

STAFF REPORT TO THE PUBLIC HEALTH COUNCIL FOR A DETERMINATION OF NEED	
Applicant Name	West Bridgewater MA Endoscopy ASC, LLC
Applicant Address	120 W. Center St. West Bridgewater, MA 02379
Filing Date	October 4, 2024
Type of DoN Application	Ambulatory Surgery
Total Value	\$10,371,384
Project Number	# CEC-24082115-AS
Ten Taxpayer Groups (TTG)	None
Community Health Initiative	\$518,569.20
Staff Recommendation	Approval
Public Health Council	February 15, 2025
<p style="text-align: center;"><b><u>Project Summary and Regulatory Review</u></b></p> <p>West Bridgewater MA Endoscopy ASC, LLC (Applicant) filed a Determination of Need Application (“DoN Application”) for an expansion of service of a freestanding ambulatory surgery center (“ASC”) by adding 2 procedure rooms and associated clinical space, and a transfer of site from 120 West Center Street, West Bridgewater to 3 Washington Place, Easton (“Proposed Project”). The Total Value for the Proposed Project is \$10,371,384.00. The Community Health Initiatives (“CHI”) contribution is \$518,569.20.</p> <p>This DoN Application falls within the definition of Ambulatory Surgery, 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 Determination of Need Factor set forth within 105 CMR 100.210. This staff report addresses each of the six factors set forth in the regulation.</p>	

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## Background and Application Overview

West Bridgewater MA Endoscopy ASC, LLC (the “Applicant” or “W. Bridgewater”), a for-profit Tennessee limited liability company, is a joint venture between Amsurg Holdings, Inc. (“AMSURG”) and Commonwealth Endoscopy Center, Inc. (“CEC”) whereby AMSURG owns 51% and CEC owns 49%. The Applicant is a DPH licensed single specialty ambulatory surgery center (“ASC”) that is certified by Medicare and MassHealth<sup>1</sup>. The Applicant has been performing same day gastrointestinal (GI) surgery since June 1997, and at its current site since 2009; it is eligible to expand through the grandfathering provision of 105 CMR 100.715.<sup>2</sup>

CEC, a physician group practice, is owned by a group of 7 physicians who have provided specialized gastroenterology care to the Southeastern Massachusetts region for over 30 years. In May 2024, 5 additional physicians began performing procedures at the facility, including the 3 “New Physicians” who may obtain a minority interest in the practice; this change will not result in a change in control of the Applicant.

AMSURG jointly owns and manages over 250 ASCs across 34 states; it has 9 centers located in Massachusetts. It focuses on GI, ophthalmology and orthopedic surgery.

### The Proposed Project

Through this Proposed Project, the Applicant is requesting to expand ASC services from two (2) to four (4) procedure rooms and six (6) to twelve (12) pre-and post- operative bays. In order to accomplish this expansion, the Applicant must relocate from 120 West Center Street. The Applicant does not anticipate changes to its Patient Panel because the offices of the referring physicians will not change nor will the site of its partner physician’s practices change.<sup>3</sup>

As described herein, the Applicant states the Proposed Project has been developed to respond to increased need due to (1) the national shift in GI care from hospital-based outpatient departments (“HOPDs”) to ASCs, (2) changes in the incidence of GI diseases and (3) the aging population. Accordingly, the Applicant states that by increasing access within the service area, the Proposed Project will reduce costs for patients, commercial and government payers.

### Patient Panel<sup>4</sup>

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<sup>1</sup> The Applicant’s MassHealth provider contract has been effective since October 8, 2015.

<sup>2</sup> An Expansion, Conversion, Transfer of Ownership, Transfer of Site, or change of designated Location for a Freestanding Ambulatory Surgery Center that received an Original License as a Clinic on or before January 1, 2017. 105 CMR 100.715(B)(2)(a)(iv).

<sup>3</sup> The physicians have a number of consultative practice locations in the primary service area, including 189 Quincy Street, Brockton, MA 02302; 1 Donalds Way, Ste. 203, E. Bridgewater, MA 02333; 35 Summer Street, Taunton, MA.

<sup>4</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.

The Applicant's Patient Panel, shown in Table 1, consists of unique patients who have received care at the Applicant's facility over the last three fiscal years and annualized data for nine months of fiscal year 2024. From FY 2021 and through 2024, the Patient Panel has grown 13.8%.

**Table 1: Overview of Patient Panel- FY21-FY24 (Annualized)**

2021	2022	2023	1-9 2024
#	#	#	Annualized
5,345	5,198	5,868	6,083

Table 2 summarizes elements of the Applicant's demographic profile; there are year over year fluctuations in the reported data, however no significant trends are noted.

**Table 2: Demographic Profile of Patients- CY 21-24 Annualized**

	2021	2022	2023	2024 Annualized
Patient Gender	%	%	%	%
Female	53.0%	51.0%	52.0%	49.0%
Male	47.0%	49.0%	48.0%	51.0%
Patient Age				
0-44	17.9%	15.2%	11.6%	11.4%
45-49	6.6%	10.4%	15.9%	12.7%
50-69	59.7%	58.1%	56.7%	56.7%
70+	15.7%	16.4%	15.8%	19.2%
Race				
American Indian or Alaskan Native, Asian, Native Hawaiian or Pacific Islander, Other	3.1%	3.1%	4.0%	3.5%
Black / African American	3.9%	4.8%	7.6%	6.3%
White	79.5%	86.1%	79.4%	82.7%
Race not reported by patients	13.5%	6.0%	8.9%	7.5%
Ethnicity Total				
Hispanic or Latino	2.4%	2.6%	4.8%	3.2%
Not Hispanic or Latino	63.0%	63.3%	65.9%	75.3%
Ethnicity not reported by patients	34.6%	34.2%	29.3%	21.5%

**Gender:** In 2024, 49% and 51% of the Applicant's patient panel are female and male, respectively. The patient gender mix was relatively stable from 2021-2024.

**Age:** The over half of patients are ages 50-69. The share of 45-49 and 70+ age cohorts show small increases over the reporting period.

**Race:** The Applicant reports that patients predominantly self-identify as white with slight growth in patients identifying as Black and a decrease in number of patients declining to identify.

**Patient Origin:** The Applicant's Primary Service Area consists of the following 16 Massachusetts towns, where 75% of the applicant's 2024 patients reside: Bridgewater, Brockton, East Bridgewater, East Taunton, Hanson, Lakeville, Mansfield, Middleboro, Norton, North Easton, Raynham, South Easton, Stoughton, Taunton, West Bridgewater, and Whitman. The remaining 25% of the Applicant's patients travel from 93 other towns in Massachusetts. (Table 3)

**Table 3: Patient Origin by Town**

Patient Origin	2023	2024 Jan-May annualized
City/Towns	%	%
Taunton	11%	11%
Brockton	13%	10%
Bridgewater	9%	9%
Middleboro	7%	8%
Raynham	6%	6%
East Bridgewater	4%	4%
Lakeville	4%	4%
West Bridgewater	3%	4%
North Easton	2%	3%
Stoughton	2%	3%
Whitman	4%	3%
East Taunton	2%	2%
Norton	2%	2%
South Easton	2%	2%
Hanson	2%	2%
Mansfield	2%	2%
Total PSA Towns (16)	74%	75%
Other Towns	26%	25%
Total Towns (109)	100%	100%

**Payer Mix.** In 2024, 64% of the Applicant's cases were paid by commercial payers, 28% by Medicare, 7% by Medicaid, and 1% by other payers, including VA plans and self-pay. (Table 4)

**Table 4: Payer Mix FY 21-24 January-May**

Payor Type	2021	2022	2023	2024 Jan-May
Commercial	64%	63%	61%	64%
Medicare	28%	28%	28%	28%
Medicaid	7%	8%	11%	7%

Other (incl. VA and Self Pay)	1%	1%	1%	1%
Total	100%	100%	100%	100%

## Factor 1a: Patient Panel Need

The Applicant states the Proposed Project has been developed to respond to increased need for patients to access surgical care in ASCs. The Applicant attributes need for the Proposed Project to the following:

1. The Overall Procedure Volume Growth
2. Increased Incidence of Colon Cancer
3. Growth in the Aging Population
4. Need to Expand Upon the Limited ASC Supply in Massachusetts

### 1. The Overall Procedure Volume Growth at the existing ASC

Table 5 below shows the procedure volume distribution by age and by year since 2019. Staff calculated changes in volume for two time-frames – from 2019 (pre-COVID-19 pandemic) and from 2022 to the Applicant’s annualized 2024 volume.

**Table 5: FY 19-24 Procedures by Age Cohorts**

Age Range	2019		2020		2021		2022		2023		2024 Annualized		Change from 2019	Change from 2022
	#	%	#	%	#	%	#	%	#	%	#	%		
<b>0-44</b>	894	15%	688	16%	1,131	18%	955	16%	792	12%	835	12%	-7%	-13%
<b>45-49</b>	383	6%	241	5%	423	7%	620	10%	1,031	16%	867	13%	126%	40%
<b>50-69</b>	3,805	63%	2,795	63%	3,631	59%	3,440	57%	3,696	56%	3,813	56%	0%	11%
<b>70+</b>	933	16%	690	16%	981	16%	1,005	17%	1,072	16%	1,352	20%	45%	35%
<b>Total</b>	6,015	100%	4,414	100%	6,166	100%	6,020	100%	6,591	100%	6,867	100%	<b>14%</b>	<b>14%</b>

Overall, for both time-frames there was an increase in procedure volume of ~14%. From FY 2022, the largest volume growth, 40% and 35%, occurred in the 45-49 and in the 70+ age cohorts, respectively. The 0-44 age cohort experienced declines over both time periods, while the other age cohort, the 50–69-year-old, regained their pre-pandemic volume.

The Applicant asserts that even before the New Physicians began treating patients at the Applicant’s ASC in early 2024, utilization of the facility was approaching or exceeding 100% capacity. In response to staff inquiry about how the Applicant calculated capacity, the Applicant stated it is based on the following:

- 30-minute time slots per patient;
- 8 minutes for cleaning turnaround time;
- Monday through Friday;

- for 8 hours per day;
- excluding 10 holidays.

As a result of these assumptions, the Applicant determined the maximum booking slots for each room is 3,183 in a year (6,366 for 2 rooms), resulting in the following utilization rate calculations for CY2019 through CY2024, as detailed in Table 6.

**Table 6: Annual Utilization Rates of W. Bridgewater Endoscopy Center**

Calendar Year	Procedures (see Table XX)	Utilization (2 rooms)
CY2019 Actual	6,015	94%
CY2020 Actual	4,414	69%
CY2021 Actual	6,166	97%
CY2022 Actual	6,020	95%
CY2023 Actual	6,591	104%
CY2024 Jan-May annualized	6,867	108%

Table 6 shows the Applicant has been operating at high utilization rates, exceeding 100% in 2023 and 2024. The high utilization has been possible due to higher-than-average efficiency for some physicians and opening the ASC for occasional Saturday procedures to accommodate increased demand. The Applicant asserts it is unable to sustain year-round weekend hours based on staffing limitations. However, upon further staff inquiry about how the expanded facility will be staffed, the Applicant states that it has developed a staffing plan that anticipates the following final complement:

- Nursing: 9 full time equivalents (“FTE”) (current staffing 3.8 FTE)
- Technicians: 6 FTE (current staffing 3 FTE, plus 2 per diem)
- Administrative Staff: 6 FTE (current staffing 4.75 FTE)
- Management: 2 FTE (current staffing 2.6 FTE)

The Applicant asserts that growth in procedural volumes supports the need for this expansion of service by 2 ORs and can be attributed to several factors outlined below.

## **2. Increased Incidence of Colon Cancer**

Colorectal cancer (“CRC”) is the third most common type of cancer diagnosed and the second leading cause of cancer deaths in the U.S.<sup>i</sup> The incidence of colon cancer has been rising in young people since the 1990s. The proportion of cases among those younger than 55 years increased from 11% in 1995 to 20% in 2019. While CRC mortality declined by 2% annually from 2011–2020 overall, it increased by 0.5%–3% annually in all individuals younger than 50 years (regardless of race and/or ethnicity) and in Native Americans younger than 65 years. Early onset patients are also more often diagnosed with advanced disease, including 27% with distant metastases versus 20% of older patients.<sup>ii</sup> A study of symptomatic patients found a 40% longer time to diagnosis among individuals younger than 50 years versus older individuals,

including both longer duration of symptoms and work-up time, often because of misdiagnosis with more common conditions.<sup>iii</sup> To address this trend, in May 2021, the American College of Gastroenterology recommended lowering initial screening for colon cancer from age 50 to age 45.

The Applicant reports that consistently ~50% of all ASC volume, among all age cohorts, is for two procedure codes: Z12.11- *Encounter for screening for malignant neoplasm of colon* (31%), and Z86.010- *Personal history of colonic polyps* (22%). The applicant reports that overall colonoscopy procedure volume increased 21% from 2019 through 2024, and that 56.4% of the colonoscopy growth occurred in the 45-49 age cohort. For this age cohort, colonoscopy procedural growth was 220% from 2019-2024, and 49.4% from 2022-2024.

Across all procedures, the Applicant's volume growth for the 45-49 age cohort is significantly higher than the other cohorts during the two reported time-frames; from 2019-2024 growth was 126%, and from 2022-2024 growth was 40%. Further, this age cohort's annual proportion of all GI procedures has grown relative to the other age cohorts; it increased from 6% in 2019 to 13% in 2024.

### **3. Growth in the Aging Population**

The Proposed Project will allow the Applicant to address the needs of its aging Patient Panel by improving access to outpatient GI procedures in a convenient outpatient setting. As noted above, 68% of the Applicant's Patient Panel is 65 years of age or older. Table 5 shows procedures by age cohort. The 70+ age cohort accounts for approximately 20%, and the 50-69 cohort accounts for 56% of all of the GI procedures performed at the ASC.

UMass Donahue Institute is forecasting significant growth in the aging population in the 16 towns comprising the Applicant's primary service area. The 65 and older population is projected to grow 17% over 5 years, 33% over 10 years, and 44% over 20 years.<sup>iv</sup>

According to Beckers ASC, endoscopic procedures will remain the "cornerstone" of the GI practice due to population demographics, and the continued migration away from HOPDs to convenient, lower-cost ASCs.<sup>v</sup> Market forecaster Sg2 is forecasting higher growth for select procedures, including GI procedures, as procedural volumes shift to lower-cost sites of care. Sg2 is forecasting a 21% 10-year growth in outpatient upper GI endoscopy cases and a 24% 10-year growth in outpatient colonoscopy cases.<sup>vi</sup>

### **4. Need to Expand Upon the Limited ASC Supply in Massachusetts**

The Applicant cites the Health Policy Commission's reports from June 2023 and February 2024 which found that Massachusetts has the fourth lowest per capita number of ASCs of all states, and 23 ASC operating rooms per million population versus a national average of 56.<sup>vii</sup> One reason for this is that Massachusetts enacted restrictions on new ASCs from 1971 to 2017.<sup>viii</sup> The lack of ASCs has resulted in the lower risk ASC appropriate surgeries being provided in HOPDs.<sup>ix</sup>



In Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, the Massachusetts Health Policy Commission (“HPC”) reported limited access to GI procedures in ASCs across the Commonwealth when compared to national averages. According to the HPC Report, there are only 12 single specialty GI/Endoscopy ASCs, and 18 total ASCs offering GI/Endoscopy services in Massachusetts. Massachusetts has 2.6 GI/Endo ASCs per million population, compared to 5.9 Gi/Endo ASCs per million population nationally.<sup>x</sup> The Applicant's ASC is the only free-standing ASC offering GI procedures in Plymouth and Bristol counties according to HPC Report.<sup>5</sup>

The lack of GI ASC resources has been experienced by the Applicant’s physicians and patients who report that wait times for GI procedures in the service area have increased. The Applicant's existing physicians are currently reporting three-week wait times to book GI procedures at both the Applicant's ASC and local community hospitals. The New Physicians have been reporting wait times of 45 to 90 days to schedule GI procedures at local community hospitals. The Applicant is not able to differentiate between wait times for diagnostic versus screening wait times, but if the Applicant receives a referral for a diagnostic, urgent or direct screening exam, scheduling is expedited as much as possible. In the short term, the existing physicians have been sharing their block time to allow the New Physicians to start performing procedures at the Applicant's ASC; also, to try to meet demand, the ASC has opened up some Saturday hours which is not a long-term solution due to staffing concerns.

Staff acknowledges that these wait times do not appear to be exceedingly long however, with the increased incidence of colon cancers described herein, the Applicant is proactively creating capacity to meet the need in the clinically appropriate setting. The United States has not established any industry standards or national benchmarks for acceptable wait times for endoscopy services and it has been shown to outperform other nations in terms of rates for screening for colorectal cancer.<sup>xi</sup> Studies show that longer wait times are associated with increased patient anxiety, lower overall patient satisfaction and patient perceptions of their providers and quality of care.<sup>xii</sup>

The Applicant states that access to GI procedures within the service area has been challenged by the significant service disruptions at the three community hospitals, including the Steward Health System bankruptcy (affecting Morton Hospital and Good Samaritan Hospital), and the fire at Signature Brockton Hospital. In follow up questions, the Applicant states that even with the resumption of operations at Brockton Hospital and the new ownership at the Steward hospitals, the physicians continue to experience high demand for GI ASC services in part because “...patients appreciate the ease of access and the lower out of pocket costs at a freestanding ASC compared to an HOPD.” Moving more GI procedures to an ASC setting will enable the community hospitals to focus their limited resources on higher acuity GI procedures.

The Applicant believes that an expanded ASC will better serve the current patient needs and be positioned to meet the future patient needs. Accordingly, they believe that the Proposed

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<sup>5</sup> Staff compared the PSA of this Proposed Project with that of the approved but not yet operational Weymouth Endoscopy Center and found that they do not overlap.

Project will benefit both the ASC's existing patient panel as well as the New Physicians' patient panel.

## Projections

As indicated above, historical volume trends indicate utilization rates at and above capacity for the GI procedures provided by the Applicant's ORs. The physicians who perform procedures at the Applicant's ASC also perform procedures at local community hospitals.

If the ASC expansion is approved, the year 1 (2025) growth for existing physicians is projected to be ~10% over the current annualized 2024 volume (see Table 6). This accounts for the shift in ASC eligible procedures currently being performed at HOPDs. For the New Physicians, year 1 volume is based on New Physicians' evaluation of current cases that would be eligible for an ASC setting. The Applicant forecasts that ~40% of future case volume at the new expanded Facility will originate from the New Physicians.

Following the initial year one shift in ASC eligible procedures, the Applicant has applied a year-over-year 3% growth rate to both existing and New Physicians cases to reflect demographic trends, and the market shift to outpatient GI procedures. (Table 7).

**Table 7: 5-year Volume Projections**

Physician Cases	2025 (4 ORs)	2026 (4 ORs)	2027 (4 ORs)	2028 (4 ORs)	2029 (4 ORs)
Existing Physicians Cases	7,595	7,823	8,058	8,300	8,548
Existing Physicians Annual Growth %		3%	3%	3%	3%
New Physicians Cases	4,505	4,641	4,780	4,923	5,071
New Physicians Cases Annual Growth %		3%	3%	3%	3%
Total Cases	12,101	12,464	12,838	13,223	13,619
Total Cases Annual Growth %	64%	3%	3%	3%	3%

## Analysis

Based on the Applicant's calculation that 6,366 procedures is the total capacity with 2 ORs, capacity will double and therefore 100% capacity would be reached at 12,732 procedures, which according to the Applicant's projections, it will exceed that by 2027. The Applicant has demonstrated that need exists for the Proposed Project since it is currently operating at 100% capacity. Two new operating rooms are needed to address the current overall procedure growth, increased incidence of colon cancer, growth in the aging population, and the need to expand upon the limited ASC supply in Massachusetts and the service area; as stated (under #4 of Need) the Applicant is the only ASC in the service area. To address the need, the Applicant has added five physicians who are experiencing delays in OR scheduling at either this ASC or HOPDs due to the lack availability, other than the Applicant's two ORs, in the region.

The Applicant's projections of 3% annual growth appear reasonable given the need for increased screening capacity and market forecasts.

### **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 Applicant states the expanded capacity will accommodate the growth in demand within the Patient Panel and will increase the Facility's ability to offer accessible, lower-cost and high-quality GI procedures. Therefore, by increasing the number of booking slots, for this diagnostic screening and treatment modality, more cancers will be either ruled out or detected early and the public's health will benefit.

#### **Clinical Benefits of ASC GI Services**

Endoscopy is a minimally invasive tool used for screening, diagnostic and treatment purposes.<sup>6</sup> The technology allows specialists to view and operate on the patient's internal organs without requiring the patient to experience the more invasive aspects of conventional surgery such as large incisions and long recovery times. Endoscopy is also used as a diagnostic tool to evaluate stomach pain, ulcers, gastritis, and polyps or growths in the colon.<sup>xiii</sup> As a diagnostic tool, endoscopy of the upper digestive system has been shown to be more effective than x-rays at detecting abnormal growths, including cancer.<sup>xiv</sup>

National statistics indicate that CRC is the second most common cause of death due to cancer in the United States when numbers for men and women are combined.<sup>xv</sup> In 2024, CRC is expected to cause about 53,010 deaths.<sup>xvi</sup> The American Cancer Society (ACS) expects about 106,590 new cases of colon cancer and about 46,220 new cases of rectal cancer in 2024.<sup>xvii</sup> While the incidence of cancer has historically been higher in adults aged 50 and older, the cancer incidence of various organs in patients younger than age 50 has risen; this is known as early-onset cancer.<sup>xviii</sup> As previously noted, in recognition of rising incidence of CRC in younger populations, the United States Preventive Services Task Force (USPSTF) and ACS recommend that CRC screenings begin at age 45 (previously, screening was recommended for those ages

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<sup>6</sup> Endoscopy is a non-invasive procedure, that examines a patient's digestive tract using a flexible tube with a light and a camera.

50-75 years).<sup>xix</sup> High-risk patients are advised to begin screening before age 45.<sup>xx, 7</sup> Additionally, the USPSTF continues to recommend selectively screening adults aged 76 to 85 years for CRC.<sup>xxi</sup>

Colonoscopy is the preferred method for screening because the exam is not just a means of cancer detection, it is a mode of treatment; when polyps (abnormal growths that could become cancer) are found they can be excised during the exam (the tissue is sent to be assessed for malignancy in a clinical laboratory). Therefore, colonoscopy can reduce risk of death from cancer through detection of tumors at an earlier, more treatable stage.<sup>xxii</sup> Once an adenoma has been detected, patients need more frequent follow-up colonoscopies, within three to seven years.<sup>xxiii</sup>

Other tests for CRC include at home test kits, such as Cologuard, which may provide preliminary screening for patients who might not otherwise have sought screening. However, these test kits, are not a replacement for a colonoscopy. One citation states colonoscopies can detect 95% of large polyps while Cologuard can detect 42%, and while colonoscopy can detect and treat some cancers early before they develop, it can also help prevent cancer through biopsies and polyp removal, whereas Cologuard tests can only detect some polyps and it cannot prevent cancer since there is no ability to simultaneously excise and biopsy polyps.<sup>xxiv, xxv</sup>

### **Public Health Value/Outcome-Oriented**

Health outcomes studies have shown that patients who underwent an outpatient procedure in an ASC were less likely to visit an ER or be admitted to the hospital than those treated in an HOPD, and that patients at all risk levels had improved health outcomes.<sup>xxvi, xxvii</sup> Finally, ASC patients experience improved pain levels, less nausea, and better 30-day outcomes when receiving surgery versus a hospital setting.

### **Quality Tracking**

The Applicant will continue to implement quality metric tracking to measure and ensure high levels of patient satisfaction and quality of care. AMSURG's national portfolio of 250+ ASCs allows it to establish baseline rates to ensure all centers meet or exceed expectations related to health outcomes, quality of life, and health equity. It is accredited by the Association of Ambulatory Health Care ("AAHC") and will pursue accreditation for the new site as well. AMSURG's risk management department reviews all events submitted in the event reporting platform and determines the need for a root cause analysis ("RCA") to analyze serious adverse events. When deemed necessary an RCA is performed by risk management to investigate gaps in processes, identify contributing factors, develop corrective action plans to prevent reoccurrence and define outcome measures that provides a target for success. Each center

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<sup>7</sup> Patients who have a history of CRC or polyps; a first-degree family member with CRC or advanced polyps (those that would have gone on to become CRC if they had not been removed); a family history of certain genetic syndromes; or a history of inflammatory bowel disease (like Crohn's disease or ulcerative colitis) are some examples of high-risk factors.

maintains a Quality Assurance Performance Improvement (“QAPI”) committee, where risk management is linked operationally to maximize patient, staff, and visitor safety. The QAPI committee serves as the oversight committee for risk management and safety. Risk management and safety reports are presented to the QAPI committee on an ongoing basis. The Facility maintains a Governing Board, which has the ultimate authority and accountability for the QAPI program.

To assess the impact of the Proposed Project, the Applicant developed quality metrics and a reporting schematic, as well as goals for quality indicators that will measure patient satisfaction and quality of care. The measures are discussed in Appendix 1.

### **Public Health Value: Health Equity-Focused**

The Applicant affirms its commitment to promoting health equity and equal access for all patients, including underserved populations. The Applicant states it will ensure its commitment in several ways.

1. The Applicant states it does not engage in discrimination based on a patient’s ability to pay for services or the patient’s insurance. The Applicant currently receives referrals for GI procedures from primary care physicians (“PCPs”) across its service area, including PCPs at Manet Community Health Center in Taunton as well as Brockton Neighborhood Center which historically have provided care to underserved populations.

The HPC’s research shows that ASCs in the Commonwealth are less frequently utilized by MassHealth patients than commercial patients, and more research is needed to understand and address drivers of this difference.<sup>xxviii</sup> The Applicant states it will continue to work with existing and New Physicians as well as referring PCPs to promote access to the ASC for MassHealth patients and mitigate patients’ barriers to access thereby promoting health equity.

2. The Applicant asserts it does not discriminate based on patients’ physical ability, sensory or speech limitations, or religious, spiritual, and cultural beliefs. Additionally, the Applicant does not discriminate based on gender, race, religion, sexual orientation, disability status, financial situation, or any other status protected by law.

3. The Applicant engages in cultural competency training for all staff and physicians. Within 30 days of the start date and annually thereafter staff complete training on care delivery that is culturally and age specific. The applicant states that all staff had completed their training by October 31, 2024.

4. The Applicant adds it is currently exploring transportation options with Uber Health to be able to provide improved access for patients who are unable to secure travel to or from their procedures based on financial or other barriers. Currently, because all of the procedures performed at the Facility require anesthesia, public transportation is not a viable option, and patients must rely on a friend or relative to transport them home following their procedures.

5. The Applicant states it provides access to interpreter services and continues to explore options to improve this access to mitigate language barriers but does not track the number of translation services provided (as part of proposed post-DoN Approval reporting, the Applicant will be required to provide this information)

### ***Analysis***

As described throughout the application, the Proposed Project will increase access to high quality, lower cost GI care in the service area. This expands patient access to quality care. This also allows cases to move from HOPDs to ASCs, allowing Hospitals to have shorter wait times for more complex and inpatient cases.

The need to increase access to lower cost GI procedures is supported by the HPC findings from an analysis of the CHIA 2019 Massachusetts Health Insurance Survey, which indicates that among Massachusetts commercially insured patients with lower incomes, 59.3% had trouble accessing care due to cost; and that lower-income residents disproportionately forgo needed care.<sup>xxix</sup>

The Applicant provided several measures to track 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 and health equity for the Patient Panel.

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

The Applicant attributes clinical efficiencies to its highly trained staff, and operational efficiencies to the partnership with AMSURG, an experienced ASC management company. The Applicant states the Proposed Project will operate efficiently and effectively through continuation of the Applicant's existing processes. The Applicant's patients are referred to the GI specialists by their PCPs if they are either symptomatic or need to schedule routine screening. The GI Specialists then schedule procedures at the Applicant's ASC or an HOPD. The Applicant provides patients with findings from the procedure and next steps prior to discharge and also faxes procedural operative notes to the patient's PCP on the day of the procedure. The GI specialist follows up with the patient following each procedure to ensure there are no post-procedure complications and to discuss if additional care is needed based on findings from the procedure. The Applicant has a recall system that schedules patients' follow-up at the proper intervals based on their GI specialist's recommendations.

The Applicant reports that patients have provided feedback indicating the patient flow process from booking all the way through to the completion of the procedure is much smoother and

quicker than they have experienced at other facilities; it plans to continue to engage in close collaboration among patients' PCPs and GI specialists following completion of the Proposed Project.

Upon completion of the Project, the Applicant intends to upgrade to a new version of a system called Provation APEX. The updated Provation APEX system is 98% paperless. It is a web-based portal that will allow physicians greater access to system, as well as better security safeguards and includes the following features that will contribute to improved efficiencies and coordination of care:

- Ability to collect health information from patients prior to visit, which are incorporated into nursing notes before the patients arrive for their appointment, and allow staff to screen for patients who require a higher acuity setting;
- Ability to track patients from arrival through discharge;
- Ability to collect and report patient demographics such as race and ethnicity information for each patient.
- Ability to create discharge letters printed for patients to take home.
- Ability to communicate the patient reports with the patient's PCP once completed by the physician creating the report;
- Ability to generate pathology letters to patients;
- Automatic Coding upgrades to stay current so there is no need to wait for upgrades for accurate coding.

### ***Analysis***

Consistent with reporting in the literature, clinical efficiencies have been attributed to highly trained staff. 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> While the Applicant's EHR cannot be integrated with PCP offices, a strong referral base and positive patient feedback, and accreditation reflect a history of satisfaction that the Applicant believes has led to its current high utilization. .

Staff has reviewed the information provided and concurs that the Proposed Project will likely improve efficiencies with the additional capacity and upgraded EHR system.

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

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

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

The Department's Guideline<sup>xxx</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>xxxi</sup>

The Applicant engaged patients and members of the community at 2 community meetings, held on July 11, 2024 and July 15, 2024 to ensure sound community engagement and consultation throughout the development of the Proposed Project.

The first session was held virtually via Zoom on July 11, 2024, with 10 attendees at the Town of Easton Economic Development Council meeting, The second was held on July 15, 2024 at an in-person Board meeting at the Easton Town Offices with 15 in-person attendees and additional virtual attendees.

Prior to the meetings, Notices were emailed to patients and posted on the Applicant's website. Additionally, the Town of Easton publicized the meetings and agendas on its website. At the meetings, the Applicant provided information on the Proposed Project and the benefits of ambulatory surgery centers and solicited feedback from participants. All participants at the two community meetings expressed overwhelming favor of the Proposed Project and appreciation to have the Applicant expanding and relocating its ASC services to Easton.

### ***Analysis***

Staff reviewed the information on 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 asserts the Proposed Project will have a positive impact on competition in the Massachusetts healthcare market based on price and total medical expense since the ASC is a lower cost alternative to outpatient GI procedures performed in an HOPD. ASCs are able to achieve this lower cost due to significantly lower overhead costs as compared to HOPD's. By expanding the capacity of the ASC, more patients in the primary service area will be able to utilize an ASC for GI procedures.



The Applicant provided the information in Table 8 for comparing Medicare costs at an ASC vs. HOPD for the top five (5) procedures performed at the Applicant's ASC.<sup>8</sup> Under the heading “Cost Variance”, the table shows the significant out of pocket savings for patients when using an ASC versus an HOPD; likewise, it shows significant savings for Medicare in payments to the provider in the ASC versus an HOPD.

Procedure	ASC Costs		HOPD Costs		Cost Variance- Savings	
	Total	Patient	Total	Patient	Total	Patient
45385- Lesion Removal Colonoscopy	\$857.00	\$171.00	\$13,690.00	\$273.00	\$12,833	\$102.00
43239- Upper GI Endoscopy, Biopsy	\$604.00	\$120.00	\$997.00	\$198.00	\$393.00	\$78.00
45380 - Coloscopy and Biopsy	\$805.00	\$160.00	\$1,317.00	\$262.00	\$512.00	\$102.00
G0121 - Colon Cancer Screening; not high risk	\$652.00	\$0.00	\$1,048.00	\$0.00	\$396.00	\$0.00
G0105 - Colon Cancer Screening; high risk individual	\$652.00	\$0.00	\$1,048.00	\$0.00	\$396.00	\$0.00

Overall payments to ASCs are lower for the same procedures as hospitals. For example, Medicare pays ASCs 55% percent of what it pays hospitals for the same surgery.<sup>xxxii</sup> On average, the total cost of a colonoscopy (flexible with biopsy) is 41% less at an ASC as compared to an HOPD, and the total cost of a small intestinal endoscopy is 52% less at an ASC.<sup>xxxiii</sup> MassHealth prices are also generally far lower in ASCs than in HOPDs with the difference in total price coming from lower facility prices in ASCs since MassHealth pays the same rate for professional services in ASCs and HOPDs.

Lower ASC prices typically result in lower patient cost sharing for patients. For example, the average commercial cost sharing for a colonoscopy with polyp removal was roughly 12% lower in an ASC.<sup>xxxiv</sup> While MassHealth patients pay minimal cost sharing regardless of setting, the Commonwealth still benefits from reduced facility prices.<sup>xxxv</sup>

Combined with the convenience offered by ASCs, the lower out of pocket costs may encourage more patients to seek the types of preventative services offered by the Facility, which the Applicant states will result in lower costs for the Commonwealth, as earlier detection of cancer and other illnesses results in better patient outcomes and fewer deaths and reduces overall health care costs in the long term.<sup>xxxvi</sup>

## Analysis

Consistent with the findings of the HPC’s 2024 Report: Trends in ASCs in Massachusetts<sup>xxxvii</sup> and 2023 Cost Trends Report<sup>xxxviii</sup> and DPH’s 2017 changes to the DoN Program<sup>xxxix</sup>, the Proposed Project will compete based on price, total medical expense (“TME”), provider costs, and other

<sup>8</sup> according to the Medicare Procedure Price Lookup at <https://www.medicare.gov/procedure-price-lookup/>.

recognized measures of health care spending because it will provide a lower cost alternative to higher cost HOPDs for the same surgical procedures.<sup>xi</sup>

Staff finds the Proposed Project has the potential to reduce healthcare costs through expansion of its services at a lower cost ASC site. The Applicant provided data demonstrating cost savings that can result from surgeries performed in the ASC versus the HOPD. Additionally, it has outlined savings that can occur for all payers and patients through increasing access to services in an efficient cost-effective setting and reducing wait-times. Staff finds that the Proposed Project will likely compete on the basis of price, TME provider costs, and other measures of health care spending and therefore, the requirements of Factor 1f have been met.

### **FACTOR 1 Summary Analysis**

As a result of information provided by the Applicant and additional analysis, staff finds that with the “Other Conditions” outlined below and the standard reporting requirements, the Applicant has demonstrated that the Proposed Project has met Factor 1(a-f).

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

### **Cost Containment**

The Applicant cited the HPCs goals for cost containment in Massachusetts. As stated on the mass.gov website, "The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform...The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth." The HPC continues to monitor performance toward this goal and at the HPC Board meeting on June 7, 2023, the Board included the following finding in its Selected Preliminary Findings from Cost Trends Report Chapters: Massachusetts has fewer than half as many ASCs as the average state; the same surgeries are typically paid 50-100% more when taking place in HOPDs.<sup>xli</sup>

Aligning with these goals, the Applicant asserts the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment by increasing access to high-quality care in a lower-cost setting. As discussed under Factor 1(f), procedures occurring in an ASC bill less and are reimbursed at lower rates in comparison to HOPDs or inpatient settings.<sup>xlii</sup>  
<sup>xliii</sup> By adding more procedure room capacity, the Proposed Project will allow more cases to be moved from the inpatient or HOPD settings to an ASC thereby contributing to healthcare cost containment. According to the Ambulatory Surgical Center Association (“ASCA”), patients choosing to have surgeries at ASCs could result in up to \$42.2 billion in savings across the healthcare industry.<sup>xliv</sup>

Also as discussed in Factor 1(f), because of ASCs' lower pricing, out-of-pocket expenses for patients are lower, and therefore the Applicant asserts more patients are likely to seek the types of effective preventative services offered by the Facility. This in turn will result in lower costs for the Commonwealth, as earlier detection of cancer and other illnesses results in better patient outcomes and fewer deaths and reduces overall health care costs in the long term.<sup>xlv</sup>

## **Public Health Outcomes**

The Proposed Project will improve public health outcomes in several ways: by improving access to care in the ASC setting, by doubling the number of patients it can treat, by providing care in a more affordable setting, and by expanding its reporting to the GI Quality Improvement Consortium.

The doubling of capacity through the Proposed Project will provide improved access and reduce wait times for needed gastrointestinal care in a more convenient setting. As noted throughout the Application, cost is an important factor in patients' ability to access high quality care. "In 2023, 27% of American adults skipped some form of medical treatment because they couldn't afford it, according to the Federal Reserve. This is lower than the 32% who avoided care in 2013, when data collection began, but ties with 2015 and 2017 as the fourth-highest year on record."<sup>xlvi</sup> By allowing increased access to high quality care with lower patient cost-sharing obligations, the Proposed Project will result in additional patients obtaining potentially life-saving screening including screening endoscopies to detect colorectal cancer.<sup>xlvii</sup>

The Facility utilizes GI Quality Improvement Consortium, Ltd ("GIQuIC"), a medical registry designed to collect, organize, and display data for the purpose of improving patient outcomes through benchmarking, identifying gaps in care, and developing specific and targeted quality improvement initiatives. The GIQuIC performance measures include adenoma detection rate, age-appropriate screening, colonoscopy, and appropriate follow up intervals based on colonoscopy findings.

## **Delivery System Transformation**

Throughout the Application, the Applicant has described current efforts and systems in place that are intended to promote equity, access, continuity and coordination of care; the applicant states its intension to expand and shore up these efforts with the New Physicians as the Patient Panel is expanded following the implementation of the Proposed Project, if approved. One initiative is to serve more patients by strengthening relationships with the aforementioned community health centers. Further, the Applicant states that with implementation of the Proposed Project, it will continue to work with patients and primary care providers from the initial intake through procedure follow-up to identify SDOH needs.

## **Analysis**

The Applicant through the proposed project, has appropriately considered cost quality and access and their impact on public health outcomes. As a result of information provided by the Applicant and additional analysis, staff finds that with the “Other Conditions” outlined below and the standard reporting conditions, the Applicant demonstrated that the Proposed Project has met Factor 2.

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

The Applicant 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 CPA reviewed the following information:

1. West Bridgewater MA Endoscopy ASC, LLC’s 5-Year Projected Financial Statements, and Assumptions, initially received from Management on July 10, 2024 with supporting documentation;
2. Three years of West Bridgewater MA Endoscopy ASC, LLC’s balance sheets and income statements;
3. West Bridgewater GI relocation and expansion presented by AMSURG to the AMSURG Board of Directors, prepared as of March 28, 2024;
4. Relevant Regulations and guidance documents from CMS, DPG and other;
5. Industry marketing and forecasting materials (e.g. Becker’s ASC, <https://www.beckersasc.com>, Intellimarker™ - by VMG Health, ASC benchmarking study, Gastrointestinal Specialists website <https://gisdoc.com>.);
6. AMSURG website <https://amsurg.com>.
7. Key Financial Metrics.<sup>9</sup>

### **Revenues**

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<sup>9</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.

In order to determine the reasonableness of the projected revenues, the CPA reviewed the underlying assumptions upon which Management relied. Since the new location is in the same patient service area, the payer-mix, and reimbursement was based upon the historic mix and payments from all payers, including Medicare, Medicaid and commercial insurance payments. The reasonableness of the projected volume was based on the Applicants historical data of services at the current location; then it created a utilization table, using what the CPA identified as conservative estimates of the volume taking into account benchmark data for the procedure room average minutes to arrive at year 1 (2026) cases and procedures with 3% annual growth projection through 2030. The CPA compared the Applicant's benchmark data to an outside, independent survey of ASCs<sup>10</sup> and found that the Applicant's benchmark data used was reasonable, and that the number of projected cases and procedures per procedure room in 2030 (year 5) were within the ranges of currently operating ambulatory surgery centers included in the independent survey.

To determine the reasonableness of using the actual payer mix for the twelve months ended February 2024 in the projections, the CPA utilized the Gastrointestinal Specialists' Productivity Analysis for the calendar year ended December 2023 which provided units, charges and payments by the various payers and compared this to the independent survey's payer mix for the Northeast and found them to be within the range. The CPA used a comparable method to test the reimbursement rates to the Applicant and determined it to be similar.

The CPA concluded that based upon its analysis, the revenue projected by Management reflects a reasonable estimation of future revenues of the Center.

## **Expenses**

The operating expenses in the analysis include salaries and benefits, medical supplies, facility rent, management fees, other operating expenses, and depreciation and amortization.

Actual Salaries were converted to a per case amount and then multiplied by the total cases for each of the projection years, and then inflated by 3% each year. Benefits were increased each year based on the actual benefits to salaries ratio from the previous twelve months ended February 2024. Salaries and Benefits amounts were compared to the Survey and were found to be consistent.

Medical Surgical Supplies and Other Expenses included in the projections were also compared to the Survey and found to be consistent with the Survey's ranges. These were also projected to increase 3% per year after the baseline year, 2026.

The CPA concluded that the forecasted operating expenses are based on reasonable assumptions and are feasible for the Applicant.

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<sup>10</sup> completed using 2021-2022 data (the latest study)

## **Capital Expenditures and Cash Flows**

The CPA reviewed the lease terms, the projected capital expenditures and the future cash flows of the Applicant in order to determine whether sufficient funds would be available to support the lease of new site, payment of the financed construction and equipment debt service and whether the cash flow would be able to support the continued operations. The Applicant has reported lease payments as rent expense as incurred which would impact the debt to capitalization ratio.

The CPA determined that the pro-forma capital expenditures, facility lease, terms of construction, equipment and working capital financing and the resulting impact on the cash flows of the Applicant are reasonable.

The CPA determined that the prospective capital requirements and resulting impact on the cash flows are reasonable.

## **Conclusion**

Following the CPA's review of the aforementioned documents and analysis of the financial projections, it determined the project and continued operating surplus are reasonable and are based upon feasible financial assumptions. Therefore, it 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 West Bridgewater MA Endoscopy ASC, LLC.

## **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**

The Applicant has provided sufficient evidence that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs identified by the Applicant pursuant to 105 CMR 100.210(A)(1). Evaluation of 105 CMR 100.210(A)(5) shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

The Applicant asserts it selected the Proposed Project after considering several alternatives including doing nothing, expansion at the current location, and evaluating 4 alternate sites. As described below, it determined that the Proposed Project is the superior alternative for meeting the existing patient panel needs identified. The Proposed Project seeks to increase access by adding 2 additional procedure rooms in order to serve more patients. As an

accredited ASC<sup>11</sup> the quality will remain high, and efficiencies may improve as patient throughput increases thereby decreasing staff scheduling pressures. The Applicant states that based on Amsurg's management experience with other ASC's, the Proposed Project will result in appropriate capital expenditures for the construction of an ambulatory surgery center while incremental operating expenses are anticipated to be \$3,304,293.00 in year 1 of operation.

**Alternative Proposal #1** Maintain current 2 procedure room ASC at the current location. This alternative is not a viable solution because the current ASC is operating at 100% capacity, Monday to Friday, 8 hours per day. With the addition of the New Physicians to address patients' needs, the number of booking slots cannot be expanded to meet the need. Efforts to expand operating hours to Saturdays have been unsuccessful in the past due to nursing and anesthesia staffing challenges. With this option, quality and efficiency would remain the same, and operating costs would only increase incrementally for staffing and supplies, if extended operating hours were feasible.

**Alternative Proposal #2:** Efforts to expand the ASC from 2 procedure rooms to 4 procedure rooms at current site were not possible within the current building configuration. The Applicant was not able to lease adjacent space in its current location.

**Alternative Proposal #3:** Expand from 2 procedure rooms to 4 procedure rooms at a different site in West Bridgewater, Bridgewater or Brockton. The Applicant asserts it explored four other alternate sites for expansion which were not acceptable for various reasons including: 1) one was on second floor with no elevator consequently worsening patient access; 2) another had no water supply or direct access thereby negatively impacting cost, quality and access; 3) the building management company did not want an ASC in the building; and 4) a former bank space which was not suitable for ASC and would require significant increased costs associated with construction and the inability to remove a large vault in the space.

### ***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: Community-based Health Initiatives**

Since this is a DoN project for a freestanding ASC that is not affiliated with a hospital, the proposed project does not require the submission of CHI forms. West Bridgewater MA Endoscopy ASC, LLC will fulfill Factor 6 requirements by directing their full CHI contribution to the Statewide Community Health and Healthy Aging Funds (CHHAF).

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<sup>11</sup> by the Association of Ambulatory Health Care (AAHC) and plans to pursue accreditation for the new site as well

With fulfillment of the below conditions, the Applicant will have demonstrated that the Proposed Project has met Factor 6.

## Findings and Recommendations

Based upon a review of the materials submitted, Staff finds that with the “Other Conditions” 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. The total required CHI contribution of \$518,569.20 will be directed to the Massachusetts Statewide CHHAF and will be paid by West Bridgewater MA Endoscopy ASC, LLC in two installments of \$259,284.60. 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 #: CEC-24082115-AS
2. The first payment of \$259,284.60 will be due to HRiA **within 30 days** from the date of the Notice of Approval. The second installment is due to HRiA within 1 year of the Notice of Approval date.  
Please send a PDF image of the check or **confirmation of payment** to [DONCHI@Mass.gov](mailto:DONCHI@Mass.gov) and [dongrants@hria.org](mailto:dongrants@hria.org)
2. In addition to West Bridgewater Endoscopy’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. In order to support equitable access to services, the Holder will report on annual efforts to promote health equity, including at Manet Community Health Center in Taunton and Brockton Neighborhood Center, and efforts to advance the provision of culturally and linguistically appropriate services at the ASC. The annual report will discuss specific programs in place, efforts to improve linkages to referral partners, including timeframe of implementation, patients served, and impact.
4. The Holder shall report on endoscopy volumes stratified by age, by race and ethnicity, and by payer mix.



5. The Holder shall report on wait times for scheduling surgical procedures differentiating between screening and diagnostic procedures. The Holder shall provide a description of how wait time is calculated.

## 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:

All measures will be reported on an annual basis following the first year of the Proposed Project's implementation. The measures are discussed below:

**1. Measure:** The Outpatient & Ambulatory Surgery Community Assessment of Healthcare Providers and Systems (OAS-CAHPS) survey will be provided to all eligible patients through a partnership the Applicant will maintain with Press Ganey. The OAS-CAHPS survey focuses on the following areas:

- Preparation for the surgery or procedure;
- Check-in and pre-operative processes;
- Cleanliness of the surgery facility;
- The surgery facility staff;
- Discharge from the facility;
- Preparation for recovering at home;
- Communication; and
- Overall experience and recommendation.

**Monitoring:** Reports provided by Press Ganey will be reviewed at quarterly QAPI meetings as well as Applicant board meetings. Areas for improvement based on scores will be analyzed with changes in policy and practice implemented as necessary. The Applicant will monitor improvements accordingly.

**2. Infection Rates:** Infections at the Facility are detected through surveillance (i.e. reports received from physician, patient, or any other sources of information which confirms post-operative infection). Infections are captured by submission to AMSURG's risk management event reporting platform. The intent is to reduce the number of admissions (patients) who experience infections at the Facility. AMSURG utilizes an internal dashboard to track and trend post operative infection rates per center and benchmarks rates as compared to the Ambulatory Surgery Center Quality Collaboration ("ASCQC").

**Measure:** The number of admissions (patients) with infections.

**Projections:** The Applicant sets quarterly targets and compares performance to AmSurg Benchmarks.

**Monitoring:** By participating in the ASCQC, AMSURG and the Applicant have the ability to measure, track, and benchmark clinical outcome metrics with other ASCs to improve quality and enhance patient safety. Events are reviewed on a routine basis, trends noted are assessed, and performance improvement plans implemented.

**2. Fall rates:** Falls are captured by Facility submission via AMSURG's risk management event reporting platform. The intent is to reduce the number of admissions (patients) who experience a fall within the Facility. AMSURG utilizes an internal dashboard to track, and trend falls that occur in the ASC and benchmark rates as compared to the ASCQC.

**Measure:** The number of admissions (patients) who experience a fall within the Facility.

**Projections:** The Applicant sets quarterly targets and compares performance to AmSurg Benchmarks.

**Monitoring:** Debrief huddles are performed in the Facility immediately following a fall. Events are reviewed on a routine basis, trends noted are assessed, and performance improvement plans implemented.

**3. Other Metrics:** In addition to infections and falls, AMSURG tracks burns, wrongs (that is all ASC admissions experiencing a wrong site, wrong side, wrong patient, wrong procedure or wrong implant (including wrong device or lens)), hospital transfers, medication variances, unplanned anterior vitrectomy, normothermia, colon perforations, adenoma detection, scope reprocessing issues, serious safety events, mortality rate, as well as incident reporting rates per applicable center. These measures are tracked and trended via AMSURG's internal dashboard and where an ASCQC benchmark is available are compared to those national benchmarks for quality improvement. ASCQC benchmarks are available for burns, falls, wrongs, hospital transfers, infections, medication variances, unplanned anterior vitrectomy, and normothermia. Where the national ASCQC benchmark is not available, AMSURG tracks center variances and implements performance improvement plans.

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<sup>i</sup> Islami F, Goding Sauer A, Miller KD, et al. Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States. *CA Cancer J Clin*. 2018; 68(1): 31-54. doi:[10.3322/caac.21440](https://doi.org/10.3322/caac.21440)

<sup>ii</sup> *id*

<sup>iii</sup> Chen FW, Sundaram V, Chew TA, Ladabaum U. Advanced-stage colorectal cancer in persons younger than 50 years not associated with longer duration of symptoms or time to diagnosis. *Clin Gastroenterol Hepatol*. 2017; 15(5): 728-737.e3. doi:[10.1016/j.cgh.2016.10.038](https://doi.org/10.1016/j.cgh.2016.10.038)

<sup>iv</sup> Source: [UMass Donahue Institute Massachusetts population projections](https://www.pep.donahue-institute.org/) updated May 2024. accessed at <http://www.pep.donahue-institute.org/>

<sup>v</sup> <https://www.beckersasc.com/gastroenterology-and-endoscopy/gastroenterology-in-2030-what-the-specialty-will-look-like-in-10-years.html> Gastroenterology in 2030: What the specialty will look like in 10 years...Updated Friday, December 20th, 2019, accessed July 2024

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- <sup>vi</sup> Sg2 2023 Impact of Change Forecast Highlights, page 13, viewed at <https://www.ascfocus.org/ascfocus/content/articles-content/articles/2023/digital-debut/sg2-2023-annual-report-forecasts-significant-growth-in-asc-volume> accessed July 2024
- <sup>vii</sup> HPC DataPoints, Issue 26: Trends in Ambulatory Surgical Centers in Massachusetts, MASS. HEALTH POLICY COMM. (Hereafter “HPC”) (Feb. 15, 2024) (<https://www.mass.gov/info-details/hpc-datapoints-issue-26>) (updating the June 2023 findings that Massachusetts has the six fewest ASCs per capita among all states), and HPC Board Meeting 27, HPC (June 07, 2023) (<https://www.mass.gov/doc/presentation-board-meeting-june-7-2023/download>).
- <sup>viii</sup> *Supra*, note 5 HPC Board Meeting; See also, *Proposed Revisions of the Determination of Need Regulations 105 CMR 100.100*, MASS. DPH (Aug. 23, 2016) (available at <https://www.mintz.com/sites/default/files/viewpoints/orig/8/2016/08/Proposed-Revision-Presentation-8.23.16.pdf>); See also, JAY YOUMANS, ET AL., FINAL PROPOSED REVISIONS OF 105 CMR 100.00: DETERMINATION OF NEED MEMORANDUM (Jan. 11, 2017) (available at <https://www.mintz.com/sites/default/files/viewpoints/orig/8/2017/01/DPH-Final-PHC-Memo-Determination-of-Need-105-CMR-100.000-FINAL-1-11-17.pdf>).
- <sup>ix</sup> *Supra*, note 5 HPC Board Meeting.
- <sup>x</sup> <https://masshpc.gov/publications/datapoints-series/issue-26-trends-ambulatory-surgical-centers-massachusetts> accessed July 2024.
- <sup>xi</sup> The Commonwealth Fund, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcome* (January 31, 2023), available at <https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022>.
- <sup>xii</sup> Megan A. Adams et. al, *Trends in Wait Time for Outpatient Colonoscopy in the Veterans Health Administration, 2008-2015*, J Gen Intern Med 35(6):1776-82 (Published Online March 24, 2020), available at [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7280466/#:~:text=At%20the%20facility%20with%20the,26%20days%2C%20respectively\).](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7280466/#:~:text=At%20the%20facility%20with%20the,26%20days%2C%20respectively).)
- <sup>xiii</sup> *Colorectal Cancer Screening*, AM. SOC’Y FOR GASTROINTESTINAL ENDOSCOPY, <https://www.asge.org/home/about-asge/newsroom/media-backgrounders-detail/colorectal-cancer-screening> (last reviewed 2017).
- <sup>xiv</sup> *Colorectal Cancer Screening*, AM. SOC’Y FOR GASTROINTESTINAL ENDOSCOPY, <https://www.asge.org/home/about-asge/newsroom/media-backgrounders-detail/colorectal-cancer-screening> (last reviewed 2017).
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<sup>xxxvii</sup> *Supra*, note 5 HPC DataPoints.

<sup>xxxviii</sup> *See, 2023 Annual Health Care Cost Trends Report and Policy Recommendations 28, HPC (Sep. 2023)* (<https://www.mass.gov/doc/2023-health-care-cost-trends-report/download>) (finding that most prices for most ambulatory services provided in HOPDs typically exceeded the Medicare-based benchmark, most care delivered in HOPDs can be safely provided in ASCs, and that payments for ASCs are typically lower than for hospitals for the same procedure).

<sup>xxxix</sup> *See, supra* note 6 Youmans; *See also, supra* note 5 HPC DataPoints, at “Regulatory environment.”

<sup>xl</sup> THE MEDICARE PAYMENT ADVISORY COMMISSION, MARCH 2022 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, CHAPTER 5: AMBULATORY SURGICAL CENTER SERVICE 168 (Mar. 15, 2022) (available at <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>) (“evidence suggests that ASCs are a lower-cost setting than HOPDs. Studies that used data from the National Survey of Ambulatory Surgery found that the average length of time for ambulatory surgical visits for Medicare patients was 25 percent to 39 percent shorter in ASCs than in HOPDs, which likely contributes to lower costs in ASCs” (citing Hair et al. 2012, Munnich and Parente 2014)); *See also, supra*, note 5 HPC DataPoints; *See also, infra* note 16.

<sup>xli</sup> Massachusetts Health Policy Commission, HPC Board Meeting slides, June 7, 2023, p.28

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