is less than the national average across all specialties. Massachusetts has **12** single-specialty endoscopy ASCs, and **6** multi-specialty ASCs that offer endoscopy services, for a total of **18** ASCs providing GI/Endoscopy services.<sup>mm</sup> While GI/Endoscopy is a common single specialty ASC in Massachusetts, Massachusetts has only **2.6** ASCs providing GI/endoscopy services per one million residents, as compared to the national average of **5.9** (2023).<sup>nn</sup> The Applicant also cited slides from the HPC's board meeting which show that of the share of surgical procedures performed in ASCs in Massachusetts, only **25%** of colonoscopies and biopsies and **24%** of upper gastrointestinal endoscopy and biopsies are performed in an ASC (2021).<sup>oo</sup>

In their 2023 Annual Cost Trends Report, the HPC notes that endoscopy procedures are performed in HOPDs, ASCs, and physician offices. The HPC states, "In 2021, 66 percent of endoscopies among commercially insured patients were performed in HOPDs, 29 percent occurred in ASCs, and 5

percent occurred in offices,” and that “Provision of an endoscopy in a HOPD is likely not necessary for the majority of cases.”<sup>pp</sup>

The Applicant states that reports show that Medicare reimbursement rates for ASCs are, on average, 50% of the amount paid to HOPDs. ASCs are projected to save the Medicare Program a total of \$73.4 billion from 2019 to 2028, an increase from \$4.3 billion in savings in 2019 to \$12.2 billion in savings in 2028. <sup>qq</sup> Table 20 shows the cost savings to Medicare patients for endoscopy procedures performed in the ASC setting as compared to an HOPD.

**Table 20: Procedure Costs in ASC vs. HOPD, 2025<sup>27</sup>**

Procedure	ASC Cost	HOPD Cost	ASC Savings	ASC Savings Change from 2024
Sigmoidoscopy	\$203	\$966	79%	+1%
Endoscopy	\$1,001	\$2,033	51%	+1%
Endoscopy with biopsy	\$1,016	\$2,048	50%	No Change
Sigmoidoscopy with biopsy	\$559	\$981	43%	+1%
EGD	\$621	\$1,055	41%	+1%
EGD with biopsy	\$635	\$1,069	41%	+2%
Colonoscopy with biopsy	\$824	\$1,371	40%	+1%
Colonoscopy	\$666	\$1,088	39%	+1%

Additionally, the Applicant cites the HPC’s DataPoints Issue 26 findings that Medicaid and commercial payers also recognize savings from shifting clinically appropriate patients from HOPDs to ASCs.<sup>rr</sup>

The Applicant states that as ASC availability has increased, utilization of ASCs has increased as well, because ASCs offer high-quality care in a lower-cost setting. The Applicant points to the shift in endoscopy cases from Emerson Hospital to the Center that has occurred since the Center’s opening, as evidence of the increase in utilization of ASCs, and reduced reliance on HOPDs. In 2022, the share of endoscopy procedure volume at Emerson Hospital and the Center was 69% at Emerson Hospital and 31% at the Center, in 2024 it was 43% at Emerson Hospital and 57% at the Center.

### **Analysis**

Staff finds that, on balance, the requirement that the Proposed Project will likely compete on the basis of price, TME provider costs, and other measures of health care spending and therefore, the requirements of Factor 1(f) have been met.

### **Summary, Factor 1**

As a result of information provided by the Applicant and additional analysis, staff finds that with the “Other Conditions” outlined below and the standard reporting requirements, the Applicant has

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<sup>27</sup> The Applicant states that total cost is based on Medicare’s 2025 payments and copayments rates as reviewed on June 2, 2025.



demonstrated that the Proposed Project has met Factor 1(a-f).

## **Factor 2: Cost containment, Improved Public Health Outcomes and Delivery System Transformation**

### **Cost Containment**

The Applicant states, “the Proposed Project will contribute to the Commonwealth’s goal of containing the rate of growth of total medical expenses” and total health care expenditures (THCE). To demonstrate that the Proposed Project will contribute to the Commonwealth’s cost containment goals, which include providing high-quality care at a lower cost, the Applicant points to the Proposed Project’s potential to improve access to high-quality endoscopy services, in a lower cost setting. The Applicant cited the HPC’s reporting that “prices are 75% higher, on average, in hospital outpatient departments (HOPDs) for surgeries commonly performed in both ambulatory surgery centers (ASCs) and HOPDs.”<sup>ss</sup> Additionally, the screening services provided at the Center will allow for earlier detection and treatment, which will also contribute to lower healthcare costs. As noted in Factor 1f, Medicare reimbursement for procedures performed in the ASC setting is, on average, 50% the amount paid to HOPDs, and Medicaid and commercial payers also benefit from lower prices paid for procedures performed in the ASC setting. The Applicant also points to the lower overhead costs of single-specialty ASCs as compared to HOPDs as another measure of their cost effectiveness.

### ***Analysis: Cost Containment***

Staff finds that the Applicant demonstrated how the Proposed Project aligns with the Commonwealth’s cost containment goals through the expansion of access to high-quality ambulatory surgery in a lower cost setting, and through reducing delays in access to endoscopy services. As a Condition of approval, the Applicant will report annually on the continued shift of clinically appropriate cases from Emerson Hospital to the Center. The full text of the Condition is listed in the “Other Conditions” section of this report. Therefore, DoN Staff conclude that with the “Other Condition” the Proposed Project will likely meet the cost containment component of Factor 2.

### **Improved Public Health Outcomes**

As noted in Factor 1b, the Proposed Project will improve access to endoscopy services in the community setting, and this in turn will improve health outcomes and patient experience. The Applicant states that improved access to endoscopy services will improve patient adherence to screening recommendations, and higher screening rates will improve detection of cancer earlier, when treatment is more effective, and less costly, and with greater improvements to patient quality of life. The Applicant states further that patient experience will be improved through an accessible facility that is easier to navigate than the hospital setting, and with scheduling that will reduce wait times for appointments and scheduling delays.

### ***Analysis: Public Health Outcomes***

Staff finds that the Applicant demonstrated how the Proposed Project will improve health outcomes through increasing access to the Center’s services, which the Applicant has shown to be high-quality, and through reducing scheduling delays, and delays in diagnosis and treatment. Therefore, DoN

Staff conclude that the Proposed Project will likely meet the Public Health Outcomes component of Factor 2.

### **Delivery System Transformation**

The Applicant states that the Center does not currently have a process in place to screen patients for social determinants of health (SDoH) needs. Patients are screened for transportation prior to their procedure to ensure that each patient has a safe ride home from their procedure. The Applicant states that staff provide referral resources to patients with SDoH needs that are identified or suspected during pre-procedure screenings and appointments and staff update the medical record to allow for the patient's PCP to be aware of and to follow-up on any SDoH needs.

### ***Analysis: Delivery System Transformation***

The Applicant demonstrated how the proposed ASC will evaluate patients for transportation prior to the procedure, and address SDoH needs that are detected. Therefore, DoN Staff can conclude that the Proposed Project will likely meet the Delivery System Transformation component of Factor 2.

### **Summary, Factor 2**

As a result of information provided by the Applicant and additional analysis, staff finds that with the "Other Conditions" outlined below and the standard reporting conditions, the Applicant demonstrated that the Proposed Project has met Factor 2.

### **Factor 3: Relevant Licensure/Oversight Compliance**

The Applicant provided evidence of compliance and good standing with federal, state, and local laws and regulations. This will not be addressed further in this report. As a result of information provided by the Applicant, staff finds the Applicant has reasonably met the standards of Factor 3.

### **Factor 4: Financial Feasibility**

Under Factor 4, the Applicant must demonstrate that it has sufficient funds available for capital and operating costs necessary to support the Proposed Project without negative effects or consequences to the existing Patient Panel. Documentation sufficient to make such finding must be supported by an analysis conducted by an independent certified public accountant (CPA). The Applicant submitted a report performed by Bernard L. Donohue, III, CPA (CPA Report).

The CPA analysis included a review of numerous documents in order to form an opinion as to the reasonableness and feasibility of the projections regarding the Proposed Project. The projections are deemed reasonable, within the context of this report, if they are supportable and proper given the underlying information. The Proposed Project is feasible if, based on the assumptions used, the plan is not likely to result in insufficient funds available for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's existing Patient Panel.

To arrive at its conclusions, the scope of the CPA report is limited to an analysis of the five-year Projections for the fiscal years ending December 31, 2026 through December 31, 2030, prepared for EDHC, actual operating results for the trailing twelve months ended November 30, 2024, and the

supporting documentation. The CPA states “the Projections exhibit a net pre-tax profit margin ranging from 26.5% to 46.6% for fiscal years ending December 31, 2026 through December 31, 2030.” The CPA states further, “Based on my review of the relevant documents and analysis of the projected financial statements, I determined the project and continued operating surplus are reasonable expectations and are based on feasible financial assumptions.”

Sources of information used and relied upon in the report:

- Emerson Endoscopy and Digestive Health Center, LLC’s 5-Year Projected Financial Statements, and Assumptions initially received from Management on December 12, 2024 and updated on March 28, 2025;
- Various documentation supporting calculations included in the projected financial statements initially received from Management on December 12, 2024 and updated on March 28, 2025;
- Emerson Endoscopy and Digestive Health Center, LLC’s balance sheets and income statements as of and for the trailing twelve months through November 30, 2024, initially received from Management on December 12, 2024;
- Construction estimate provided on December 13, 2024;
- Emerson Endoscopy and Digestive Health Center, LLC’s federal and Massachusetts partnership tax returns for the fiscal years ended December 31, 2022 and December 31, 2023 received from Management on December 12, 2024;
- Emerson Endoscopy and Digestive Health Center, LLC DoN Appendix 2 Narrative, draft provided March 5, 2025;
- Emerson Endoscopy and Digestive Health Center, LLC Massachusetts Department of Public Health Determination of Need Application Form provided on March 10, 2025;
- Determination of Need Application Instructions dated March 2017;
- CMS.gov (Medicare) Ambulatory Surgical Center Payment System website;
- Mass.gov Executive Office of Health and Human Services;
- VMG Health’s Intellimarker 2023 ASC Benchmarking Study, based on 2021-2022 data;
- Emerson Endoscopy & Digestive Health Center website  
<https://emersondigestivecenter.com/>

The CPA reviewed key metrics falling into three categories: liquidity, operating and solvency. Liquidity metrics measure the quality and adequacy of assets to meet current obligations as they come due. Operating metrics are used to assist in the evaluation of management performance in how efficiently resources are utilized. Solvency metrics measure the company’s ability to serve debt obligations. The CPA report provides an overview of how each of the Key Metrics are calculated.

**Revenues:** Projected volume at the Center is based on a ramp-up schedule based on the Center’s current case volume, the hiring of additional physicians to service the Center, and the impact of the closure of NVMC on the Center’s operations.<sup>28</sup>

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<sup>28</sup> Refers to the hiring of physicians by Emerson Health’s GI practice and Atrius Health. The Center does not employ any physicians. Recently, Emerson Health hired two providers and Atrius Health hired one provider, for a total of three providers.

- Ramp-up schedule for years 2 through 5 (2027 to 2030) included an 18% increase from 2026 to 2027, followed by a 8.8% increase through year 5 (2030).
- Payer-mix was based on the Center's current payer mix.
- Reimbursement was based on historical overall payment per care.

The CPA compared the Center's benchmark data to an outside independent survey of ambulatory surgery centers that was completed using 2021 to 2022 data, which the CPA states is the latest study. The CPA found the Center's benchmark data to be reasonable, and the number of procedures per procedure room in year 5 (2030) to be within the ranges of currently operating ambulatory surgery centers.

The CPA compared the independent survey's payer mix for the Northeast United States to the Center's and found them to be within the ranges published in the survey. The CPA tested the reasonableness of the Center's starting average reimbursement rate (\$864 per case and \$483 for anesthesia in the projections), which inflated by 3% each year of the projections, and found that the rates compared favorable to the rates used in the projections.

The CPA found the projected revenue reflects a reasonable estimation of future revenues of the Center.

**Expenses:** The CPA analyzed Salary and Benefits, Other Operating Expenses, for reasonableness and feasibility as they related to the Projections. Staffing hours were compared to the independent survey and were found to be consistent with survey results. Wage rates for all clinical and administrative categories were also found to be consistent with the survey results for the Northeast United States. Medical Surgical Supplies in the projection were compared to the independent survey and found to be consistent with the ranges in the survey, and Other expenses were compared to the independent survey and were found to be reasonable.

The CPA found the operating expenses projected by Management of the Center to be reasonable.

**Capital Contribution:** The CPA reviewed the lease terms, projected capital expenditures, and future cash flows of the Center. EDHC leases its space for \$269,585. Insurance and property taxes bring annual fixed expenses to \$315,317. The lease will include a 1% increase every year. The additional treatment room is included in the original lease.

The CPA found the total occupancy costs included in the projections to be within the range of the independent survey.

As a result of the aforementioned, the CPA determined the pro-forma capital expenditures, facility lease, terms of equipment and working capital financing, and the resulting impact on the cash flows of EDHC to be reasonable.

### **CPA's Conclusion of Feasibility**

The CPA concluded "Based upon my review of the relevant documents and analysis of the projected

financial statements, I determined the project and continued operating surplus are reasonable and are based upon feasible financial assumptions. Accordingly, I determined that the Projections are feasible and sustainable and not likely to have a negative impact on the patient panel or result in a liquidation of assets of Emerson Endoscopy and Digestive Health Center, LLC.”

### ***Analysis***

Staff is satisfied with the CPA’s analysis of the Applicant’s decision to proceed with the Proposed Project. As a result, staff finds the CPA analysis to be acceptable and that the Applicant has met the requirements of Factor 4.

## **Factor 5: Assessment of the Proposed Project’s Relative Merit**

The Applicant has provided sufficient evidence that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs identified by the Applicant pursuant to 105 CMR 100.210(A)(1). Evaluation of 105 CMR 100.210(A)(5) 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.

The Applicant considered and rejected two alternatives to the Proposed Project.

**Alternative #1:** Renovate and re-license an endoscopy procedure room at Emerson Hospital.

- **Quality:** This alternative does not address patient preference to receive care in the ASC setting, with its associated benefits.
- **Efficiency:** The ASC setting has certain operational efficiencies that a procedure room in an HOPD would not have.
- **Capital Expense:** Because the current procedure rooms at Emerson Hospital do not meet current Facilities Guidelines Institute (FGI) guidelines, Emerson Hospital would have to undertake significant, more costly renovations to create a new procedure room that is compliant with square footage requirements.
- **Operating Costs:** Operating costs would increase, due in part to the additional staff needed to accommodate an increase in patients. The Applicant states that this alternative would not have any cost implications for the Center.

**Alternative #2:** Expand the Center’s hours of operation beyond Monday through Friday, 7:00a.m. to 5:00p.m.

- **Quality:** Patients may be more likely to delay or defer care if they are not able to obtain appointments during the day, as opposed to the evening.
- **Efficiency:** This alternative would require recruiting staff to cover the extended operating hours, and this alternative would not provide sufficient capacity to meet the Center’s projected need, stating that opening the Center for a full weekend day would only increase case volume by 14 cases per week or 728 cases per year. This is compared to the additional 3,500 cases a year that would come from the additional operating room, or only 20% of cases that could be achieved with the proposed procedure room (assuming a case room capacity of 3,500).

- Capital Expense: This alternative would not require a capital expense.
- Operating costs: This alternative would likely result in higher operating costs, such as overtime pay, due to the additional personnel needed to cover the extended hours of operation. Additionally, physician staffing for the extended hours of operation poses particular issues with respect to call coverage and other hospital commitments.

The Applicant compared the projected operating capacity of the Center that would result from Alternative 2 to the projected operating capacity that would result from the Proposed Project, to show that in Alternative 2, the Center would be operating above optimal operating capacity, which would negatively impact wait times and access to care. This is shown in Table 21. As noted above in Factor 1a, the Applicant anticipates being able to maintain utilization below 90% with the addition of a third procedure room.

**Table 21: Alternative 2 Projected Cases and Operating Capacity**

	Alternative 2		Proposed Project	
	Projected Cases	Projected Operating Capacity	Projected Cases	Projected Operating Capacity
2026	5,564	72%	5,564	53%
2027	6,564	85%	6,564	63%
2028	7,564	98%	7,564	72%
2029	8,564	111%	8,564	82%
2030	9,314	121%	9,314	89%

### ***Analysis***

Staff finds that the Applicant has appropriately considered the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives. As a result of information provided by the Applicant and additional analysis, staff finds the Applicant has reasonably met the standards of Factor 5.

## **Factor 6: Fulfillment of DPH Community-based Health Initiatives Guideline**

As a co-owner of the Applicant and a hospital with a Community Health Needs Assessment (CHNA) covering the Applicant's service area, Emerson Hospital will carry out the local CHI project associated with this DoN application. Emerson Hospital will pool the local CHI funding with an existing CHI project from the original DoN project approved ([# 20090210-AS](#)). The Applicant will also contribute to the Statewide Community Health and Healthy Aging Fund.

To fulfill Factor 6 requirements, Emerson Hospital utilized the CHI forms submitted for the original DoN project, as well as provided an updated CHI Narrative. Due to the timing of the current project, the CHI team received a supplemental narrative from Emerson Hospital that provided additional context on their ongoing community engagement processes and how it's informing their upcoming 2025 CHNA.

Emerson Hospital will work with its Community Benefits Advisory Committee (CBAC) to determine

the most appropriate distribution of the CHI funding associated with the Proposed Project. The timeline, processes, and use of evaluation and administrative funds are appropriate and in line with CHI planning guidelines.

*Summary Analysis:* As a result of information provided by the Applicant and additional analysis, staff finds that with the conditions outlined below, and the ongoing communication outlined above, the Applicant will have demonstrated that the Proposed Project has met Factor 6.

## Findings and Recommendations

Based upon a review of the materials submitted, Staff finds that, with the addition of the recommended Conditions detailed below, the Applicant has met each DoN Factor for the Proposed Project and recommends that the Department approve this Determination of Need, subject to all applicable Standard and Other Conditions.

## Other Conditions

1. Of the total required CHI contribution of \$24,242.80
  - a. \$2,375.79 will be directed to the CHI Statewide Initiative.
  - b. \$21,382.15 will be dedicated to local approaches to the DoN Health Priorities.
  - c. \$484.86 will be designated as the administrative fee.
2. To comply with the Holder's obligation to contribute to the CHI Statewide Initiative, the Holder must submit a check for \$2,375.79 to Health Resources in Action (the fiscal agent for the CHI Statewide Initiative) **within 30 days** from the date of the Notice of Approval.
  - a. Payments should be made out to:  
Health Resources in Action, Inc. (HRiA)  
2 Boylston Street, 4th Floor  
Boston, MA 02116 Attn: MACHHAF c/o Bora Toro  
DoN project: # EDHC-25021711-AS
  - b. Please send a PDF image of the check or **confirmation of payment** to [DONCHI@Mass.gov](mailto:DONCHI@Mass.gov) and [dongrants@hria.org](mailto:dongrants@hria.org). If you should have any questions or concerns regarding the payment, please contact the CHI team at [DONCHI@Mass.gov](mailto:DONCHI@Mass.gov).
3. With its annual report, the Holder will submit a plan to the Department detailing how it will increase MassHealth in its payer mix. The Holder shall update this plan and report annually to the Department to demonstrate measurable progress resulting from its efforts to increase its MassHealth payer mix, detailing the strategies being implemented to achieve this goal and the outcomes of the Holder's efforts.

The DoN Program shall review the data received in accordance with Condition 3. If the DoN Program determines that the Holder's MassHealth payer mix materially decreased year-over-year, the Holder shall provide to the Department an explanation for MassHealth decrease in

its payer mix. After review of the Holder's explanation, the Department may refer the matter to the Public Health Council for review and consideration of the Holder's compliance with the DoN approval.

4. The Holder shall report on the Center's patients stratified by race, ethnicity, language, zip code of residence, and payer mix.
5. To demonstrate that clinically appropriate/routine cases continue to shift from Emerson Hospital to the Center proportional to the increase in procedure room capacity, the Holder shall report annually on total routine endoscopy procedure volume at Emerson Hospital Endoscopy Department and at the Center (count and percent).

The DoN Program shall review the data received in accordance with Condition 5. If the DoN Program determines that the ratio of routine endoscopy procedures performed at the Center to total routine endoscopy procedures performed at the Center and Emerson Hospital has materially decreased year-over-year, the Holder shall provide to the Department an explanation for the decrease. After review of the Holder's explanation, the Department may refer the matter to the Public Health Council for review and consideration of the Holder's compliance with the DoN approval.



## Appendix I: Required Measures for Annual Reporting

The Holder shall, on an annual basis, commencing with approval of this DoN, and continuing annually for a period of five years after the Project is complete, report on the following data elements, pursuant to 105 CMR 100.310(A)(12). Reporting will include a description of numerators and denominators. If applicable, include baseline data for measures (a year prior to implementation of DoN-approved project).

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

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

**Numerator:** Total number of withdrawal minutes for all patients.

**Denominator:** Total number of patients.

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

- 2. Adenoma Detection Rate:** The Adenoma Detection Rate (ADR) is the minimum target for adenomas detected among an individual provider's patient panel. An increased ADR is associated with a reduction in CRC incidence and a reduction of cancer mortality.<sup>29</sup>

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

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

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

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

**Measure:** The Holder shall report annually on the Adenoma Detection Rate stratified by race and ethnicity, and by payer mix.

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

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<sup>29</sup> Quality Indicators for GI Endoscopic Procedures, AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY, [https://www.asge.org/docs/default-source/default-document-library/quality-indicators-for-gi-endoscopic-procedures.pdf?sfvrsn=e0d2ea51\\_0](https://www.asge.org/docs/default-source/default-document-library/quality-indicators-for-gi-endoscopic-procedures.pdf?sfvrsn=e0d2ea51_0) (last visited January 15, 2025).

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

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

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

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

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

5. The Holder shall report annually on its efforts to implement a SDoH screening process to assess and respond to the SDoH needs of its Patient Panel. Annual reporting shall include, but not be limited to a description of the screening process (e.g. domains screened for and the referral process for positive SDoH screens), the number of patients screened, and the number of positive screens identified.

## REFERENCES

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- <sup>n</sup> 2024—First Year the US Expects More than 2M New Cases of Cancer.  
<https://www.cancer.org/research/acs-research-news/facts-and-figures-2024.html>
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