

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

Applicant Name	Southcoast Health System, Inc.
Applicant Address	101 Page Street New Bedford, MA 02740
Filing Date	May 28, 2024
Type of DoN Application	Transfer Of Ownership
Total Value	\$5,300,000.00
Project Number	#SHS-24050109-TO
Ten Taxpayer Groups (TTG)	NONE
Community Health Initiative (CHI)	Exempt from Factor 6
Staff Recommendation	Approval with Conditions
Public Health Council	September 11, 2024

**Project Summary and Regulatory Review**

Southcoast Health System, Inc. (“Applicant”, “Southcoast”, “SHS”), filed an application for a Notice of Determination of Need with respect to a Transfer of Ownership of Same Day Surgicare of New England, Inc. (“SDS”) a licensed Ambulatory Surgery Center (“ASC”) located at 272 Stanley Street, Fall River, Massachusetts 027720-6009. The Applicant’s subsidiary, Southcoast Health Surgical Holdings, LLC, intends to acquire a majority interest in the ownership of SDS by becoming the sole stockholder of SDS. (“Proposed Project”).

This Determination of Need (DoN) Application falls within the definition of Transfer of Ownership, which is reviewed 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 DoN Factor set forth within 105 CMR 100.210. A DoN Application for a Transfer of Ownership is subject to factors 1, 2, 3, and 4 of the DoN regulation. This staff report addresses each of the four factors set forth in the regulation.

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## Background and Application Overview

### Southcoast Health System, Inc. (“SHS”)

The Applicant, SHS is a not-for-profit, multi-institutional, integrated health care system that serves Southeastern Massachusetts and Rhode Island. It operates three community hospitals under the one license, Southcoast Hospitals Group Inc. with a total of 787 licensed beds:

- Charlton Memorial Hospital, Fall River (“Charlton”) with 328 licensed beds
- Saint Luke’s Hospital, New Bedford (“St. Lukes”) with 391 licensed beds
- Tobey Hospital, Wareham (“Tobey”) with 68 licensed beds

SHS has the region’s only Level II trauma center at St. Luke’s Hospital, that is a referral center for Southeastern Massachusetts. All three hospitals have primary stroke services and emergency and acute care. Charlton and Saint Lukes provide coronary care, pediatrics, and Level IIA obstetrics. SHS also includes Southcoast Physicians Group, Inc., which has a network of more than 40 medical practices, Southcoast Health Surgery Center (Dartmouth), and Southcoast Visiting Nurse Association, Inc., accountable care organizations participating in the Medicare Shared Savings Program and MassHealth Medicaid ACO program.

### Same Day Surgicare of New England, Inc. (“SDS”)

SDS opened in 1984, and is the first freestanding, licensed multi-specialty ambulatory surgery center (“ASC”) in MA. It operates 4 operating rooms (“OR”) and 4 procedure rooms. It is a Medicare certified ASC that offers a range of specialties including eye surgery, gastroscopy and colonoscopy, general surgery, gynecology, orthopedics, pain management, urology, plastic surgery, and podiatry services. Prior to 2022 SDS was wholly owned by physician partners. Since 2022, SDS became a joint venture where 51% is owned by 11 individual physician stockholders and 49% is owned by Southcoast Health Surgical Holdings, LLC (“SHSH”), a corporate subsidiary of the Applicant.<sup>1</sup> This DoN Application, the second stage of the acquisition, comprises the Proposed Project.

### The Proposed Project

The Applicant found the individual physician stockholders of SDS wished to wind down their practice and retire and determined that maintaining and expanding access to freestanding ambulatory surgical services in a lower cost ASC setting in the Fall River area was needed. The applicant reports that *“SDS views SHS as a critical community partner for its physician network.”*

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<sup>1</sup> The first stage was not for a controlling interest, it was for a minority share, (49%), and therefore it was not subject to DoN review. Following that transaction, 3 SHS representatives became board members.

As described further in this staff report, the Applicant notes that with the gradual retirements of the physician shareholders, the clinical and operational infrastructures have not undergone necessary updates due to financial constraints of SDS.

With the Proposed Project, SHSH proposes to acquire the remaining 51% ownership of SDS, following all regulatory approvals, constituting a transfer of ownership. As a result of this transaction, SDS will keep being licensed as an ASC clinic with SHSH having 100% ownership.<sup>2</sup> There is no change or expansion of services associated with this application.

### Patient Panel<sup>3</sup>

The tables below include demographic information from the Applicant. SDS does not have an electronic health record (“EHR”) system and therefore does not maintain a comprehensive demographic data set. With Project approval the Applicant reports it will extend its EHR to SDS and this information will be collected. Table one shows that the overall numbers of unique patients has grown since 2021.

**Table 1: Overview of Patient Panels- FY21-FY24**

	<b>FY 21</b>	<b>FY 22</b>	<b>FY 23</b>	<b>FY 21-23 % change</b>
Southcoast	281,623	321,998	342,546	22%
SDS	5,673	5,804	6,115	8%

**Table 2: Demographic Profile of SHS and SDS Patients- FY 22-23**

<b>Facility</b>	<b>Southcoast</b>		<b>SDS</b>	
	<b>FY 22</b>	<b>FY 23</b>	<b>FY 22</b>	<b>FY 23</b>
<b>Gender</b>				
Female	56%	56%	61%	62%
Male	44%	44%	39%	38%
Unknown	0%	0%	-	-
<b>Age</b>				
0-17	12%	13%	2%	1%
18-64	62%	62%	69%	73%
65+	26%	25%	29%	26%

<sup>2</sup> The terms of the Stock Purchase Agreement (“Definitive Agreement”) provide for the ASC’s current leadership to continue for a period of time in order to maintain continuity of care for the community.

<sup>3</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.

Unknown	0%	0%		
<b>Race/Ethnicity*</b>			not collected	not collected
White or Caucasian	79%	77%		
Black or African American	5%	5%		
My race is not listed	5%	5%		
Hispanic	5%	4%		
N/A	4%	5%		
I don't know	3%	4%		
I choose not to answer	2%	2%		
Asian	1%	1%		
American Indian	<1%	<1%		
Native Hawaiian	<1%	<1%		
<b>Patient Origin</b>			not collected	not collected
New Bedford, MA	20%	20%		
Fall River, MA	17%	17%		
North Dartmouth, MA	4%	4%		
Somerset, MA	4%	3%		
Fairhaven, MA	3%	3%		
Westport, MA	3%	3%		
Swansea, MA	3%	3%		
Tiverton, RI	2%	2%		
Wareham, MA	2%	2%		
South Dartmouth, MA	2%	2%		
Portsmouth, RI	2%	2%		
Acushnet, MA	2%	2%		
Middleboro, MA	2%	2%		
Middletown, RI	2%	2%		
Lakeville, MA	1%	1%		

**Gender:** The SHS patient mix during FY23 was 56% female and 44% male each year. While 62% of the patients served by SDS are female and approximately 38% are male.

**Age:** At SHS ~62% of the patients were ages 18-64; 25% were 65 and older, and 13% were ages 0-17. At SDS, 73% are age 18-64, 26% are age 65 and older, and ~1% are aged 0-17.

**Race:** At SHS the self-reported racial mix is ~77% white, 5% Black or African American, 1% Asian, 4% Hispanic, and <1% American Indian or Alaska Native. These are self-reported figures and

there is a significant percentage (~16%) of the population that either chose not to report or “didn’t know”.

**Patient Origin:** SHS serves patients residing in southeastern MA. The largest percentages of patients live in New Bedford (20%) and Fall River (17%); the next highest concentration of patients reside in North Dartmouth (4%). SDS does not track patient origin.

**Table 3: FY ’23 Payer Mix for Outpatient Surgical Services**

	SHS	SDS
<b>Commercial Total</b>	<b>29.1%</b>	<b>66.6%</b>
Commercial PPO/Indemnity	16.3%	54.6%
Commercial HMO/POS	12.8%	12.1%
<b>Medicaid Total</b>	<b>20.5%</b>	<b>2.9%</b>
MassHealth FFS	3.1%	2.9%
Managed Medicaid	17.3%	0%
<b>Medicare Total</b>	<b>47.1%</b>	<b>24.6%</b>
Medicare FFS	30.7%	18.1%
Managed Medicare	16.4%	6.5%
<b>Subtotal Non-Commercial</b>	<b>67.6%</b>	<b>27.5%</b>
<b>All other</b>	<b>3.4%</b>	<b>5.9%</b>
<b>TOTAL</b>	<b>100.0%</b>	<b>100.0%</b>

**Payor Mix:** Table 3 shows that SHS has a 67.6% public payer mix while SDS’s is 27.5%. As described in this staff report, SHS will be using SDS as a site for its ACO patients and this mix is expected to change.

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

The Applicant attributes need for the Proposed Project to multiple factors including the following:

1. Need to maintain and improve access to ASC services for SDS’s patients in light of the retirement of the SDS physician shareholders and other medical staff
2. Need for financial resources to replace clinical staff, and upgrade equipment
3. Need access to lower cost ASC services for SHS’s patients whose procedures are currently performed in a hospital and are experiencing long wait times and need access to address projected regional demand among all specialties going forward
4. Need To Improve Access to and Management of Patients enrolled in ACO and Public Plans
5. Need to address the increasing demands for ASC services by the aging population.

#### **1. Need To Maintain And Improve Access To ASC Services For SDS’s Patients In Light Of The Retirement Of The SDS Physician Shareholders And Other Medical Staff**

Since 2019, SDS has been affected by the national shortage of anesthesiology providers, reducing the volume of surgical procedures SDS can provide. SDS's anesthesiologists declined from four to one and two part-time CRNAs. If the Project is approved, the parties anticipate that together they will recruit a full complement of anesthesia providers at SDS enabling increased access to surgical procedures. Tables 4 and 5 show the impact of COVID 19 and physician departures on both the Applicant and SDS.

**Table 4: Six years of Inpatient and Outpatient Surgical Procedure Volumes at SHS, Charlton, and SDS**

Site	Surgical location	FY18	FY19	FY20	FY21	FY22	FY23	% Change FY 2018-23
SHS	Inpatient	11,361	11,722	10,381	10,744	10,239	10,476	-7.8%
Charlton	Inpatient	5,772	6,272	5,461	5,640	5,398	5,579	-3.3%
SHS	Outpatient	30,775	30,249	24,301	27,902	28,655	30,468	-1.0%
Charlton	Outpatient	11,447	10,251	8,109	9,104	8,986	9,505	-17.0%
SDS	ASC	9,576	7,781	4,155	5,673	5,820	6,138	-35.9%

Also, from 2019 through 2021, SDS experienced the post-COVID departures of surgeons, proceduralists and support staff. Certain departures were related to retirements and others were related to changes in practice or location. Seven SDS shareholders retired in the last four years. The retired physicians include 1 ENT surgeon, 2 plastic surgeons, 2 general surgeons, and 2 orthopedic surgeons. SDS states that two more retirements are expected late summer or early fall of 2024. Further, 4 gastroenterology ("GI") physicians built out their office-based surgery capacity and discontinued performing surgeries at SDS, which was a loss of ~3,000 procedures.

As a result of these losses, and recognizing the need for its patients, SDS determined it needed the resources and expertise of a larger entity to continue operations; and because of their proximity and existing relationships, the acquisition by SHS was approved by the SDS board.

Working together the parties initially plan to increase Gynecology ("GYN"), Pain Management and Orthopedics procedures and to transfer appropriate GI patients to SDS in order to reduce wait times and provide access to care in a lower cost setting. Due to antitrust concerns, prior to closing the acquisition, planning for the complement of specialties being offered has not been finalized. Staff notes that the Holder will report utilization by specialty to the Department as part of post-DoN reporting. Staff further notes that the list of procedures approved for payment by the Center for Medicare and Medicaid ("CMS") changes annually and thus could result in changes in procedures being offered at ASCs including this one.

**Table 5: SDS's Historical Procedure Volume By Specialty**

<b>Surgical Specialty</b>	<b>FY18</b>	<b>FY19</b>	<b>FY20</b>	<b>FY21</b>	<b>FY22</b>	<b>FY23</b>	<b>FY24TD</b>	<b>% Change FY 18-23</b>
<b>Gastroenterology</b>	7,456	5,775	2,550	3,417	3,862	4,478	1,079	-39.9%
<b>Ophthalmology</b>	83	91	396	770	658	523	43	530.1%
<b>Plastic/Reconst.</b>	704	717	524	682	598	441	71	-37.4%
<b>Gynecology</b>	373	410	298	405	436	518	110	38.9%
<b>Pain Mgmt.</b>	440	384	282	250	159	134	17	-69.5%
<b>ENT</b>	156	235	89	91	60	0	0	-100.0%
<b>All Other</b>	364	169	16	58	47	44	6	-87.9%
<b>Total</b>	9,576	7,781	4,155	5,673	5,820	6,138	1,326	-35.9%

## **2. Need for Financial Resources to Replace Clinical Staff and Upgrade Equipment**

The Applicant reports that independently, SDS cannot afford to recruit a full complement of anesthesia, surgical and clinical providers. The Applicant anticipates that with project approval and as the integration plans develop more fully, that certain specialty surgeons will operate at SDS and at SHS facilities. SHS notes that it has hired additional providers to grow specialty areas like general surgery, orthopedics, and gastroenterology and has worked to attract and retain clinicians to support surgical/procedural service lines by increasing compensation, remaining current with market trends, and by creating more flexible options for providers. It anticipates that these models will be applicable to SDS following project implementation.

Additionally, as a result of the loss of general surgery and orthopedic cases, the surgical equipment and instruments at SDS have not been upgraded and SDS does not independently have the resources to invest in upgrades for both general surgery and orthopedics. The parties expect that the Project will allow them to make necessary investments in surgical equipment and instruments to appropriately meet the needs of patients and meet the demand for ASC surgical cases for its patient panels.

Finally, as more fully discussed under Factor 1(c) with project approval, there will be full integration of all services and patient records through expansion of SHS's electronic medical records system ("EMR") to SDS.

## **3. Need Access to Lower Cost ASC Services for SHS's Patients Whose Procedures are Currently Performed in a Hospital and are Experiencing Long Wait Times and Need Access to Address Projected Regional Demand Among All Specialties Going Forward**

The SHS 2022 CHNA revealed that 55% of respondents cited long wait times for appointments as their top concern. The current scheduled wait time for elective outpatient surgery at SHS is



approximately 1-3 months, depending on the specialty. With project approval, the Applicant anticipates that the wait time will be improved as SDS will provide additional timely access to ASC services. (SDS does not currently maintain a wait list and there is no national standard for wait times.)

In planning the Proposed Project, the Applicant reports it reviewed three years of its hospitals' historical outpatient procedure volumes to identify the lower-acuity and less-invasive procedures that SDS performs; as a result of that analysis, it estimates that more than 33,000 patients (9,000 in FY21, in 11,400 FY22, and 12,600 in FY23) may have been eligible to have their surgical procedure at an outpatient facility, such as SDS.

The Applicant used the Advisory Board projections for the SHS-SDS PSA which take into consideration demographic factors such as age, population growth and population movement; it also considers market drivers such as service line, and sub-service line, and factors that impact transitions to the ASC setting (such as reimbursement). Table 6 shows that 5 and 10-year projected growth within the PSA and therefore SHS seeks to provide patients with convenient, timely, access to surgical services outside of the main hospital campuses, in a lower cost ASC setting, through the Proposed Project.

**Table 6: Projected Growth in Ambulatory Surgery in the PSA of SHC and SDS Over 2022**

<b>Service Line</b>	<b>2022 Volume</b>	<b>2027 Volume</b>	<b>2032 Volume</b>	<b>5 Yr. Growth</b>	<b>10 Yr. Growth</b>
Spine	443	656	866	48.0%	95.4%
Pain Management	2,812	3,529	4,099	25.5%	45.7%
Orthopedics	12,632	14,587	16,286	15.5%	28.9%
Vascular	3,201	3,704	4,112	15.7%	28.5%
Ophthalmology	8,286	9,511	10,581	14.8%	27.7%
General Surgery	1,484	1,684	1,868	13.5%	25.9%
Gastroenterology	4,437	4,960	5,326	11.8%	20.0%
Podiatry	1,513	1,658	1,790	9.6%	18.3%
Neurosurgery	362	386	417	6.5%	15.2%
Trauma	895	944	998	5.5%	11.4%
ENT	10,379	10,810	11,246	4.1%	8.4%
Dermatology	5,515	5,743	5,934	4.1%	7.6%
Urology	6,328	6,596	6,752	4.2%	6.7%
Cosmetic Procedures	4,173	4,322	4,344	3.6%	4.1%
Gynecology	2,567	2,583	2,644	0.6%	3.0%
Thoracic Surgery	103	106	105	3.3%	2.0%

#### **4. Need to Improve Access to and Management of Patients enrolled in ACO and Public Plans**

Through its direct subsidiaries Southcoast Health Network, LLC (“SHN”) and Southcoast Accountable Care Organization, LLC (“SACO”), the Applicant, is a Health Policy Commission (“HPC”) certified ACO and provides population health support and resources to its members, including, participation by SHN in the MassHealth Medicaid ACO program, WellSense Health Plan f/k/a BMC HealthNet, and participation by SACO in the Medicare Shared Savings Program.<sup>i</sup> SHN’s integrated care navigation program supports the ACOs’ most complex, highest need populations via a portfolio of services, including complex medical, behavioral, social and pregnancy care management, bridge counseling, and pharmacy navigation.

SHS’s payer mix shows that it has a higher rate of patients covered under public plans than SDS (respectively 67.6% and 27.5%; see Table3). SHS’s acquisition of SDS brings the ASC within Southcoast Health thereby allowing SDS to serve as an integrated site of care for SHS’ ACO patients who need ASC services and provides patients with improved coordination of care and medical management of needed services in a lower cost setting.

#### **5. Need To Address the Increasing Demands for ASC Services by the Aging Population**

From 2015 to 2035, the state’s 65+ population is projected to increase at a higher rate compared to all other age groups (from 15.8% in 2015 to 23% in 2035).<sup>ii</sup> UMDI estimates indicate that as of July 2022, 51.5% of the Bristol County population was 40 years or older, and 18% was 65 years or older (up from 17.5% in July 2021 and 17.2% in July 2020).<sup>iii</sup>

The 65+ age cohort has experienced the greatest increase in the number of surgeries since 1990<sup>iv</sup> which is likely related to improved life expectancy rates, higher patient expectations and improved outcomes after surgery; the need to treat age-related comorbidities; and changes in anesthetic and surgical techniques.<sup>v</sup>

There are many age-related conditions that may lead to surgery. The Applicant highlights three surgical specialties that one or both entities serve: Digestive Health, ENT, and Orthopedics.

Aging is a factor in digestive health disorders,<sup>vi</sup> In *HPC Datapoints*, the Health Policy Commission reports that, in 2021, gastrointestinal services (mainly endoscopies and colonoscopies) performed at ASCs in Massachusetts represented 64% of all ASC encounters by volume, and 50% of payments in the commercially insured population; for MassHealth and other public payors, gastrointestinal services are also one of the top ASC service lines.<sup>vii</sup> Additionally, the US Preventive Services Task Force currently recommends beginning colonoscopy screenings at age 45, recently reduced from age 50,<sup>viii</sup> which will increase the demand for endoscopy services.

The chart below shows historical volume of GI procedures for all ages at both entities; the combined impact of the COVID emergency and the physician departures and retirements is shown. With the recruitment of additional gastroenterologists, the Applicant anticipates it will be able to increase the number of patients it serves.

<b>GI Procedures</b>	<b>FY18</b>	<b>FY19</b>	<b>FY20</b>	<b>FY21</b>	<b>FY22</b>	<b>FY23</b>	<b>FY24 YTD</b>	<b>% Change FY 18-23</b>
SHS	7,456	5,775	2,550	3,417	3,862	4,478	1,079	-39.9%
SDS	2,401	2,327	2,042	2,221	1,941	1,947	925	-18.9%

The Southcoast gastroenterology service currently has transitioned some GI procedures to SDS and uses a lower dose anesthetic with an increased use of moderate/conscious sedation as compared to hospital settings. This value-based approach is part of a multi-site approach of screening for, and early diagnosis of colorectal cancers.<sup>4</sup>

The growing geriatric population is associated with an increase in the number of elderly patients presenting for orthopedic surgeries.<sup>ix</sup> Southcoast has an Advanced Total Hip and Knee Program, certified by The Joint Commission. The program uses risk stratification, and evidence-based guidelines that enable safe use of ambulatory settings as well as triage to hospital settings for appropriate inpatients. Extending the program to SDS will enhance safe, value-based care. A Physician Advising program includes subspecialty review for appropriateness of level of care. These active areas will bring safety and effectiveness to the growing ambulatory orthopedic procedures as SDS becomes an important value-based site of care. The Chart below shows the historical volume of Orthopedic Procedures at SHS,<sup>5</sup> and that the Applicant has regained its pre-COVID volume. Staff notes that in 2024, CMS added 5 orthopedic procedure codes<sup>6</sup> to the ASC payable list suggesting that demand for orthopedic procedures in the lower cost setting is likely to increase.

<b>Orthopedic Procedures</b>	<b>FY18</b>	<b>FY19</b>	<b>FY20</b>	<b>FY21</b>	<b>FY22</b>	<b>FY23</b>	<b>FY24 YTD</b>	<b>% Change FY 18-23</b>
SHS	1,608	1,803	1,503	1,517	1,600	1,670	833	3.9%

Also, Adult and older adult patients account for a disproportionately large number of outpatient ENT visits.<sup>x, xi</sup> Adults ages 45-64 accounted for 32% of visits to ENT physicians and older adults ages 65+ accounted for 21% of visits.<sup>xii</sup> As SHS's aging population continues to grow, it is expected that the number of individuals with risk factors for ENT related conditions will grow, leading to increases in demand for ENT procedures many of which can be performed in an ASC.

<sup>4</sup> In a presentation to Southcoast's leadership, Board of Trustees, and the CRICO/Ambulatory Safety Net on February 12, 2024, Dr. Dani Hackner, Chief Clinical Officer of Southcoast Health, presented about how a successful, multisite program can reduce wait times and delays, and produce high efficiency screening for colorectal cancers..

<sup>5</sup> None were provided for SDS

<sup>6</sup> including 23470 (Reconstruct shoulder joint), 23472 (Reconstruct shoulder joint), 27006 (Incision of hip tendons) 27702 (Reconstruct ankle joint), 29868 (Meniscal transplant knee with knee scope)

## **Factor 1: b) Public Health Value, Improved Health Outcomes and Quality of Life; Assurances of Health Equity**

In this section the Applicant must demonstrate that the Proposed Project adds measurable 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 /Evidence-Based:**

The patients served in an ASC setting are generally of lower-acuity and may be at lower risk for surgical complications.<sup>xiii</sup> Taking this into account, and realizing that these benefits would likely not inure to patients in the service area without the Proposed Project, the Applicant cited research that supports the public health value of the provision of approved surgical procedures in the ASC setting, including the following:

1. ASC facilities can provide the same or higher quality services, and access to highly-skilled physicians as hospitals.<sup>xiv</sup> ASC facilities enhance patient care by: (i) enabling clinical staff to focus on a small subset of procedures; (ii) allowing for tightened quality control processes since ASCs are focused on a smaller infrastructure than a hospital; and (iii) facilitating more direct communications among patients and their care teams concerning their case and proposed treatment.<sup>xv</sup>
2. Quality Data and evidence-based research related to surgical service delivery sites show lower rates of revisits within one-week post-surgery,<sup>xvi</sup> and lower rates of infection for procedures performed in ASCs vs HOPDs.<sup>xvii</sup> Clinical outcomes in ASCs are generally comparable to or better than HOPDs, including with respect to adverse events as outlined in the previously referenced recent *HPC Datapoints* report.<sup>xviii</sup>
3. ASCs generally provide enhanced convenience and satisfaction and are often selected by patients and families as they are accessible and focused specifically on surgical services.<sup>xix</sup> At SDS, patients enter the easily navigable ASC facility directly from the free parking lot, with a configuration that facilitates access by ill, injured, or elderly patients. Through the Project, these benefits will be made available to SHS patients and the wider community who select the ASC for their individual multi-specialty surgical needs.

The Applicant reports that SHS has experience with leveraging its resources to tailor programs and services to meet the needs of the communities it serves; and it has multidisciplinary team in place with extensive experience in community benefit programs, value-based care and risk contracting which will be incorporated to SDS with approval of the Proposed Project.

### **Improving Health Outcomes and Quality of Life:**

The Applicant anticipates that the Proposed Project will provide SHS's and SDS's combined patient panels with improved access to integrated ASC services, thus leading to improved outcomes and quality of life. Shifting patients to an ASC setting allows for high-quality and

lower-cost care. Researchers have found that high-risk Medicare patients are less likely to visit an emergency department or be admitted to a hospital following outpatient surgery in an ASC setting.<sup>xx</sup> Provision of care in the ASC setting is associated with efficiencies, convenience, and cost savings, all of which promote patient satisfaction and may lead to improved quality of life.<sup>xxi</sup>

### **Public Health Value- Health Equity- Integration of a Health Equity Lens:**

The Applicant states SHS has prioritized health equity system-wide, including data collection and analysis, and training. SHS has also created a multidisciplinary Health Equity advisory committee. SHS and its Health Equity Committee leadership will work closely with SDS leadership and community stakeholders to integrate SDS into existing efforts. This may include conducting additional education and outreach and expanding data collection and analysis capabilities to identify equity-related opportunities and facilitate access to care. SHS states it will expand its equity-focused assessment of services to include SDS, as these services are not provided there at this time.

The Applicant describes its commitment to advancing health equity in its community and to addressing social determinants of health (“SDOH”); it uses internal and external data to assess trends in health needs and health outcomes of its patients and community. Its 2022 Community Health Needs Assessment (“CHNA”) indicates the strong impact that SDOH issues have on the health of residents in its service area.<sup>xxii, xxiii</sup> In SHS’s and SDS’s service area, the population experiences SDOH-related issues including low-income, minoritized racial and ethnic disparities, and an aging population. SHS’s service area is centered on Fall River and New Bedford, Massachusetts, each of which have poverty rates that are nearly double the state average (according to SHS’s 2022 CHNA); more than 62% of the region’s public-school students are classified as economically disadvantaged; the average annual wages in the Southcoast region are a 63.3% of the state average. The Applicant’s parties will help patients who have these disparities by ensuring equitable access to the health benefits created by the Proposed Project.

The Applicant asserts it does not discriminate based on ability to pay or payer source, and that it has a “robust” financial assistance policy for patients. The Applicant states it will expand its commitment to meeting the needs of medically indigent and/or Medicaid eligible individuals to SDS following Project implementation resulting in expanded access to surgical services for SDS’s patients and will ensure continued access to such services for both SHS’s and SDS’s patients.

### **Culturally Appropriate Care and Language Access**

The Proposed Project will allow SHS to incorporate SDS into its language access initiatives (services not currently available at SDS) thereby facilitating access for culturally and

linguistically diverse patients presenting to SDS.<sup>7</sup> SHS's 2022 CHNA supports the need for health information and resources to be understandable and accessible, including provider education about how to communicate medical information to its culturally and linguistically diverse patients; and training in clinicians in cultural humility as a means to deliver culturally sensitive care.

SHS has systems and dedicated staffing to advance health equity, which will incorporate SDS post-transaction including: (1) system-wide efforts to improve data collection (e.g., the collection of self-reported race, ethnicity, language, disability, sexual orientation, and gender identity [RELD SOGI] data), (2) staff training to ensure competency in collecting these data from their patient population, (3) stratified analyses of RELD SOGI data to identify disparities, and (4) targeted initiatives, such as clinical-community partnerships, to address identified disparities.

As a result of these initiatives, the Applicant asserts that the Proposed Project will result in improved health outcomes and quality of life while providing reasonable assurances of health equity for SDS's patients.

### ***Analysis***

The Applicant provided several measures to track in order to assess the impact of the Proposed Project, which are found in Appendix 1. The Applicant will track and report the measures as part of their annual reporting.

Staff has reviewed and concurs that the Proposed Project will add to public health value in terms of improved access, health outcomes and quality of life while providing reasonable assurances of health equity for SDS's patients.

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

The Applicant reports that the acquisition of SDS, will bring it within the Southcoast Health network of providers which will enhance continuity and coordination of care through facilitated clinical integration among sites and providers; and it further asserts that all SHS care entities, from its emergency departments, to hospitals, to post-acute care settings, to primary and specialty care providers, are all positioned to support longitudinal, integrated, collaborative care following the implementation of the Proposed Project.

The Applicant reports that SDS will be transitioned to SHS's Electronic Medical Record ("EMR"). SDS currently has a paper-based system which means all data collection is manual and labor-

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<sup>7</sup> SHS offers access to interpreter and translation services via Language Services Associates' services which are available 24 hours/day, 7 days/week both in person, over the phone, or a combination of in person, video and/or audio services and offer patients access to qualified interpreters skilled in 200+ languages including American Sign Language free of charge.

intensive, and therefore the ASC does not collect demographic data on race, gender identity, socio-economic data, or SDOH needs, and all referrals and medical records are transmitted via fax and other means.

By utilizing a single EMR, electronic referrals can be sent and processed more accurately, comprehensively, and rapidly, allowing for direct scheduling by the practice at time of referral which decreases patient wait times for procedures. Southcoast Physicians Group has an Epic queue-management process with designated staff for gastrointestinal procedures that the Applicant states has resulted in “best-in-class” throughput on preventative and diagnostic colonoscopies. SHS believes that through implementing Epic at SDS, and assigning SHS staff to additional cases at SDS, benefits in throughput and access will occur for all procedural services. Complete electronic integration allows for streamlined referrals, scheduling, and pre-procedural optimization (testing, etc.) for patients. Procedural documentation and results will be available to patients and their Southcoast Health care team members via Epic's MyChart and the EMR.

The Applicant reports the following examples of how the Proposed Project will benefit patients in terms of improved efficiency, continuity, and coordination of care:

- SHS’s patients, including its ACO’s patients, will benefit from a new site for ambulatory surgery which will offer time efficiencies for patients and families related to ease of site navigation, parking and access to all their providers via an integrated network, of providers.
- SDS patients will also benefit from gaining access into SHS’ care coordination initiatives. While most care coordination needs for ambulatory surgical procedures are arranged in advance of the procedure day, should SDS care coordination needs arise on the day of surgery, SHS has made internal and cross continuum infrastructure investments to support a “longitudinal” patient-centered approach to care, whereby post-surgical recovery will be more efficiently coordinated with access to services such as rehabilitation, which may help patients avoid complications.
- SDS patients will experience integrated access to primary care and wellness services to efficiently manage their conditions, and to facilitate consultations and treatment at hospital and outpatient sites as needed.

### ***Analysis***

Studies show that integrated health information technology systems directly affect health outcomes, as access to a single, integrated health record improves care coordination, can reduce errors, improve patient safety, and support better patient outcomes.<sup>88</sup> Successful care coordination includes strong communication and effective care plan transitions among providers and the provision of clear and simple information that patients can understand.<sup>ee</sup> Effective care coordination can improve patient experience, increase patient safety and reduce medical errors.<sup>ff</sup> Uniform, integrated IT systems that include scheduling, EHR and patient communication tools, are timesavers which improve efficiencies. Accordingly, staff find that the

Proposed Project will create efficiencies through the support of continuity and coordination of care initiatives for the Patient Panel.

### **Factor 1: d) Consultation**

The Applicant has provided evidence of consultation, prior to 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>xxiv</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."<sup>xxv</sup>

The Applicant reports that community voice is central to SHS's work and decision-making. To inform and consult the community about the Proposed Project, it sought to engage the patient panel, family members, community members and local stakeholders that may be affected by the Project. The Applicant reports that engagement occurred through the following activities:

1. PFAC: SHS presented the Project at its Patient and Family Advisory Council ("PFAC") meeting on April 8, 2024. PFAC members' feedback is supportive of the Project.<sup>8</sup> The Applicant reports that SHS worked closely with its PFAC Committee to understand and address patients' interests, needs and concerns, foster ethnic/racial diversity representation; provide interpreter services for Limited English speaking and the deaf and hard of hearing to members when needed.
2. Community Forum: On May 29, 2024, SHS and SDS hosted an open forum in Fall River regarding the Project. The event was advertised on the Southcoast internet site, and direct invitations to key constituency groups within the community were sent out.
3. The Applicant is working with SDS's individual physician owners to inform their patients in the greater Fall River community about the Project. It is important to engage these patients because they will benefit from SDS's increased integration with SHS post-transaction.
4. Community Benefits: SHS has a robust Community Benefits Advisory Committee (CBAC) that is representative and inclusive of the community within SDS service area, and its stakeholders across a variety of sectors, including but not limited to transportation, recreation, and immigrant assistance services, and faith-based organizations.

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<sup>8</sup> The PFAC represents the voice of SHS's patients, families and communities and is an important forum for creating partnerships and ensuring the delivery of high-quality, safe and positive health care experiences. The goals of the PFAC are to: (1) enhance the delivery of care and services; (2) ensure representation of the community's perspective; (3) foster a culture of patient-centered care.



5. Engage Local Public Health: Community Health Needs Assessment Review and Update-SHS has partnered with local departments of health to review its 2022 CHNA findings with community stakeholders; it has also partnered with the New Bedford Health Department to develop a Community Health Improvement Plan (CHIP) including co-hosting an all-day, interactive planning process to develop the components of the CHIP with over 40 participants representing a wide variety of community organizations.

### **Analysis**

The community engagement initiatives described above are not currently conducted by SDS. SHS has demonstrated its commitment to developing and maintaining linkages with community partners within the SDS service area and therefore the SDS patient panel is likely to benefit from those initiatives. Staff reviewed the information regarding the Applicant's community engagement and finds that it has met the required community engagement standard of Consult in the planning phase of the Proposed Project.

### **Factor 1: f) Competition on Price, Total Medical Expenses (TME), Costs and Other Measures of Health Care Spending**

The Applicant states the Proposed Affiliation is not anticipated to have an adverse impact on competition in the Massachusetts health care market based on price, total medical expense ("TME"), provider costs, or other recognized measures of health care spending. With the implementation of the Proposed Project, SDS's costs and reimbursement structures will not change as the ASC will maintain its freestanding ASC status. The Applicant states that the Proposed Project seeks to promote utilization of the ASC setting for appropriate patients as a lower-cost alternative to many of the same procedures performed in a hospital outpatient department ("HOPD").

Because Medicare reimbursement rates for ASCs are lower than HOPDs, "the cost to Medicare is lower when a surgical procedure is performed in an ASC rather than an HOPD" <sup>xxvi</sup> according to the *March 2024 Report to the Congress: Medicare Payment Policy* section concerning ASCs. In Massachusetts, as reported in the Health Policy Commission's ("HPC") *DataPoints*, focusing on ASC trends<sup>xxvii</sup> prices are generally "far lower" than in HOPDs across commercial insurers, MassHealth, and Medicare; in 2021, they ranged from 27% to 57% lower in ASCs for the commercial population for common surgeries.<sup>xxviii</sup> The HPC attributes these lower prices primarily to lower facility payments to ASCs than to hospitals.

ASC related annual savings from the shift to ASC's from HOPDs for the Medicare program and its beneficiaries increased steadily from \$3.1 billion in 2011 – to \$4.2 billion in 2018;<sup>xxix</sup> and a recent study from 2020 projects cumulative Medicare savings from 2019 to 2028 of \$73.4 billion, with increases in projected annual savings from \$4.3 billion in 2019 to \$12.2 billion in 2028.<sup>xxx</sup>

Studies also address cost savings at ASCs that are attributable to procedure length.<sup>xxxvi</sup> Researchers have found that ASCs are substantially faster than hospitals at performing outpatient procedures and that the shorter procedure times are attributable to operating efficiencies which in turn lead to cost reductions since more procedures per day can be performed with the same number of staff and operating and recovery rooms than a HOPD.<sup>xxxvii</sup> According to the study, procedures performed in ASCs take, on average, “31.8 fewer minutes than those performed in hospitals – a 25% difference relative to the mean procedure time.”<sup>xxxviii</sup> Researchers estimate the associated cost savings at \$363 – \$1,000 per outpatient case. Annually, ASCs perform more than 7 million procedures for Medicare beneficiaries; by specializing in specific procedures, ASCs can maximize efficiencies leading to cost savings,<sup>xxxix</sup> while maintaining quality outcomes for patients.<sup>xl</sup>

SHS’s commercial relative price in Massachusetts is below the mean and median relative price (“RP”) of its cohort of *Community High Public Payer Hospitals* where the median S-RP in of the cohort is .92 whereas Southcoast Health’s is .83. (The mean is statewide across all cohorts is 1.00.<sup>9</sup> For a comparative list of providers within this cohort, see Appendix 2.)

Overall, the Applicant’s Proposed Project aims to lower the cost of multi-specialty surgery services for SHS’s patient panel and community through its acquisition of SDS; it seeks to encourage patients to consider the cost-effective ASC setting for appropriate surgical procedures.

## **Analysis**

The acquisition of SDS by SHS will allow for improved collaboration and more coordinated care within the community which is better for the patients and better for the financial success of value-based programs by reducing unnecessary emergency department usage, inpatient surgeries, readmissions, and the overall cost of care, all of which has been cited within the literature and studied by the HPC as the associated benefits of ASCs.

Given that SDS is an operating facility, and that the Applicant is already a minority shareholder, consistency will be maintained. Following project approval, the management structure will be improved, and stabilization of resources and staffing will occur improving efficiencies and volume of procedures offered that likely would otherwise be performed in a higher-cost HOPD setting. In addition, there is no expansion of OR capacity associated with this project. Thus, the Project will likely have a positive impact on the Massachusetts healthcare market through the expansion of operating efficiencies through the single EHR, cost reductions in overall care, and ultimately total medical expense (TME).

## **FACTOR 1 Summary Analysis**

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<sup>9</sup> This S-RP can be generally and broadly applied since it includes all payers, however it is not specific enough to calculate exact comparative percentages of one provider over/under another. While comparing cohorts can be insightful, there are also geographic considerations that may impact price.

Staff finds that the Applicant has demonstrated the Proposed Project will address the ongoing need for high-quality, cost-effective, ambulatory surgical care. This acquisition of the SDS ASC will provide an alternative lower cost site with improved access to community resources for SDS's and SHS's combined Patient Panels with better integration, and the stabilization of the surgical staffing and better management of resources at SDS. Staff notes that the facility has accommodated ~9,000 procedures (2018) and in 2003 performed ~6,000 procedures suggesting that there is additional operational capacity at the site. Staff highlights SHS's assertion that without the acquisition, SDS is not in a financial position to continue to invest in its clinical staffing recruitment efforts, or its infrastructure, including modernizing its recordkeeping and EMR systems which, Staff notes, could result in gaps in access as more shareholders retire.

As a result of the information provided by the Applicant and additional analysis, staff finds that the Applicant has demonstrated that the Proposed Project meets Factors 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 providing high-quality care in a lower cost setting. The Proposed Project will meet these goals by SHS, a lower cost provider with a high public payer Patient Panel, gaining management control of a freestanding ASC and shifting clinically appropriate cases from a HOPD to the ASC, where reimbursement rates are lower and will remain unchanged. As previously addressed in both the *Patient Panel Need* and *Competition* sections, reimbursement rates for procedures performed in ASCs are approximately 60% of the rate for the same outpatient procedures performed in a hospital setting.<sup>xxxvi</sup>

Also, the Proposed Project will meet these goals by strengthening an existing freestanding ASC where many physician retirements have resulted in lower volumes and investments in infrastructure have not been made. Following project implementation, the Applicant states such investments will occur, including in equipment, and physician and clinical staff recruitment.

The Applicant Asserts, given that contracted rates will not increase, and that more patients will have access to this lower cost setting, as opposed to a higher priced HOPD, the Proposed Project will not negatively impact the overall cost growth benchmark set for the state.

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

Staff finds that the Applicant has adequately explained how it aligns with cost containment goals through the expansion of access to ambulatory surgery in a lower-cost setting. In their *DataPoints* series, the HPC examines ASC's and suggests that additional savings can be gained

from expanding access to ASCs and supporting greater shifts of care from HOPDs to ASCs.<sup>xxxvii</sup> Therefore, DoN Staff can conclude that the Proposed Project will likely meet the cost containment component of Factor 2.

### **Improved Public Health Outcomes**

The Applicant asserts the Proposed Project can improve patient health outcomes through increasing access to freestanding ASC care, in particular for the Applicant's ACO patients, in an existing licensed facility that has been under-resourced for a number of years following the retirements and departures of many of the physician partners. Through investment in a full complement of clinical staffing, the Proposed Project will ensure capacity for more surgeries to be performed in the community which offers patients improved convenience through an easily navigable site, and shorter wait times for scheduling procedures. More affordable, local, timely access will contribute to improved patient experience and satisfaction. By reducing costs through the provision of care in a freestanding ASC, the Proposed Project seeks to expand access to patients of all financial means, limiting the impact that cost of care influences the patient's decision to seek needed care.

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

According to a recent Kaiser Family Foundation poll, *"One in four adults say that in the past 12 months they have skipped or postponed getting health care they needed because of the cost... six in ten uninsured adults (61%) say they went without needed care because of the cost."*<sup>xxxviii</sup> In June, 2024, the Center for Health Information and Analysis ("CHIA") published *Findings from the 2023 Massachusetts Health Insurance Survey*.<sup>xxxix</sup> The survey reports that the MA uninsurance rate declined to 1.7% while the national rate declined to 8.4%.<sup>xl</sup> These rates are lower than the 2021 uninsurance rates (2.4% vs 9.2%, respectively). Despite these advances in MA, 41.3% reported that they or their families had an issue affording health care.

Staff finds that the Proposed Project will provide the Patient Panel with increased access to ambulatory surgery in the ASC setting, a need for which is growing due to population changes and the increasing prevalence of certain health conditions discussed in Factor 1(a). These procedures have the ability to improve health outcomes, quality of life, and functioning status. Therefore, DoN Staff can conclude that the Proposed Project will likely meet the Public Health Outcomes component of Factor 2.

#### ***Delivery System Transformation***

The Applicant states that with project approval, patients who seek care at SDS will have services that are not currently available to them including interpreter services, financial counseling, assistance with social determinants of health (SDoH) needs, improved care management, better coordinated clinical staff, and an integrated medical record as outlined in Factors 1(b) and (e). Through Integration of the two entities, the SDS patients and primary care providers will be linked via existing SHS channels thereby improving access to social service organizations that

may be needed including post-acute care services through the Applicant's visiting nurses' association and other resources.

In Fiscal Year 2023, 27,665 patients covered by public payers received surgical procedures at SHS while only 1,703 similarly covered patients received care at SDS. Following the completion of the first phase of the SDS acquisition in 2022, the Applicant moved SDS to Tier 1 of their health plan allowing for improved access and affordability. The Proposed project offers a greater opportunity to shift a portion of these patients to the lower cost setting with a potential significant cost savings as described above and in Factor 1(e).

The Applicant states that parties cannot implement integration plans until after the transfer of ownership is complete due to antitrust reasons; once the transfer of ownership is complete, SHS and SDS will be able to work collaboratively to integrate services and processes so that scheduling and patient care are highly coordinated. Key components of the integration include incorporating SHS anesthesiology providers into coverage and staffing models at SDS. These actions will make it easier for SHS surgeons and proceduralists to begin transitioning outpatient cases from the SHS operating rooms to SDS where patients will experience operational efficiencies provided in an ambulatory setting.

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

Staff analysis of the Payer-mix for out-patient surgical procedures for SHS and SDS provided by the Applicant indicates that 67.5% of SHS's and 27.5% of SDS's surgical out-patients are covered by government payers. SDS serves no managed Medicaid patients, and just 6.5% managed Medicare patients, compared to SHS's 17.3% and 16.4%, respectively. As part of the conditions of approval, the Applicant will report demographic and payer mix data to the Department.

The Applicant has demonstrated how the Proposed Project will provide services that support SDoH services, which are not currently available to SDS patients, and which has the potential to improve the continuity of care and health outcomes. Therefore, with the Other Conditions, DoN Staff can conclude that the Proposed Project will likely meet the Delivery System Transformation component of Factor 2.

### **FACTOR 2 Summary Analysis**

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

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

The Applicant has provided evidence of compliance and good standing with federal, state, and local laws and regulations and this Factor 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: Demonstration of Sufficient Funds Independent CPA Analysis

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 by an independent CPA.

To arrive at its conclusions, the scope of the CPA report is limited to an analysis of the seven-year projections for the fiscal years ending September 30, 2024, through 2030, prepared by Management, and the supporting documentation including the following:

1. Both ASC and SHS seven-year Prospective Financial Schedules, prepared as of April 10, 2024 and associated revenue and expenditure assumptions;
2. SHS historical audited financial statements;
3. An overview of the Proposed Project and associated business case rationale provided by SHS Management;
4. CPA Report Guidelines from the Determination of Need Program, dated March 2021; and
5. Correspondence with SHS and ASC Management.

The CPA evaluated historical and projected standard key financial accounting metrics, reflecting profitability, liquidity, and solvency of the projections to assess the feasibility and reasonableness of the Projections.<sup>10</sup>

### 1. Revenue

To determine the reasonableness of the prospective revenues, the CPA reviewed the underlying assumptions upon which SHS Management relied. Prospective net patient service revenues were projected to grow annually at approximately 5% (based on 2.5% annual growth in both patient volume and reimbursement). Prospective other operating revenues which include SHS' retail, specialty, and contracted pharmacy activity were assumed to grow approximately 10% annually.

Relating to this Application, the ASC's total revenue is less than 1% of SHS revenue for each year of the Prospective Period. The CPA's opinion is that the revenue growth of the Applicant,

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<sup>10</sup> The Key Metrics fall into three primary categories: profitability, liquidity, and solvency. Profitability metrics are used to assist in the evaluation of management performance in how efficiently resources are utilized. Liquidity metrics, including common ratios such as "days of available cash and investments on hand", measure the quality and adequacy of assets to meet current obligations as they come due. Solvency metrics measure the company's ability to take on and service debt obligations. Additionally, certain metrics can be applicable to multiple categories.

including the ASC, estimated by Management reflects a reasonable estimate of future revenues of the Applicant.

## **2. Operating Expenses**

The CPA analyzed the expense categories included in the SHS Prospective Financial Schedules for reasonableness including a historical review and expense growth assumptions in the Applicant's Prospective Period, including the ASC.

The operating expenses include salaries and benefits, supplies and drugs, contract physicians, services, insurance, other expenses, depreciation and amortization, and interest expense. Throughout the projection period, salaries and benefits account for approximately 63%- 68% while supplies and drugs account for approximately 15%-16% of total operating expenses.

SHS salaries were forecasted to increase 5-6% annually throughout the Prospective Period, based on a 3% annual inflationary increase, and added expenses to account for the forecasted increase in patient volume. Expenditures including contract physicians, services, insurance, and other expenses were forecasted to grow at approximately 3% annually.

Other operating expenses for SHS including the Hospital Health Safety Net Tax Assessment, software expenses/maintenance, utilities, and right of use assets, repairs/maintenance, patient linens and various other miscellaneous items, represent approximately 8% of total operating expenses.

Relating to this Application, the ASC's total operating expenses are less than 1% of SHS operating expenses for each year of the Prospective Period. Based upon the foregoing, it is the CPA's opinion that the operating expenses forecasted by SHS Management are based on reasonable assumptions and are feasible for the Applicant.

## **3. Capital Expenditures and Proposed Project Funding**

The CPA reviewed the capital expenditures and future cash flows to determine whether sufficient funds would be available to sustain the operation of the Applicant. Capital expenditures for the ASC are less than 1% of SHS capital expenditures therefore, the CPA determined that the prospective capital requirements and resulting impact on the cash flows are reasonable.

## **Conclusions on Feasibility**

As described herein, the CPA analyzed multiple sources of information pertaining to the Applicant and the Proposed Project and notes that the SHS Prospective Financial Schedules exhibit a cumulative EBIDA<sup>11</sup> surplus of approximately 5% of cumulative projected operating revenue for the six years from 2024 – 2030. Based upon its review, the CPA concluded that the Prospective Financial Schedules are based upon reasonable and feasible assumptions and

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<sup>11</sup> defined as earnings before interest, depreciation, and amortization or "EBIDA"

determined that the SHS Prospective Financial Schedules are a reasonable expectation and based on feasible and sustainable financial projections which are not likely to have a negative impact on the patient panel or result in a liquidation of assets of the Applicant.

#### **Factor 4 Analysis**

Staff is satisfied with the CPA's analysis of the Proposed Project's projections. 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 4.

#### **Factor 5: Relative Merit** NOT Required for Transfers of Ownership

#### **Factor 6: Community-based Health Initiatives** NOT Required for Transfers of Ownership

### **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. In addition to the measures provided in Appendix 1, commencing with the approval of this DoN, and continuing for a period of five years after the Proposed Project is complete, the Holder shall provide the following information as part of the annual report required by 105 CMR 100.310(A)(12):
  - a. Annually, for both SHS (outpatient) and SDS, the applicant will report the following:
    - i. Surgical volume by specialty
    - ii. Surgical payer-mix
    - iii. Surgical Patients by race and ethnicity
    - iv. Surgical Volume by Age
  - b. In addition to SDS's obligation to participate in MassHealth, pursuant to 105 CMR 100.310(A)(11), the Holder must certify annually that all physicians and health professionals who practice at SDS are enrolled as participating providers of MassHealth to support equitable access to all clinicians at the facility regardless of payer.



## Appendix 1

The Holder shall provide, in its annual report to the Department the following outcome measures. These metrics will become part of the annual reporting on the approved DoN, required pursuant to 105 CMR 100.310(A)(12). To assess the impact of the Proposed Project, annually the Applicant will evaluate and report the following measures by quarter:

To assess the impact of the proposed Project, the Applicant developed the following quality metrics and reporting schematic, as well as metric projections for quality indicators that will measure patient satisfaction and quality of care. The measures are discussed below:

**1. Patient Satisfaction:** Patients that are satisfied with their care are more likely to seek needed diagnostics, appropriate treatments and follow-up services. The Applicant and SDS staff will review patient satisfaction levels with SDS's surgical services.

**Measure:** The Outpatient and Ambulatory Surgery Community Assessment of Healthcare Providers and Systems ("OAS-CAHPS") Survey will be provided to eligible patients. The OAS-CAHPS Survey is a patient experience survey administered to patients of ambulatory and outpatient facilities that includes questions related to six key areas: (1) Before a patient's procedure; (2) Facility and staff; (3) Communications about the procedure; (4) Recovery; (5) Overall experience; and (6) Patient demographics. OAS-CAHPS results are reported as "top-box," "middle-box," and "bottom-box" scores; the top-box is the most positive response to survey items, the middle-box captures intermediate responses, and the bottom-box is the least positive response category.

The Applicant has selected three indicators of care experience across the continuum from the OAS CAHPS slate:

- I. Before the Procedure
  - Before your procedure, did your doctor or anyone from the facility give you all the information you needed about your procedure?
- II. About the Facility and Staff
  - Did the doctors and nurses treat you with courtesy and respect?
- III. Communication about the Procedure / Transitions
  - Discharge instructions include things like symptoms you should watch for after your procedure, instructions about medicines, and home care. Before you left the facility, did you get written discharge instructions?

**Projections:** As the Project relates to the change in ownership of SDS, the Applicant has established a new benchmark for this measure to be implemented post-transaction. Specifically, the Applicant has established a benchmark of 88% for top-box scores for "Overall Experience" at SDS, which is the top decile for reporting providers.

**Monitoring:** Results will be reviewed on a quarterly basis and reported to DPH, as required.

**2. Clinical Quality and Safety:** As with all health care delivery, quality and safety are a top priority. The Applicant and SDS staff will review clinical quality and safety performance in accordance with Ambulatory Surgical Center Quality Reporting Specifications Manual Versions 13.0a, which is published by CMS and allows for national benchmarking including the measures targeted below:

**Measure:** As defined by Ambulatory Surgical Center Quality Reporting Specifications Manual Versions 13.0a, we will track the web-based and claims-based measures:

Measure	Description
ASC -3 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	The number of admissions (patients) who experience a wrong site, side, patient, procedure, or implant
ASC -4 All Cause Hospital Transfer/Admission	The percentage of ASC admissions (patients) transferred or admitted to a hospital upon discharge from the ASC
ASC -9 Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients	Percentage of patients aged 45 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report.
ASC -12 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	The Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy Measure, hereafter referred to as the colonoscopy measure, estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of an outpatient colonoscopy among Medicare Fee-for-Service (FFS) patients aged 65 years and older.
ASC -17 Risk-Standardized Hospital Visits within 7 Days after Orthopedic Ambulatory Surgical Center Procedures	The measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of an orthopedic surgery at an ambulatory surgical center (ASC) among Medicare Fee-for-Service (FFS) patients aged 65 years and older.

SHS will track the entire ASC panel of quality for indicated cases, and SHS has selected a subset for emphasis on safety (wrong site surgery), coordination with all clinical sites of care (hospital visits after ambulatory surgery), and to drive population health (colorectal cancer prevention). SHS has selected two populations, orthopedics, and gastroenterology, that we anticipate will have high utilization in the region. SHS has placed a high emphasis on colorectal screening procedure access and throughput. It earned Joint Commission Advanced Total Joint Replacement certification.

**Projections:** As the Project relates to the change in ownership of SDS, the Applicant intends to meet or exceed the ASC Quality Collaboration (“ASC-QC”) and/or CMS benchmarks.

**Monitoring:** Results will be reviewed on a quarterly basis and reported to DPH, as required.

## Appendix 2

### Community-High Public Payer Hospitals – Statewide Relative Price

*\*\*Table reflects Statewide (Cross-Payer) Relative Price attributed to Community-High Public Payer Hospitals in MA (Insurance Category = Commercial – Self & Fully Insured); table sorted in descending order by CY21 RP(Source: CHIA)*

Hospital	System	Public Pay (FY21)	CY17 (RP)	CY18 (RP)	CY19 (RP)	CY20 (RP)	CY21 (RP)
Falmouth Hospital	Cape Cod Healthcare	71.8%	1.394	1.391	1.450	1.438	1.480
Cape Cod Hospital	Cape Cod Healthcare	74.7%	1.304	1.312	1.339	1.350	1.360
Fairview Hospital	Berkshire Health Systems	67.0%	1.380	1.333	1.349	1.086	1.190
Steward Saint Anne's Hospital	Steward Health Care System	71.6%	0.955	0.988	0.999	1.051	1.060
Sturdy Memorial Hospital	Sturdy Memorial Foundation	65.0%	1.023	1.102	1.124	1.088	1.060
Berkshire Medical Center	Berkshire Health Systems	72.6%	1.235	1.231	1.215	1.019	1.040
Steward Good Samaritan Medical Center	Steward Health Care System	69.8%	0.916	0.872	0.974	1.005	0.980
Baystate Franklin Medical Center	Baystate Health	72.7%	1.047	1.110	1.002	0.967	0.960
North Shore Medical Center	Mass General Brigham	70.0%	1.000	1.000	0.980	0.962	0.960
Steward Holy Family Hospital	Steward Health Care System	69.5%	0.873	0.853	0.907	0.950	0.950
Marlborough Hospital	UMass Memorial Health Care	66.1%	0.878	0.876	0.908	0.907	0.940
Morton Hospital	Steward Health Care System	69.0%	0.848	0.835	0.912	0.928	0.940
Nashoba Valley Medical Center	Steward Health Care System	64.3%	0.952	0.867	0.897	0.898	0.940
Cooley Dickinson Hospital	Mass General Brigham	70.4%	1.068	1.067	1.011	0.975	0.920
MetroWest Medical Center	Tenet Healthcare	66.6%	0.897	0.953	1.003	0.931	0.920
Beth Israel Deaconess Hospital - Plymouth	Beth Israel Lahey Health	68.7%	0.869	0.905	0.881	0.939	0.910
Athol Memorial Hospital	Heywood Healthcare	70.1%	0.901	0.797	0.825	0.861	0.900
Melrose Wakefield Healthcare	Tufts Medicine	65.0%	0.916	0.915	0.924	0.920	0.900
Signature Healthcare Brockton Hospital	Signature Healthcare Corporation	76.0%	0.798	0.808	0.827	0.889	0.900
Harrington Memorial Hospital	UMass Memorial Health Care	68.8%	0.895	0.852	0.841	0.894	0.850
HealthAlliance-Clinton Hospital	UMass Memorial Health Care	72.8%	0.827	0.866	0.807	0.859	0.850
Northeast Hospital	Beth Israel Lahey Health	65.0%	0.847	0.857	0.832	0.858	0.850
Mercy Medical Center	Trinity Health	77.1%	0.785	0.792	0.838	0.829	0.840
Southcoast Hospitals Group	Southcoast Health System	74.6%	0.868	0.875	0.824	0.856	0.830
Lawrence General Hospital	Lawrence General Hospital and Affiliates	75.8%	0.739	0.790	0.777	0.823	0.810
Lowell General Hospital	Tufts Medicine	66.5%	0.789	0.826	0.846	0.847	0.810
Holyoke Medical Center	Valley Health System	79.8%		0.771	0.727	0.726	0.760
Baystate Wing Hospital	Baystate Health	70.5%	0.840	0.786	0.773	0.734	0.740
Baystate Noble Hospital	Baystate Health	69.1%	0.684	0.718	0.736	0.692	0.730
Heywood Hospital	Heywood Healthcare	66.8%	0.712	0.728	0.719	0.728	0.730

- <sup>i</sup> Massachusetts Health Policy Commission, *The HPC Accountable Care Organization (ACO) Certification Program* <https://www.mass.gov/service-details/the-hpc-accountable-care-organization-aco-certification-program> (identifying SHS, inclusive of its SACO and SHN entities, as a HPC-certified ACO)..
- <sup>ii</sup> UMass Donahue Institute, Massachusetts Population Estimates Program, *Massachusetts Population Estimates by County* (“By 2035, the 65-and-over population will represent 23% of the state’s population.”).
- <sup>iii</sup> UMass Donahue Institute, Massachusetts Population Estimates Program, *Massachusetts Population Estimates by County* <https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-estimates-by-massachusetts-geography/by-county> (applying the interactive filters of the Massachusetts County Population by Characteristics to identify the population distribution for Bristol County, by Year and Age Groups).
- <sup>iv</sup> Partridge JSL, et al., *Frailty in the older surgical patient: a review*, 41 AGE AND AGEING 142 (2012), available at <https://academic.oup.com/ageing/article/41/2/142/47699>; Yang R, et al., *Unique Aspects of the Elderly Surgical Population: An*
- <sup>vid.</sup>
- <sup>vi</sup> Travis A, et al., *Endoscopy in the Elderly*, 107 AM. J. GASTROENTEROLOGY 1495 (2012).
- <sup>vii</sup> Massachusetts Health Policy Commission, *HPC Datapoints: Trends in Ambulatory Surgical Centers in Massachusetts*, Issue 26: Feb. 2024, [hereinafter, “HPC Datapoints”], <https://www.mass.gov/info-details/hpc-datapoints-issue-26> (“Available evidence suggests that safety and quality metrics at ASCs are comparable to and in some cases better than those in HOPDs, including the rates of adverse events, although many studies caveat the need to appropriately select patients for surgery at ASCs based on the complexity of the case”);
- <sup>viii</sup> Colorectal Cancer: Screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>. Accessed December 15, 2021.
- <sup>ix</sup> Gheno R, et al., *Musculoskeletal Disorders in the Elderly*, 2 J. CLINICAL IMAGING SCI. 1 (2012), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3424705/>; Bajwa SIS, *Clinical conundrums and challenges during geriatric orthopedic emergency surgeries*, 5 INT’L J. CRITICAL ILLNESS & INJURY SCI. 38 (2015), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4366827/>.
- <sup>x</sup> Kost KM, *Geriatric Otolaryngology: Why It Matters*, 34 CLINICAL GERIATRIC MED IX (2018), available at [https://www.geriatric.theclinics.com/article/S0749-0690\(18\)30012-0/fulltext](https://www.geriatric.theclinics.com/article/S0749-0690(18)30012-0/fulltext); Creighton Jr. FX et al., *The growing geriatric otolaryngology patient population: A study of 131,700 new patient encounters*, 123 LARYNGOSCOPE 97 (2012). CDC, National Ambulatory Medical Care Survey, *Factsheet – Otolaryngology*, [https://www.cdc.gov/nchs/data/ahcd/NAMCS\\_2010\\_factsheet\\_otolaryngology.pdf](https://www.cdc.gov/nchs/data/ahcd/NAMCS_2010_factsheet_otolaryngology.pdf).
- <sup>xi</sup> Kaylie DM, Merck Manual, Consumer Version, *Effects of Aging on the Ears, Nose, and Throat*, (last modified Sept. 2022), <https://www.merckmanuals.com/home/ear,-nose,-and-throat-disorders/biology-of-the-ears-nose-and-throat/effects-of-aging-on-the-ears-nose-and-throat>; Kost KM, *Geriatric Otolaryngology: Why It Matters*, 34 CLINICAL GERIATRIC MED IX (2018), available at [https://www.geriatric.theclinics.com/article/S0749-0690\(18\)30012-0/fulltext](https://www.geriatric.theclinics.com/article/S0749-0690(18)30012-0/fulltext); Creighton Jr. FX et al., *The growing geriatric otolaryngology patient population: A study of 131,700 new patient encounters*, 123 LARYNGOSCOPE 97 (2012).
- <sup>xii</sup> According to data from 2010, of an estimated 20 million visits to non-federally employed ENT physicians and surgeons, *Factsheet – Otolaryngology*.
- <sup>xiii</sup> Munnich EL, Parente ST, *Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up*, *Health Aff (Millwood)* 2014;33:764-9. 10.1377/hlthaff.2013.1281. (noting that “ASCs tend to treat a healthier mix of patients than hospitals do”); Crawford DC, et al., *Clinical and Cost Implications of Inpatient Versus Outpatient Orthopedic Surgeries: A Systematic Review of the Published Literature*, 7 ORTHOPEDIC REVIEW 116 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4703913/pdf/or-2015-4-6177.pdf> (“All of the reviewed studies reported that outpatient surgeries had similar or improved level of pain and rates of nausea. This review found that outpatient procedures in North America appear to be less expensive and safe alternatives to inpatient care for patients who are at lower risk for complications and procedures that do not necessarily require close hospital level care monitoring following same day surgery.”); Cook D, et al., *From ‘Solution Shop’ Model to ‘Focused Factor’ In Hospital Surgery: Increasing Care Value and Predictability*, 33 HEALTH AFFAIRS 746 (2014), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.1266> (advancing the idea of a “focused factory” model of healthcare, which is “characterized by a uniform approach to delivering a limited set of high-quality products” to “increase[] care value and the predictability of care process, outcomes, and costs while preserving []the strengths of the solution shop”).
- <sup>xiv</sup> Munnich EL, Parente ST, *Returns to specialization: Evidence from the outpatient surgery market*, J. of Health Econ., v. 57, 2018, p. 147-167, <https://www.sciencedirect.com/science/article/abs/pii/S0167629617310743> (explaining that these effects were valid even after accounting for differences in patient health and case mix).
- <sup>xv</sup> Ambulatory Surgery Center Association, *Ambulatory Surgery Centers: A Positive Trend in Health Care*, [hereinafter “ASCA Report”], <https://www.ascassociation.org/advancingsurgicalcare/aboutasc/industryoverview/apositivetrendinhealthcare> (“Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers.”);
- <sup>xvi</sup> Munnich & Parente (2018), *supra* note xiv.

- <sup>xvii</sup> Hall MJ, et al, Hall MJ, Schwartzman A, Zhang J, et al. Ambulatory surgery data from hospitals and ambulatory surgery centers: United States, 2010. Nat Health Stat Rep 2017;102:1-14, <https://pubmed.ncbi.nlm.nih.gov/28256998/>; McKinsey & Company, *Walking out of the hospital: The continued rise of ambulatory care and how to take advantage of it*, Sept. 18, 2020, [hereinafter “McKinsey ASC Report”], <https://www.mckinsey.com/industries/healthcare/our-insights/walking-out-of-the-hospital-the-continued-rise-of-ambulatory-care-and-how-to-take-advantage-of-it> (projecting the ASC market to grow “at a compound annual growth rate of 6 percent between 2018 and 2023—reaching around \$36 billion by 2023.”); (“ASCs allow patients to be discharged within 23 hours of care, reducing their risk of infection and allowing recovery to take place in the comfort of their own homes.”).
- <sup>xviii</sup> HPC Datapoints *supra* note vii
- <sup>xix</sup> Medicare Payment Advisory Commission, *March 2024 Report to the Congress: Medicare Payment Policy* (March 15, 2024), Chapter 10: Ambulatory Surgical Center Services: Status Report, [hereinafter “MedPac ASC Report”], p. 297, [https://www.medpac.gov/wp-content/uploads/2024/03/Mar24\\_Ch10\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch10_MedPAC_Report_To_Congress_SEC.pdf); (“For patients, ASCs can offer more convenient locations, shorter waiting times, lower cost sharing, and easier scheduling relative to hospital outpatient departments.”).
- <sup>xx</sup> Munnich & Parente (2018), *supra* note xiv; AAOS American Academy of Orthopedic Surgeons, Ambulatory Surgical Centers Position Statement, [hereinafter “AAOS Position Statement”], <https://www.aaos.org/globalassets/about/position-statements/1161-ambulatory-surgical-centers.pdf> (providing support for the role of ASCs and stating with respect to patient safety that: “It has been reported that ASCs treat lower acuity patients when compared to HOPD’s. In the absence of standardized and widely reported quality measures with respect to patient safety, this is probably prudent. Preliminary patient safety data shows problem occurrence rates less than 0.1 percent on all four indicators. One study has demonstrated even high-risk Medicare patients are no more likely for re-admission after treatment in an ASC compared to a hospital”).
- <sup>xxi</sup> Munnich EL, Parente ST, *Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up*, *Health Aff (Millwood)* 2014;33:764-9. 10.1377/hlthaff.2013.1281; AAOS Position Statement, *supra* note xx; ASCA Report, *supra* note xv; Levitt L, The Benefits of Outpatient Surgical Centers. The Centers for Advanced Orthopedics (Jun. 15, 2017)
- <sup>xxii</sup> *Southcoast Health Community Health Needs Assessment 2022*, available here: <https://www.southcoast.org/wp-content/uploads/2022/09/Southcoast-Health-CHNA-2022.pdf>.
- <sup>xxiii</sup> See generally, DHHS, Healthy People 2030, *Social Determinants of Health*, <https://health.gov/healthypeople/priority-areas/social-determinants-health>. SDoH are the conditions in the environments in which people live, learn, work, play, and age; they affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- <sup>xxiv</sup> Community Engagement Standards for Community Health Planning Guideline. <https://www.mass.gov/doc/community-engagement-guidelines-for-community-health-planning-pdf/download>.
- <sup>xxv</sup> DoN Regulation 100.210 (A)(1)(e). at <https://www.mass.gov/files/documents/2018/12/31/jud-lib-105cmr100.pdf>.
- <sup>xxvi</sup> Medicare Payment Advisory Commission, *March 2024 Report to the Congress: Medicare Payment Policy* (March 15, 2024), Chapter 10: Ambulatory Surgical Center Services: Status Report, [hereinafter “MedPac ASC Report”], p. 297, [https://www.medpac.gov/wp-content/uploads/2024/03/Mar24\\_Ch10\\_MedPAC\\_Report\\_To\\_Congress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch10_MedPAC_Report_To_Congress_SEC.pdf); ; Ambulatory Surgery Center Association, *Reducing Medicare Costs* (October 2020), [hereinafter “ASCA Medicare Costs Report *supra* note xv.”
- <sup>xxvii</sup> HPC Datapoints, *supra* note vii.
- <sup>xxviii</sup> *Id.*
- <sup>xxix</sup> ASCA Medicare Costs Report, *supra* note xv, section on Past Savings (Appendix B – Table 1) (“During the eight-year period from 2011 to 2018, the total FFS Medicare savings generated by ASCs was \$28.7 billion. The savings per year increased from \$3.1 billion in 2011 to \$4.2 billion in 2018.”); ASCA Report, *supra* note xv (noting average annual increases of \$2.6 billion per year prior to 2011); *The ASC Cost Differential*, *supra* note xxi.
- <sup>xxx</sup> ASCA Medicare Costs Report, *supra* note xv, section on Future Savings (Appendix B – Table 2).
- <sup>xxxi</sup> Munnich EL, Parente ST, *Procedures take less time at ambulatory surgery centers, keeping costs down and ability to meet demand up*, *Health Aff (Millwood)* 2014;33:764-9. 10.1377/hlthaff.2013.1281.
- <sup>xxxii</sup> *Id.*
- <sup>xxxiii</sup> *Id.*
- <sup>xxxiv</sup> Makanji HS, Bilolikar VK, Goyal DKC, Kurd MF. *Ambulatory surgery center payment models: current trends and future directions*, *J Spine Surg.* 2019 Sep;5(Suppl 2):S191-S194, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6790812/> (“In 2017, more than 50% of all outpatient surgeries were conducted in ambulatory surgery centers (ASCs)—a market which is projected to reach \$40 billion in 2020. At the center of this massive growth are ASCs.”). (“ASCs . . . typically focus on a small subset of routine procedures and treatments. This approach allows ASCs to reduce the overall perioperative costs of surgery... since the adoption of the Affordable Care Act (ACA), reimbursements to ASCs have become approximately 42% less when compared to hospitals for the same procedure”).
- <sup>xxxv</sup> *Id.*
- <sup>xxxvi</sup> Louis Levitt, *The Benefits of Outpatient Surgical Centers*. The Centers for Advanced Orthopedics (Jun. 15, 2017), <https://www.cfaortho.com/media/news/2017/06/the-benefits-of-outpatient-surgical-centers>; Michael Barbella, *The ABCs of ASC Cost*

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*Savings*, Orthopedic Design & Technology (Mar. 22, 2017), [https://www.odtmag.com/issues/2017-03-01/view\\_columns/the-abcs-of-asc-cost-savings/](https://www.odtmag.com/issues/2017-03-01/view_columns/the-abcs-of-asc-cost-savings/).

<sup>xxxvii</sup> HPC Datapoints *supra* note vii

<sup>xxxviii</sup> <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>

<sup>xxxix</sup> <https://www.chiamass.gov/assets/docs/r/survey/mhis-2023/2023-MHIS-Report.pdf>

<sup>xl</sup> From the 2022 National Health Interview Survey (NHIS), the most recent available.