

**STAFF REPORT TO THE PUBLIC HEALTH COUNCIL
FOR A DETERMINATION OF NEED**

Applicant Name	Mass General Brigham Ambulatory Surgery - Cambridge, LLC
Applicant Address	399 Revolution Dr Somerville, MA 02145
Filing Date	October 1, 2025
Type of DoN Application	Ambulatory Surgery
Total Value	\$7,349,450.00
Project Number	MGB-C-25070908-AS
Ten Taxpayer Groups	One Formed
Community Health Initiative (CHI)	\$367,472.50
Staff Recommendation	Approval
Public Health Council Meeting	February 11, 2026

Project Summary and Regulatory Review

Mass General Brigham Ambulatory Surgery - Cambridge, LLC filed a Determination of Need (DoN) application to establish a freestanding single-specialty ambulatory surgery center, located at 799 Concord Avenue, Cambridge, MA. The proposed ASC will operate three procedure rooms and ten pre/post-operative bays. The total value for the Proposed Project is \$7,349,450.00. The Community Health Initiative (CHI) contribution is \$367,472.50.

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.

The Department did not receive any public comments on this DoN application. One Ten Taxpayer Group (TTG) formed in connection with this DoN application.

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Background and Application Overview

Mass General Brigham Ambulatory Surgery – Cambridge, LLC

Mass General Brigham Ambulatory Surgery – Cambridge, LLC (Applicant) seeks to establish a freestanding single-specialty ASC in Cambridge, MA (Proposed Project). The Applicant is owned by New England Surgery Center Holdings, LLC, a joint venture between Mass General Brigham, Inc and Regent Surgical Health, LLC. Staff notes that the proposed ASC does not fall within the primary service area (PSA) of an independent community hospital.

Mass General Brigham, Inc

Mass General Brigham, Inc (MGB), is a Massachusetts not-for-profit corporation. Table 1 shows acute and non-acute care hospitals in Massachusetts that comprise the MGB system.¹

Table 1: The Hospitals that Comprise the Mass General Brigham, Inc. System

Acute Hospital	Type (Per CHIA Category ^a)
1. Brigham and Women's Hospital (BWH)	Academic Medical Center (AMC)
2. Massachusetts General Hospital (MGH)	Academic Medical Center
3. Massachusetts Eye and Ear Infirmary	Specialty Hospital
4. Brigham and Women's Faulkner Hospital	Community Hospital
5. Newton-Wellesley Hospital	Community Hospital
6. Cooley Dickinson Hospital	Community High Public Payer Hospital
7. Martha's Vineyard Hospital	Community Hospital
8. Nantucket Cottage Hospital	Community Hospital
9. Salem Hospital	Community High Public Payer Hospital
Non-Acute Hospital	
1. McLean Hospital	Psychiatric Hospital
2. Spaulding Rehabilitation Hospital	Rehabilitation Hospital

MGB also operates a home health agency, Mass General Brigham Home Care, and its physician network comprises approximately 7,500 employed and affiliated primary care and specialty care physicians. MGB also operates health insurance and administrative services products.² MGB's ownership interest in the joint venture is 70%.

Regent Surgical Health, L.L.C.

Regent Surgical Health, LLC (Regent) is a for-profit entity founded in 2001. It currently operates or manages ambulatory surgery centers in 13 states.³ Services include gastroenterology, ophthalmology, orthopedics (including total joint replacement), otolaryngology, pain management and general surgery. Regent's ownership interest in the joint venture is 30%.

¹ The hospitals listed in Table 1 are principal teaching affiliates of the medical and dental schools of Harvard University. Additionally, the Applicant operates a graduate level program for health sciences and maintains both the Mass General Research Institute as well as the Brigham Research Institute (both are private, non-profit medical research enterprises).

² The Applicant operated a non-profit insurance company for MassHealth (Medicaid) and ConnectorCare members, as well as for-profit insurance company for commercial populations.

³ Regent manages surgery center locations in AK, AL, FL, IL, IN, MI, NJ, NY, OH, OR, TN, TX, and WI.

Proposed Project

The Applicant seeks to establish a freestanding single-specialty ASC in Cambridge focusing on endoscopy. The proposed ASC will operate three procedure rooms and ten pre/post-operative bays in 6,095 square feet of leased space. The ASC will be open five days per week (Monday – Friday), with an annual maximum capacity for the ASC of 9,000 procedures. The Proposed Project aims to reduce endoscopy volume at the MGB Brigham and Women’s Hospital (BWH) and Massachusetts General Hospital (MGH) Academic Medical Centers (AMCs), which the Applicant asserts will alleviate the growing backlog of patients who are overdue for screening colonoscopies and achieve significant cost savings compared to the AMC setting. The Proposed Project is part of a system-wide initiative to address the backlog of endoscopy patients and notes that capacity constraints at all MGB locations prevent the AMCs from shifting volume to other facilities, as detailed in Factor 1a.

Patient Panel⁴

As a new entity, the facility has no current Patient Panel. However, the Proposed Project is meant to decant a population of endoscopy patients from BWH and MGH with the intention of performing their procedures at the new facility. Therefore, the discussion of Patient Panel in this analysis refers to the patients of the health care facilities affiliated with MGB, as directed by the regulation. The Applicant states that, while the current need for endoscopy by MGB patients extends across the region because the current capacity is insufficient to meet patient need, they relied on historical data from MGH and BWH to determine the need for the Proposed Project, focusing on historical outpatient endoscopy volume that would have been appropriate for treatment in an ASC. These data were further narrowed by patient zip codes in the Primary Service Area (PSA) to better illustrate the need for endoscopy by the MGB AMC patients. Staff finds this is an acceptable way to define Patient Panel.

The Patient Panel data in Tables 2 and 3 reflect historical BWH and MGH patients who would have been eligible to have their endoscopy procedures⁵ performed in an ASC in the PSA. The Applicant attributes the decline in outpatients within the PSA in FY2024 to the departure of several providers who previously were performing endoscopy services at MGH and BWH main campuses as well as an increase in inpatient procedures. However, the Applicant notes that unique patients increased in FY2025.⁶

⁴ 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.

⁵ Colonoscopy - Diagnostic/Screening; Colonoscopy – Procedural; EGD – Diagnostic; EGD – Procedural; Anoscopy – Procedural; Enteroscopy – Diagnostic; Enteroscopy – Procedural; Esophagoscopy – Diagnostic; Esophagoscopy – Procedural; Other GI Procedures - Dilation – Esophagus; Other GI Procedures - GI Tube Insertion/Replacement/Service – Percutaneous; Other GI Procedures - Other Tube Placement; Proctosigmoidoscopy – Diagnostic; Proctosigmoidoscopy – Procedural; Sigmoidoscopy - Diagnostic/Screening; Sigmoidoscopy - Procedural

⁶ The Applicant notes that the number of unique patients presented here are based on the PSA for Proposed Project. Therefore, the total volumes for the likely Patient Panel would not capture all MGH patients and as such the shift of patients from MGH main campus to MG Waltham, resulting from the recent addition of operating rooms would not be reflected in this Patient Panel Data.

Table 2: Patient Panel From MGB AMCs in PSA

	2022	2023	2024	2025
Unique Patients	8,184	8,422	7,716	9,160

Table 3 shows the demographics of the Applicant's Patient Panel. Staff notes the following observations about the data below:

- **Age:** More than 75% of the Patient Panel was between the ages of 40 and 80 in FY2024, with 37% of the Patient Panel between the ages of 40 and 60.
- **Race/ Ethnicity:** The majority of patients (67%) self-identified as White, 16% of patients identified as Hispanic/ Latino, 10% of patients identified as African American, and 7% identified as Asian. These statistics generally align with the demographics of Middlesex and Suffolk counties.^b
- **Payer Mix:** Public payers represent roughly 40% of the Patient Panel payer mix, with almost 30% Medicare (Medicare Fee for Service and Managed Medicare) and 10% Medicaid (MassHealth primary and Managed Medicaid).

Table 3: Overview of Patient Panel From MGB AMCs in PSA (FY2024)

	Totals
Total Patients	9,160
Gender	
Male and Other/Unknown	44%
Female	56%
Total	100%
Age	
0-19	2%
20-39	15%
40-59	37%
60-79	41%
80-100	5%
Total	100%
Race	
White	67%
Black or African American	10%
Asian	7%
Other/ Unknown ⁷	16%
Total	100%
Ethnicity	
Hispanic	16%
Not Hispanic	78%
Other	6%
Total	100%
Patient Origin - Top 75% Cities/Towns	

⁷ Includes Native Hawaiian, Race Not Listed, Unavailable, and Declined.

Totals	
Boston ⁸	43%
Cambridge ⁹	9%
Revere	8%
Chelsea	5%
Somerville ¹⁰	5%
Brookline ¹¹	5%
Medford	5%
Everett	4%
Winthrop	4%
Malden	4%
Arlington ¹²	3%
Belmont	2%
Newton	2%
Watertown	1%
Total	100%
Payer Mix	
Commercial	60%
Medicare	19%
Medicare Managed	9%
Medicaid	3%
Medicaid Managed	7%
Other	2%
Total	100%

Factor 1: a) Patient Panel Need

In this section, staff assesses whether the Applicant has sufficiently addressed Patient Panel need for the Proposed Project. The Applicant attributes Patient Panel need for a freestanding ASC to the following:

- 1) The need to address a growing backlog of MGB's outpatient endoscopy cases; and
- 2) The need to alleviate capacity constraints at the MGB AMCs, including:
 - a) Historical Utilization
 - b) Anticipated Population Growth
 - c) Projected Utilization

1) The need to address a growing backlog of MGB's outpatient endoscopy cases.

⁸ Includes the following zip codes: 02108, 02109, 02110, 02111, 02113, 02114, 02115, 02118, 02199, 02210, 02215, 02130, 02131, 02124, 02127, 02136, 02125, 02119, 02121, 02126, 02122, 02134, 02135, 02129.

⁹ Includes the following zip codes: 02138, 02139, 02140, 02141, 02142.

¹⁰ Includes the following zip codes: 02144, 02143, 02145.

¹¹ Includes the following zip codes: 02445, 02446.

¹² Includes the following zip codes: 02474, 02476.

In FY2024, the MGB AMCs performed 35,195 endoscopy procedures, including 29,723 outpatient procedures. Of those outpatient procedures, 20,117 were eligible to be performed in an ASC. The Applicant notes that at the time of this Application, there is only one dedicated endoscopy ASC in Boston.

The Applicant states as of July 2025, 26,586 MGB patients were waiting for their endoscopy procedure to be scheduled at an MGB AMC. Staff inquired about historical backlog data and the Applicant explained that backlog reports can only be run to provide a snapshot of the data as it currently exists therefore a report cannot be run for the backlog that existed historically. The Applicant explained that orders are added to the endoscopy queue daily and exceed the number of procedures performed each day. As a result, MGB has continued to see the backlog grow even as endoscopy volume has increased.

As previously noted, there are capacity constraints at all MGB locations, which prevents the AMCs from shifting volume to alternate locations within the MGB system. Table 4 shows the capacity for endoscopy at Newton Wellesley Hospital, which serves ambulatory surgery patients. The data demonstrates that Newton Wellesley's capacity has been increasing over time, limiting the hospital's ability to serve the backlog of endoscopy patients at the AMCs.

Table 4: Newton Wellesley Endoscopy Operating Capacity, 2022 to 2025¹³

Fiscal Year	<i>Number of Dedicated Rooms</i>	<i>Total Volume</i>	<i>Cases Per Room</i>	<i>Case Capacity Per Room¹⁴</i>	<i>Operating Capacity</i>
2022	8	13,651	1,706	2,564	67%
2023	9	16,822	1,869	2,564	73%
2024	9	16,633	1,848	2,564	72%
2025	9	17,794	1,977	2,564	77%
2026 ¹⁵	9	20,275	2,253	2,564	93%

Table 5 details the capacity for endoscopy at MG Waltham, a Hospital Outpatient Department (HOPD) which serves ambulatory surgery patients. MG Waltham recently increased the number of Operating Rooms with the intent of shifting eligible cases from MGH Main Campus to the facility. The data demonstrates that MG Waltham's capacity did see improvement as a result of the additional operating rooms, but continues to increase.

Table 5: MG Waltham Endoscopy Operating Capacity, 2022 to 2025¹⁶

¹³ NWH opened a ninth endoscopy room in FY2023 to perform interventional endoscopy.

¹⁴ Case capacity per room represents a weighted average of interventional case lengths and all other case lengths.

¹⁵ Projected volume and capacity for FY2026 are based on i) Q1 actual volume, ii) Q1 utilization, and iii) increased physician capacity.

¹⁶ Two dedicated endoscopy rooms opened in FY2024. Prior to FY2024, endoscopy procedures at MG Waltham were performed in one OR room 2 days per week.

Fiscal Year	<i>Number of Dedicated Rooms</i>	<i>Total Volume</i>	<i>Cases per Room</i>	<i>Case Capacity Per Room¹⁷</i>	<i>Operating Capacity</i>
2022	0.4	1,274	1,274	1,134	112%
2023	0.4	1,324	1,324	1,184	112%
2024	2	4,823	2,412	3,138	77%
2025	2	5,095	2,548	3,138	81%

Table 6 illustrates the shift of cases from MGH Main Campus to MG Waltham, limited to cases that can be performed at both facilities, including endoscopy. All cases performed at MG Waltham represent a shift of cases because all surgeries completed at MG Waltham would otherwise have been performed at the Main Campus. The percentage shift was calculated by dividing the number of cases performed at MG Waltham by the total number of cases that could have been performed at both facilities (cases performed at MG Waltham plus cases performed at MGH). The percentage of cases shifted from the main campus initially increased but is reaching a plateau because there is not available capacity to take more cases. This utilization demonstrates that the MG Waltham expansion has met its objective. The Proposed Project seeks to continue this success by focusing on the backlog of endoscopy patients not easily served by MG Waltham.

Table 6: Shift of Eligible MGH Patients to MG Waltham

	FY2021 Shift	FY2022 Shift	FY2023 Shift	FY2024 Shift	FY2025 Shift
OR Cases (Inclusive of procedure types available at Waltham and Main Campus)	24.90%	34.50%	35.40%	35.10%	34.40%
Total Outpatient Endoscopy (ORs and Suites)	1.20%	5.30%	5.10%	19.00%	17.70%
Total Outpatient Procedures (outpatient endoscopy and surgery)	10.70%	18.70%	19.30%	26.50%	25.50%

The Applicant states that the Proposed Project would establish additional capacity needed to address this growing backlog of patients waiting for endoscopy services while offering those services in a less costly setting.

Additionally, the Applicant asserts that 78% of the outpatient endoscopy services provided by the MGB AMCs are comprised of colonoscopy screens. Colonoscopy is a highly effective screening tool for colorectal cancer, and is associated with as much as a 69% decrease in new cases of colorectal

¹⁷ Case capacity increased year-over-year due to decreasing case lengths: 30 minutes in FY22, 29 minutes in FY23, 26 minutes in FY24, and 25 minutes in FY25.

cancer and an 88% decrease in the risk of death from it.^c The rate of screenings among eligible patient¹⁸ dropped from 72% at the start of the COVID-19 pandemic to 67% in 2023^d due in large part to the restrictions placed on non-essential surgeries during the pandemic,^e ongoing staffing challenges,^f and IV shortages^g. As colonoscopies were cancelled, the backlog of cases at MGH and BWH continued to grow as more adults became eligible due to their age and changes to screening guidelines.¹⁹ In addition, colorectal cancer rates have increased annually among younger adults between the ages of 20-39 since the 1990s, contributing to the increased need for colonoscopy across ages.^h

By July 2025, the number of adults waiting to be scheduled for a routine endoscopy procedure at the MGH and BWH had grown to more than 25,000 patients. As the backlog has increased, wait times for procedures have generally increased across endoscopy procedures at both AMCs by an average of 20% since FY2022, as demonstrated in Tables 7 and 8 below. The Applicant notes that while wait times decreased from FY2024 to FY2025, the decrease was 6.2% at BWH and 5% at MGH, compared to an overall increase FY2022 to FY2025 of 21.3% at BWH and 18.6% at MGH. The Applicant asserts that the decreases from FY2024 to FY2025 illustrate that MGB's initiatives to shift volume from the AMCs to other facilities such as MG Waltham, is working to reduce wait times. However, there is no additional capacity available to shift more patients to community sites, as previously discussed.

Table 7: BWH Main Campus Endoscopy Wait Times (In Days)

Endoscopy Procedure	FY2022	FY2023	FY2024	FY2025	Percent Change from FY2022-FY2025
Colonoscopy	118	142.6	166.4	147	24.6%
Endoscopic Retrograde Cholangiopancreatography	26.4	28.6	36.6	34.3	29.9%
Esophagogastroduodenoscopy	70.8	80.5	94.9	84.4	19.2%
Gastroscopy Flexible	42.8	53.6	62.5	59.1	38.1%
Sigmoidoscopy Flexible	50.2	51.1	54	50.9	1.4%
Upper Endoscopic Ultrasound	61.5	65.5	68	73.7	19.8%
Other	86.2	98.8	113.8	100.3	16.4%

Table 8: MGH Main Campus Endoscopy Wait Times (Days)

Endoscopy Procedure	FY2022	FY2023	FY2024	FY2025	Percent Change from

¹⁸ Rate of screening among adults ages 50–74 years due for CRC screening who received primary care at one of 35 primary care practices affiliated with Massachusetts General Hospital or Brigham and Women's Hospital (Boston, MA), 3/1/2020 to 3/1/2022.

¹⁹ The American Cancer society recommends screenings beginning at age 45 <https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html>

					FY2022- FY2025
Colonoscopy	121.8	164.5	162.8	148.1	21.6%
Endoscopic Retrograde Cholangiopancreatography	41.9	47.2	51.5	51.5	22.9%
Esophagogastroduodenoscopy	77.2	92.7	84.1	86.6	12.2%
Gastroscopy Flexible	62.4	66.9	70.5	76.4	22.4%
Sigmoidoscopy Flexible	40.5	45	47.8	51.3	26.7%
Upper Endoscopic Ultrasound	85.3	90.1	79.8	83.8	-1.8%
Other	101.5	133.5	127.9	120.4	18.6%

As noted above, the Applicant states MGB's metro-Boston patients do not have sufficient non-hospital options for endoscopy services creating a barrier to timely access although the need for routine and diagnostic colonoscopy screens continues to increase due to rising colorectal cancer rates in younger adults.

The Applicant anticipates the Proposed Project will improve access to outpatient endoscopy services, which is expected to reduce wait times for appointments, and improve adherence for routine screenings.

2) The need to alleviate capacity constraints at the MGB AMCs.

The Applicant reports that in FY2024, MGB and BWH performed 20,117 endoscopy procedures which could have been performed in an ASC. Of those ASC-eligible procedures at the MGB AMCs, approximately half (9,449) of those procedures were for patients residing in the PSA.

a) Historical Utilization

Table 9 provides details on the utilization of endoscopy procedures at the MGB AMCs from FY2022-FY2025 in the PSA. The Applicant notes that from FY2022-FY2025, outpatient procedures cumulatively accounted for approximately 85% of all endoscopies performed at the AMCs.

Table 9: Historical Utilization of Outpatient Endoscopy Procedures at MGB AMCs for Patients Residing in PSA

	FY2022	FY2022 %	FY2023	FY2023 %	FY2024	FY2024 %	FY 2025	FY2025 %
Outpatient Endoscopy Volume Total	9,879	100%	10,237	100%	9,449	100%	10,241	100%
Facility: BWH	2,496	25%	2,007	20%	2,055	22%	1,965	19%
Facility: MGH	7,383	75%	8,230	80%	7,394	78%	8,276	81%
Category: Diagnostic	4,232	43%	4,241	41%	3,988	42%	4,598	45%
Category: Procedural/Screenin	5,077	51%	5,503	54%	4,916	52%	4,184	41%

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Category: Other ²⁰	570	6%	493	5%	545	6%	1459	14%
Type: Upper	2,832	29%	2,660	26%	2,329	25%	2,784	27%
Type: Lower + Other	7,047	71%	7,577	74%	7,120	75%	7,457	73%

The Applicant explains that outpatient volume at BWH's main campus has been limited (as seen in the volume decreases above) in order to prioritize higher acuity inpatient procedures. The Applicant states that there has recently been an increase in the number of inpatient endoscopy procedures performed at both BWH and MGH. As demonstrated in Table 10, there was a 19% increase in inpatient procedures performed at the AMCs from FY2022-FY2025 alone. As a result of the increased inpatient volume, the average utilization rate of endoscopy rooms has increased from FY2022 to FY2025.²¹

Table 10: Historical Utilization of Inpatient Endoscopy Procedures at MGB AMCs

Inpatient Endoscopy Volume Total	FY2022	FY2023	FY2024	FY2025
Facility: BWH Main Campus	2,062	2,064	2,229	2,715
Utilization: BWH Main Campus	85%	87%	87%	88%
Inpatient Wait Time (In Days) for Endoscopy: BWH Main Campus	1.44	2.00	2.04	2.79
Facility: MGH Main Campus	3,236	3,210	3,303	3,591
Utilization: MGH Main Campus	71%	80%	82%	75% ²²
Inpatient Wait Time (In Days) for Endoscopy: MGH Main Campus	1.53	1.37	1.29	1.30

Patients requiring inpatient endoscopy procedures at an MGB AMC are waiting on average 1-2 days for procedures. This can result in longer stays for the patient, with associated higher risks of negative outcomes, such as physical and function decline and hospital-acquired infections,ⁱ as well as higher costs for payers. Longer than necessary inpatient stays prevent new patients from being admitted to an inpatient bed from the emergency department or a community hospital, contributing to throughput challenges across the MGB AMCs and region. Given the large number of procedures that are eligible to be provided in an ASC setting, the Applicant asserts that the Proposed Project will reduce the unnecessary reliance on MGB and BWH to perform these outpatient procedures, thereby improving throughput in the hospitals.

b) Anticipated Population Growth

The population of each of the top towns in the PSA are expected to grow in the coming years, resulting in almost 8,000 more residents between the ages of 45 and 75 by 2040.^j The Applicant specifically notes that Cambridge, Revere, and Somerville are projected to experience significant

²⁰ Includes follow-up for positive FIT/Cologuard and surveillance for history of polyps.

²¹ MGH's current endoscopy room utilization is down 10 percentage points from FY24 (85%) due to the opening of a second inpatient room in the afternoon to accommodate the growing number of inpatient endoscopy cases.

growth by 2035, including 20% growth of Cambridge residents ages 50-59, 33% growth of Revere residents 45-54, and 23% growth of Somerville residents ages 45-54.^k With the combination of high utilization at MGB AMCs endoscopy rooms (between 75-89%, as previously stated), and significant population growth expected in the area, the Applicant asserts that in addition to current Patient Panel need to access for outpatient endoscopy services, that need will only continue to increase in the Proposed Services Area.

c) Projected Utilization

To provide the Patient Panel with improved access to outpatient endoscopy, the proposed ASC in Cambridge will have three procedure rooms and 10 pre/post-operative care bays. Each procedure room will have a maximum procedural capacity of 12 cases per day. The ASC will be open five days per week (Monday – Friday), with closures for 11 holidays, resulting in an annual maximum capacity for the ASC of 9,000 once the ASC is fully operational. The ASC’s proposed utilization is in Table 11 below.

Table 11: Proposed Utilization of the New ASC

	FY2027	FY2028	FY2029	FY2030	FY2031
Volume	4,752	7,350	7,460	7,572	7,686
Operating Capacity	53%	82%	83%	84%	85%

With historical utilization of outpatient endoscopy procedures at the AMCs (among patients in the service area) routinely over 9,000, staff requested that the Applicant provide the methodology used to determine that three operating rooms will satisfy the Patient Panel need. The Applicant explained that the Proposed Project is not anticipated to fully address the need for moving all ASC eligible patients out of the MGB academic medical centers, but the proposed ASC will provide significant new capacity at a lower cost access point for MGB patients. To address the need for endoscopy by the Patient Panel, the Applicant looked for a suitable space within the PSA that was available for sale or lease, easily renovated into an endoscopy center, offered adequate space (e.g., one-room centers were not considered), and convenient for the Patient Panel. While the Applicant would have been interested in larger spaces, current real estate in the area did not allow for a new build and afforded very limited options. Rather than waiting for the perfect space, the Applicant chose a space that would significantly improve access within the most reasonable amount of time. The location that the Applicant secured for the project was a former ASC that can be renovated to meet current standards for endoscopy and its footprint is limited to accommodating 3 procedure rooms. The Applicant stated that due to its prior use, the location will allow for a lower expenditure required to renovate compared to other locations in the identified geography, making it a cost-effective option for providing needed access to endoscopy for the Patient Panel.

Staffing

The Applicant expects to employ 14 full-time equivalent (FTE) registered nurses and 9 FTE administrative staff at the new ASC. The ASC will also utilize 3 FTE GI physicians, 1 FTE anesthesiologist, and 3 FTE Certified Registered Nurse Anesthetists. The Applicant stated that they

will implement a scalable approach to recruiting, hiring, and developing both management and clinical staff, ensuring the ASC is staffed with high-performing professionals who support quality outcomes and operational efficiency. The Applicant plans to recruit experienced ASC professionals through national talent networks and partnerships, with a focus on clinical quality, cost management, and staff retention. The ASC's staff will be sourced with a focus on licensure, certifications, and ambulatory surgery experience, though training and experience will be available for some of the positions to be hired. The Applicant will also collaborate with MGH Institute for Health Professions and other academic institutions to develop RN graduate training programs to support a stable and sustainable nursing workforce across care settings.

Analysis

Staff finds that the Applicant has demonstrated increasing need for a freestanding endoscopy center in the region through data showing an increase in the number of patients waiting for screening, and the projected increase in the need for services over the next five years. As a result, Staff finds that, with the addition of Condition 5, 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

The Applicant states that the Proposed Project will increase the availability of ASC procedure rooms for endoscopy, thereby improving timely access to essential screening, diagnostic, and treatment services. To demonstrate that the Proposed Project will contribute to improved health outcomes, the Applicant provided information on: A) the benefits of endoscopy as a screening, B) its impact on colorectal cancer rates, and C) the advantages of endoscopy in the ASC setting.

A) The Benefits of Endoscopy: To demonstrate that the Proposed Project will contribute to improved health outcomes for the Patient Panel, the Applicant detailed the use and benefits of endoscopy as a screening, diagnostic and treatment tool. Endoscopy is a minimally invasive procedure that uses a thin, flexible tube with a camera, an endoscope, to examine a patient's organs.^l Routine endoscopies are widely used to screen, diagnose, and treat conditions including cancer, gastrointestinal disorders, and inflammatory diseases.^m The Applicant cited studies showing that a patient's single endoscopy with biopsy can detect cancer in approximately 70% of cases, increasing to 98% if a patient has seven biopsies.ⁿ The ASC will perform a variety of procedures²³, with an emphasis on the following:

²³ The Proposed ASC will perform Colonoscopy - Diagnostic/Screening; Colonoscopy - Procedural; EGD - Diagnostic; EGD - Procedural; Anoscopy - Procedural; Enteroscopy - Diagnostic; Enteroscopy - Procedural; Esophagoscopy - Diagnostic; Esophagoscopy - Procedural; Other GI Procedures - Dilation - Esophagus; Other GI Procedures - GI Tube Insertion/Replacement/Service - Percutaneous; Other GI Procedures - Other Tube Placement; Proctosigmoidoscopy - Diagnostic; Proctosigmoidoscopy - Procedural; Sigmoidoscopy - Diagnostic/Screening; Sigmoidoscopy - Procedural.

- **Esophagogastroduodenoscopies (EGD):** Evaluates the esophagus, stomach, and duodenum to diagnose ulcers, gastrointestinal disorders, and tumors.^o Physicians also use EGD to treat patients by draining abscesses, inserting medical devices, and removing polyps.^p
- **Colonoscopy:** Examines the colon and rectum as a method for routine colorectal cancer screening and to investigate symptoms, including rectal bleeding or changes in bowel habits.^q

B) Endoscopy's Impact on Colorectal Cancer Rates: In Massachusetts alone, 2,770 new colorectal cancer cases and 820 related deaths are expected this year.^r In the PSA, colorectal cancer was the fourth leading type of cancer mortality with 54 deaths recorded.^s Improving access to endoscopy promotes screening, early diagnosis, and treatment of colorectal cancer. While Massachusetts currently has one of the highest colorectal cancer screening rates in the United States at 70% across all populations, it is still below the national goal of 80%,^t which, could reduce deaths from colorectal cancer by 33% by 2030.^u The Applicant notes that the five-year survival rate exceeds 90% when colorectal cancer is diagnosed at a localized stage but drops below 20% for late-stage diagnoses.^v With the increased need for adults aged 20-75 to seek endoscopic services, the Applicant asserts that increased endoscopy capacity will aid in improving screening rates, early diagnosis, and treatment outcomes.

C) The Advantages of Endoscopy in the ASC Setting

To further demonstrate the improved health outcomes and patient experience that will result from the Proposed Project, the Applicant cited studies on the benefits of performing 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.^{w,x} The benefits of performing GI-specific endoscopy procedures in the ASC setting as compared to the hospital setting include cost savings to payers and patients, operational efficiencies such as lower overhead costs, and reduced wait times that should result in less scheduling delays and cancellations.

In support of the cost saving benefits of ASCs, the Applicant cited the HPC's February 2024 *DataPoints* report found that services provided in ASCs are substantially less expensive than those in HOPDs across both public and private insurers due primarily to lower facility fees at ASCs.²⁴ The applicant points to the example that a colonoscopy with polyp removal costs 32% less in an ASC than in a HOPD for commercially insured patients.²⁵ For MassHealth, the same procedure is 61% less expensive in an ASC.²⁶ The cost saving benefits to payers and patients are covered in greater detail in Factor 1f and Factor 2.

²⁴ HPC DataPoints, Issue 26, *supra* note Error! Bookmark not defined..

²⁵ HPC DataPoints, Issue 26, *supra* note Error! Bookmark not defined..

²⁶ HPC DataPoints, Issue 26, *supra* note Error! Bookmark not defined..

The Applicant maintains that improved access to the outpatient endoscopy in a non-hospital, lower-cost setting will improve patient adherence to colorectal screening recommendations, increase colorectal cancer screening rates, and allow for earlier detection and more successful treatment.

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.

Analysis: Improved Outcomes and Quality of Life

Staff finds that the addition of the ASC has the potential to improve cancer screening rates, which can have a significant effect on early cancer detection and improve treatment outcomes for the proposed Patient Panel. The new facility may also assist with lowering costs, as supported by the HPC's 2024 report cited above. The Applicant will report annually to the Department on the measures 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

In addition to the legal and regulatory requirement to provide language access services at no cost to patients, the Applicant outlined its plan to support equitable access to the endoscopy services in the following ways:

- A) Targeted Improvements in Colorectal Cancer Screenings:** The Applicant notes there are increasing variations in colorectal cancer screening across neighborhoods, which led to MGB implementing a system-wide community health strategy to improve screening. As part of MGB's Community Health strategy, MGB launched a Colorectal Cancer Screening Campaign in June 2025 which aims to eliminate variations in colorectal cancer outcomes by increasing colorectal cancer screening for residents in specific neighborhoods, including Chelsea, Revere, Dorchester, Hyde Park, Mattapan, Jamaica Plain, and Chinatown, which are all part of the PSA. This public health education campaign includes targeted primary care and community health initiatives, as well as a multi-channel, multilingual communications campaign. The Proposed Project will provide this targeted population with a non-hospital option for screenings.
- B) Reducing Barriers to Screening:** Within primary care, MGB is standardizing colonoscopy prep instructions and translating materials into the top six patient languages spoken across MGB: Spanish, Portuguese, Haitian-Creole, Mandarin, Arabic, and Russian. Additionally, MGB identified four primary care clinics with higher variations in colorectal cancer screening to receive targeted support from three bilingual navigators. These navigators provide support to help patients overcome barriers that have historically prevented patients from completing their recommended colorectal cancer screening, including outreach to patients who are overdue, direct education with translated materials, assistance with scheduling, reminders, transportation, and preparation instructions.

Analysis: Health Equity

Staff finds that the Proposed Project will increase access and reduce barriers to lower cost endoscopy services in the PSA, which includes neighborhoods that have been identified as having variations in colorectal cancer outcomes. Staff finds that the Applicant has demonstrated reasonable efforts to provide equitable access to endoscopy services. As a result, Staff finds that, with the addition of Conditions 3 and 4, 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.

- **Electronic Medical Record (EMR):** The proposed ASC will implement an electronic medical record system and an endoscopy documentation platform to support comprehensive physician documentation and the seamless sharing of patient data. The ASC will use Epic for its EMR, a system shared across MGB facilities. These systems will enable data exchange between providers and reporting capabilities. Given that all patients at the ASC will be part of the MGB health system, integration with these platforms will support the flow of clinical documentation directly into the broader health system. This will support timely review by care teams, enhance communication among stakeholders, and provide patients with access to relevant health information.
- **Emergency Procedures:** The Applicant states they will comply with all standards of practice related to medical emergencies, including written emergency and referral protocols, as well as appropriate staff training. Additionally, the Applicant will maintain a transfer agreement with a nearby hospital in compliance with the Department's clinic licensure regulations. While emergency transport will be coordinated through 911, the proposed ASC may also establish agreements for inter-facility transport in non-emergency situations to support continuity of care.

Analysis

Staff finds that the Applicant's care coordination will continue to contribute to efficiency, continuity, and coordination of care. The Applicant demonstrated appropriate sharing of patient records as well as communication with patients and providers to track patient progress and to promote better health outcomes. The Applicant also has a plan for emergency procedures in an effort to provide patients with efficient and effective treatment should unexpected complications occur. 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^{dd} 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.

- **Virtual Public Meeting:** In July 2025, MGB's Chief Medical Officer presented the Proposed Project to the community through a virtual public meeting that was advertised on the AMCs' websites and on TV screens within the hospitals leading up to the event. The presentation addressed the importance of colorectal cancer screening and the need for additional capacity in order for MGB to provide improved access to endoscopy for its patients. Five community members attended the meeting. No comments or questions were raised.
- **MGB AMC Patient and Family Advisory Council (PFAC):** In August 2025, the Proposed Project was presented to MGB's AMC PFAC. The presentation included information about the current backlog of screenings impacting MGH and BWH patients, and the need to prioritize timely screenings based on screening guidelines. The presentation also included specifics about the proposed ASC and how it will improve access to outpatient endoscopy, and improve capacity at the MGB AMCs for emergent, inpatient, and higher acuity outpatient cases. There were several positive comments regarding the Proposed Project as a result of the presentation.
- **Legal Notices:** The Applicant states that it published two legal notices announcing the Proposed Project in the *Boston Herald* on July 16, 2025.

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 Proposed Project will compete on the basis of price, total medical expenses (TME), provider costs, and other health spending factors by expanding access to lower-cost endoscopy at the proposed ASC.

- **Cost Benefit of ASCs:** The Applicant states that the provision of endoscopy services will generate significant cost savings for both payors and patients, as ASCs offer these

procedures at significantly lower costs than hospital-based outpatient departments (HOPD). ASCs achieve cost-efficiency through operational efficiencies which include utilizing only the staff, equipment, and supplies necessary to meet patient needs. The Applicant cited a recent study analyzing 220 procedures performed in ASCs and HOPDs, which found that ASCs outperformed HOPDs in ancillary time, procedure time, exit time, turnover time, and nonoperative time.^y As a result, ASC facility fees are considerably lower than those of HOPDs, directly translating into savings for both patients and payers.^z

- Timely Detection:** The Applicant anticipates that the Proposed Project will facilitate earlier detection of colorectal cancer, ultimately reducing TME through improved patient outcomes. The stage at which colorectal cancer is detected significantly influences treatment costs, averaging \$36,000 for patients with stage 1 colorectal cancer and rising to \$74,000 for patients with stage 4 within the first year post-diagnosis.^{aa} This demonstrates that earlier detection of colorectal cancer through adherence to screening guidelines can result in thousands of dollars of treatment cost savings within the first year after a patient’s diagnosis. The Applicant notes that the long-term savings for increased screenings are substantial, ranging from 60% to 89% in Medicare treatment costs over a 50-year period.^{bb}
- Improved Patient Throughput in Hospital Settings:** The Applicant asserts that the Proposed Project will support access to services in appropriate outpatient settings, thereby improving patient throughput in hospital settings and reducing the average length of stay at the MGB AMCs for patients requiring hospital-based endoscopy services. Between 2022 and 2025, inpatient endoscopy procedures at the AMCs increased 19%, resulting in higher-than-expected utilization. The Applicant reports that this translates into increased inpatient endoscopy wait times at the MGB AMCs, extending hospital stays by at least one day. Discharge delays due to endoscopy procedures increase admission costs and also prevent the availability of inpatient beds for patients waiting in the ED or in community hospitals who require care only available at an AMC. Reducing reliance on outpatient endoscopy procedures at the AMCs is likely to improve inpatient throughput, thereby reducing medical costs.
- Cost Savings to Payers:** The Applicant states that ASCs present cost-saving opportunity for payers through lower overall prices and TME. On average, Medicare reimburses ASCs at just 58% of the rates paid to HOPDs for the same procedures.^{cc} This pricing differential results in more than \$4.2 billion in annual Medicare savings when low-acuity procedures are performed in ASCs rather than HOPDs.^{dd} ASCs are projected to generate approximately \$73.4 billion in Medicare savings between 2019 and 2028.^{ee} As of 2024, annual savings to Medicare from ACSs was \$2.3 billion.^{ff} The potential for a high rate of savings extends beyond Medicare, and can benefit Medicaid and commercial payers as well. Table 12 below presents 2025 Medicare cost comparisons for common endoscopy services performed in ASCs and HOPDs.

Table 12: 2025 Medicare Endoscopy Services Cost by Setting²⁷

²⁷ Please note, the endoscopy services costs are based on Medicare’s 2025 payments and copayments rates, as reviewed on July 1, 2025 and are available at <https://www.medicare.gov/procedure-price-lookup/>.

Procedure	ASC Cost	HOPD Cost	Cost Savings of ASC (\$)	Cost Savings of ASC (%)
Enteroscopy - Diagnostic	\$1,001	\$2,033	\$1,032	51%
Enteroscopy - Procedural	\$1,016	\$2,048	\$1,032	50%
Esophagoscopy – Procedural	\$962	\$1,994	\$1,032	52%
Anoscopy - Procedural	\$291	\$1,252	\$961	77%
Colonoscopy - Procedural	\$824	\$1,371	\$547	40%
EGD – Diagnostic	\$621	\$1,055	\$434	41%
EGD – Procedural	\$635	\$1,069	\$434	41%
Esophagoscopy – Diagnostic	\$587	\$1,021	\$434	43%
Colonoscopy - Screening	\$666	\$1,088	\$422	39%

The data highlight the substantial cost advantages associated with shifting eligible procedures to ASCs. The total procedure price for endoscopy services performed in ASCs ranges from \$291 to \$1,016, significantly lower than the \$1,021 to \$2,049 range in HOPDs.

By increasing the number of ASCs in Massachusetts, the Commonwealth can expand access to high-value healthcare services which will contribute to earlier detection of colorectal cancer and reduce TME. Shifting low-acuity endoscopy procedures to the proposed ASC will reduce capacity constraints at the AMCs, further contributing to cost savings by reducing the length of stay for inpatients with endoscopy needs.

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. With the addition of Condition 5 to track the shift of procedures to the lower cost ASC, 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 the Applicant has 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 Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment by expanding access to endoscopy in a lower cost setting than existing options for the Patient Panel. As previously noted in sections 1b and 1e, ASCs maximize operational efficiencies, which translate into lower healthcare costs.

Table 13 below demonstrates the cost disparity of out-of-pocket costs for Medicare patients based

on the setting in which services are received. The Applicant asserts that expanding access to lower-cost endoscopy services at an ASC will help reduce the financial burden on patients. By receiving endoscopy services in ASCs rather than HOPDs, patients can significantly lower their out-of-pocket expenses and may be more likely to comply with recommendations for endoscopy.

Table 13: 2025 Medicare Procedural Out-of-Pocket Costs for Patients²⁸

Procedure	ASC Out-of-Pocket Costs	HOPD Out-of-Pocket Costs	ASC Patient Out-of-Pocket Savings
Colonoscopy	\$164	\$273	\$109
EGD	\$126	\$213	\$87
Enteroscopy	\$202	\$409	\$207
Esophagoscopy	\$191	\$398	\$208

The Applicant notes that, at the time of this Application, only 18 of the Commonwealth’s ASCs are offering endoscopy services (12 single-specialty and 6 multi-specialty),^{gg} with only one in the Boston metro area. The Applicant asserts that due to the low availability of ASC’s, patients must rely on HOPD services to receive low-acuity procedures. To address this problem, the Proposed Project seeks to create an additional ASC, thereby improving the ratio of ASCs per capita in the Commonwealth.

Increasing the availability of colonoscopies through additional procedural capacity also impacts TME through the overall reduction of colorectal cancers that require treatment. In 2020, the cost of colorectal cancer care was \$24.3 billion and accounted for 11.6% of all cancer treatment costs.^{hh} The average per-patient costs for medical services during the first year after diagnosis is \$66,500.ⁱⁱ Increasing screening prevalence to 70% among adults age 50 to 64 could reduce Medicare spending by \$14 billion (in 2010 dollars) by 2050.^{jj} Increasing the availability of colonoscopy has a direct impact on patient outcomes and health care spending.

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 endoscopy services in a lower cost setting. Therefore, DoN Staff conclude that the Proposed Project will likely meet the cost containment component of Factor 2.

Improved Public Health Outcomes

As detailed in Factor 1b, improved access to endoscopy services through the Proposed Project has the potential to improve health outcomes. The Applicant states that improved access to endoscopy services is expected to improve patient adherence to screening recommendations. Higher screening rates will improve detection of cancer earlier, when treatment is more effective and less costly. The Applicant states further that patient experience will be improved with scheduling that will reduce

²⁸ Please note, the out-of-pocket costs for patients is based on Medicare’s 2025 payments and copayments rates, as reviewed on July 10, 2025 and are available at <https://www.medicare.gov/procedure-price-lookup/>.

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 endoscopy, reducing scheduling delays, as well as 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 anticipated Patient Panel is based on existing MGB patients, and the Applicant states that the majority of patients will be referred to the proposed ASC from an MGB provider, where most patients will be screened for social determinants of health (SDoH) needs. The Applicant adds that it is MGB's policy to screen all Medicaid ACO patients annually, while many MGB primary care practices are screening all patients regardless of payer. In addition, every inpatient admission and emergency department encounter initiates a screening. While the new facility will not be involved in SDoH screenings, the ASC pre-screening and discharge process will provide connection to community resources such as home helpers, support groups, social workers and transportation resources. To accomplish this, the ASC will incorporate structured clinical and situational assessments during the Pre-Admission Testing (PAT) process to identify barriers that may impact perioperative safety and post-operative recovery. This includes evaluating transportation reliability, caregiver availability, communication or health literacy needs, functional status, and the patient's ability to comply with discharge instructions, several of which align with common SDoH domains. When these assessments identify a risk that could compromise a safe surgical experience, ASC staff follow a defined, nurse-led process to connect patients with appropriate community resources.

Analysis: Delivery System Transformation

The Applicant demonstrated that MGB has a system in place for screening patients for SDoH needs. The Applicant also plans to provide community resource connections to patients in need of post-procedure. Therefore, DoN Staff can conclude that the Proposed Project meets 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 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 a finding must be supported by an analysis conducted by an independent CPA. The Applicant submitted a report conducted 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 including: Mass General Brigham Ambulatory Surgery - Cambridge, LLC 5-Year Projected Financial Statements and Assumptions covering FY2027-FY2031, documentation supporting calculations included in the projected financial statements, Medicare rates and base rate calculations, operating agreements for both Mass General Brigham Ambulatory Surgery - Cambridge, LLC as well as New England Surgery Center Holdings, LLC, and building lease terms. The CPA assessed the reasonableness²⁹ of assumptions used in the preparation and feasibility³⁰ of the projections with regards to the Proposed Project.

Revenues: The CPA Report analyzed the revenue projections for the Proposed Project, which exhibit a net pre-tax profit margin ranging from 8.2% to 13.7% for the fiscal years 2028 through 2031. The payer mix was based on the historical data at MGH and BWH. Reimbursement rates were based upon current Medicare ASC rates, Medicaid rates and expected Commercial Insurance contracted rates based on discussions with Commercial Insurance providers. Starting with a partial year of the historical number of cases in fiscal year 2027, full ramp up was achieved in fiscal year 2028, with a modest annual increase in cases of 1.5% for fiscal years 2029 through 2031. The CPA found that the projection data compared to other data available for gastroenterology centers was reasonable, and that the number of projected cases were within the ranges of currently operating gastroenterology centers as determined by the survey of the other data. Based on this analysis, the CPA concluded that the revenue projected by Management reflects a reasonable estimation of future revenues for the Applicant.

Expenses: The CPA analyzed Salary and Benefits, as well as Medical and Surgical Supplies for reasonableness and feasibility as related to the Projections of the ASC. Salaries and benefits are projected to increase by about 2.7% per year. Clinical expenses are projected to increase by 3% per year on a per case basis. Most other expenses are also projected to increase by 3% per year on a per case basis. The only exception is the management fee which is calculated as a percent of NPSR (net patient service revenue). This percentage remains constant at 5% and is deemed reasonable. Based on this analysis, the CPA concluded that the operating expenses projected by Management are reasonable in nature.

Lease agreement, Capital Expenses, and Cash Flows

The CPA Report reviewed lease terms, projected capital expenditures and future cash flows of the Applicant in order to determine whether sufficient funds would be available to support the building lease of the Applicant, construction and equipment costs, including payment of the related debt service and whether the cash flow would be able to support the continued operations. It is noted

²⁹ Reasonableness is defined within the context of this report as supportable and proper, given the underlying information.

³⁰ Feasibility is defined as 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 existing Patient Panel.

that the Applicant will lease 6,095 square feet of space and rent will be \$42.50 per square foot. The building lease is expected to include a 3% increase every year. The projections also include capital costs for construction (build-out) and equipment at the 799 Concord Ave, Cambridge, MA location. Leasehold improvements are being depreciated on a straight-line basis over a 10-year useful life and equipment is being depreciated on a straight-line basis over a 5-year useful life. The Applicant expects to finance \$4,000,000 of the capital costs, payable in equal monthly installments over eighty-four (84) months at an interest rate of 7% per annum, which the CPA stated is reasonable for a commercial loan for quality borrowers in the current interest rate environment. The CPA concluded that the pro-forma capital expenditures, facility lease and the resulting impact on the cash flows of the Applicant are reasonable.

CPA's Conclusion of Feasibility

As a result of its analysis the CPA states that:

"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 Mass General Brigham Ambulatory Surgery - Cambridge, 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.

As previously noted, the Applicant reports that they are experiencing a system-wide backlog of endoscopy cases because there is more demand for endoscopy than OR capacity. As detailed in factor 1a, MG Waltham and Newton Wellesley Hospital (the only MGB community hospital easily accessible to the Applicant's Patient Panel), cannot accept enough volume to meaningfully address the need for endoscopy by the MGB AMC's patients. With this limitation in mind, the Applicant considered and rejected two alternatives to the Proposed Project.

Alternative #1: Use the existing procedure rooms in the HOPDs at BWH and MGH to continue to provide endoscopy procedures.

- **Quality:** Compared to HOPDs, ASCs have higher patient satisfaction rates and lower incidences of post-procedure hospitalization. This alternative would not increase capacity

and expand access for the people in the PSA.

- **Efficiency:** This alternative continues to rely on the AMC procedure rooms which further strains an already inefficient system, leading to longer wait times for endoscopy access. Extended wait times increase the risk that patients will forego their appointments altogether, perceiving the service as non-essential. Inefficient throughput in the AMC setting contributes to longer inpatient lengths of stay as patients awaiting procedures occupy beds that could otherwise be used for admissions from the ED or for patients who need a higher level of care than available in the community. This bottleneck affects the entire hospital system, delaying care for all patients waiting for a bed.
- **Capital Expense:** There are no capital expenses under this alternative.
- **Operating Costs:** Operating costs will remain the same under this alternative. However, the HOPDs at BWH and MGH have higher operating expenses than the Proposed Project due to the overhead costs required of a hospital, including clinical and administrative workforces, capital investments, utility expenses, and equipment costs.

Alternative #2: Construct and license additional endoscopy procedures rooms at BWH and MGH.

- **Quality:** This alternative would not increase capacity and expand access for the patients previously identified as part of proposed Patient Panel area. While this alternative would increase capacity, it would not support access to endoscopy services within the Proposed Project's geographic area. The proposed Patient Panel supported by the Proposed Project would still need to access services at one of the MGB AMCs
- **Efficiency:** The construction projects necessary to complete this alternative option will impact patient care, potentially increasing wait times above what they are now. This alternative does not have the operational efficiencies and financial benefits that the Proposed Project offers patients and payers.
- **Capital Expense:** The capital expenses under this alternative would be significant as there is not currently available space at the AMCs to add more procedure rooms.
- **Operating costs:** Operating costs will remain the same under this alternative. However, as previously noted, the endoscopy rooms at the MGB AMCs require higher operating costs compared to the Proposed Project due to the associated overhead expenses of a hospital, including clinical and administrative workforces, capital investments, utility expenses, and equipment costs.

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

Summary and context for this application: This is a DoN project that will result in a Tier 1 CHI. DPH

approved the Applicant's request to invest the local CHI dollars associated with this application in the city of Cambridge. Justification for this request included the needs highlighted in Cambridge's 2025 Community Health Needs Assessment (CHNA), the location of the proposed ASC, the low CHI dollars available to Cambridge in recent years in comparison to Boston and a desire to distribute the funds in one geographic community to maximize impact.

To fulfill Factor 6 requirements, the Applicant submitted the CHNA, a Self-Assessment, and a CHI Narrative. Partner Assessments will be submitted once the Cambridge-specific Advisory Committee established. The CHNA highlights social determinants of health (SDoH) needs for specific communities residing in Cambridge. The Applicant and the Advisory Body should focus CHI planning and implementation efforts in these key areas to ensure selection of funding priorities and strategies meet the CHI Guidelines.

DPH staff have determined that if the Applicant agrees to address community conditions and root causes while engaging in ongoing work with their Advisory Committee, the CHI investment will align appropriately with the CHI Guidelines.

The City of Cambridge 2025 CHNA was conducted by the Cambridge Public Health Department. The CHNA analyzed primary (key informant interviews) and secondary quantitative and qualitative data capturing community demographics, health status/behaviors, community assets, resources and barriers to care, and SDoH. With a focus on community engagement and health equity, the CHNA highlighted the experiences of residents who identify as: immigrants, refugees, and people of color, older adults and folks with disabilities, low-income families/individuals, persons who are unhoused and survivors of abuse, neglect, and exploitation, and youth, young adults and the LGBTQIA+ community. Key SDoH health needs identified in the CHNA that align with CHI guidelines include:

- *Neighborhood and Built Environment*—housing cost, quality and continuity
- *Food access*
- *Transportation*
- *Environmental Justice*—exposure to environmental hazards known to cause or exacerbate cancer risk/respiratory ailments
- *Education*—access and quality for recent immigrants and families with children who are unhoused
- *Economic Stability*—specifically among residents who identify as Black/African American and more than one race

Using the 2025 Cambridge CHNA findings, the Applicant will work with the community partners who make up their Cambridge-specific Advisory Committee to select CHI health priorities and strategies that allow for implementation and intervention at the SDoH and root cause level.

The Self-Assessment provided a summary of community engagement processes and socio-demographic information, data and highlights related to topics and themes of community needs related to the Cambridge CHNA. Through primary data collection such as key informant interviews and secondary data analysis, the Cambridge Public Health Department and participating community

partners identified the key needs outlined in the CHNA.

Partner Assessments (formally known as Stakeholder Assessments) will be submitted to DPH within 3 months following the Cambridge-specific advisory committee's first meeting in relation to this CHI project. Assessments will be reviewed upon receipt and are expected to justify strong levels of community engagement. Individuals who make up the Applicant's Advisory Committee will provide information on their individual engagement levels (e.g., their personal participation and role) and their analysis of how MGB engaged the community in CHI project planning and implementation.

The CHI Narrative provided background information for the CHI processes related to project oversight, fund distribution and breakdown, and a timeline for partner assessment submissions. Upon DoN approval, the Applicant must update the CHI team on project timeline, planned use of administrative funds and evaluation activities to ensure alignment with CHI planning guidelines. A reminder that administrative funds must support community participation activities in the CHI planning and implementation process by reducing barriers to engagement. Examples of appropriate uses of administrative dollars include stipends for advisory committee members, translation and/or facilitation services, childcare, etc.

Analysis

As a result of the information provided by the Applicant and additional analysis, staff finds that with the conditions outlined below, and ongoing communication on items 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 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. **Factor 6: CHI Contribution**
 - a. Of the total required CHI contribution of \$367,472.50
 - i. \$35,277.36 will be directed to the CHI Statewide Initiative.
 - ii. \$317,495.24 will be dedicated to local approaches to the DoN Health Priorities.
 - iii. \$14,698.90 will be designated as the administrative fee.
 - b. To comply with the Holder's obligation to contribute to the CHI Statewide Initiative, the Holder must submit a check for \$35,277.36 to Health Resources in Action (the fiscal agent for the CHI Statewide Initiative) **within 30 days** from the date of the Notice of Approval.
 - i. 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: # MGB-C-25070908-AS

Please send a PDF image of the check or **confirmation of payment** to DONCHI@Mass.gov and dongrants@hria.org. If you should have any questions or concerns regarding the payment, please contact the CHI team at DONCHI@Mass.gov.

2. **Factor 1(b):** In addition to MGB Cambridge ASC's obligation to participate in MassHealth, pursuant to 105 CMR 100.310(11), the Holder must certify annually that all physicians and health professionals who practice at the facility are enrolled as participating providers of MassHealth to support equitable access to all clinicians at the facility regardless of payer.
3. **Factor 1(b):** The Department requires the new facility to maintain or increase the percentage of MassHealth patients within its Payer Mix as compared with the Applicant's AMCs. If, during the pendency of the DoN, the Department determines that the MassHealth payer mix of the Holder is not meeting this standard or showing a material decrease over the course of the reporting period, the Holder shall submit a plan to the Department detailing its plan to increase its MassHealth payer mix. The plan shall be submitted no later than six months after such time as the Department notifies the Holder that such a plan is required. The Holder shall provide, with its annual report to the Department, a report on implementation of said plan to demonstrate measurable progress resulting from its efforts to increase its MassHealth payer mix.
4. **Factor 1(f) and Factor 2:** The Holder will report on Endoscopy Volume by procedure for MGB Cambridge ASC, MGH Main Campus, and BWH. Annual reporting should demonstrate a shift of ASC eligible procedures from the AMC's to MGB Cambridge ASC. The DoN program shall review the data received in accordance with Condition 5 to determine whether one or more of the following Referral Indicators is present:
 - a. A material increase in total volume of the outpatient endoscopy at MGH Main Campus and BWH; and/or
 - b. A material decrease in total volume of endoscopy at MGB Cambridge ASC.

If the DoN Program finds any one or more of the Referral Indicators, the matter shall be referred to the Public Health Council (PHC) for review to determine whether the Holder is in violation of one or more of the conditions and thus out of compliance with the terms of this Notice of DoN.

Upon referral to the PHC based upon any one or more of the Referral Indicators, the Holder shall have an opportunity to show cause why the PHC shall not find one or more of the Referral Indicators.

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. Wait Time for procedure:

Wait Time from Scheduling to Procedure: The Center will monitor and report the average time patients wait from the date the procedure is scheduled to the date the procedure is performed.

Measure: Average number of days between the date a procedure is scheduled and the date the procedure is performed.

Numerator: Total number of days waited by all patients from scheduling to procedure date.

Denominator: Total number of scheduled procedures.

2. Colonoscopy Screening 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. Staff notes that the recommended endoscopy withdrawal time is at least 6 minutes, with a target of 9 to 10 minutes.^{kk}

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.

3. 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.^{ll}

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.

4. Patient Satisfaction: 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.

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