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Lara Szent-Gyorgyi
Director, Determination of Need Program
Massachusetts Department of Public Health
67 Forest Street
Marlborough, MA 01752
VIA EMAIL (dph.don@state.ma.us)

RE: Determination of Need Application Project #21012113-AS Independent Cost Analysis

Dear Ms. Szent-Gyorgyi:

The Attorney General's Office (AGO) submits this written comment, pursuant to 105 CMR 100.405(D), in response to the independent cost-analysis (ICA) in the above-referenced Determination of Need (DoN) application. This comment draws on the AGO's experience promoting transparency in the health care market with a focus on ensuring equitable access to affordable health care. For over a decade, the AGO has analyzed Massachusetts health care market data and reported on health care cost trends and cost drivers.[1]

Mass General Brigham (MGB) is among the finest health care provider systems in the world and has demonstrated its commitment to caring for its patients and the communities it serves, especially over the last two years through its herculean support to the Commonwealth's pandemic response. Our comments are intended to clarify certain challenges we believe the MGB expansion proposals present for the Commonwealth's heath care cost containment goals, and for our shared commitment to access and equity.[2] We offer these comments as a party of record for the Department of Public Health (DPH) as it considers the ICA and MGB's applications.

I. Health Care Costs

The ICA concluded that MGB's proposed ambulatory expansion is consistent with the Commonwealth's health care cost containment goals, but its analysis does not account for three key market dynamics. First, the ICA does not address the role of provider networks and referral relationships in directing where patients receive health care services. In analyzing the ambulatory surgery and imaging services MGB plans to offer at the new sites, the ICA does not include analysis of the primary care and other services to be offered there, and that patients who shift their care from another health care system to obtain a service at one of the new ambulatory sites are not likely to

[1] Reports on Health Care Cost Trends and Cost Drivers, MA Attorney General's Office, *available at* https://www.mass.gov/lists/reports-on-health-care-cost-trends-and-cost-drivers.
[2] While we submit this comment in connection with the ambulatory site expansion proposal, it relates to the combination of all three proposals currently before DPH.

come for a single episode of care (such as a single surgery or scan). These patients will be creating a relationship with the MGB system that will (or may) likely involve long-term shifts in where they obtain primary, specialty, and hospital care. Analysis of the project's impact on the Commonwealth's health care cost containment goals is not complete without considering the financial impact of the shift of commercially insured patients to the MGB system for all their care. In its 2018 planning process, MGB itself anticipated that creation of new ambulatory care centers would increase patient affiliation with the whole MGB system and would generate referrals to MGB hospitals.[3]

Second, the ICA does not account for MGB's existing market power. Focusing on the marginal increase to MGB's market power from the new sites, the ICA ignores that MGB is already a "must-have" system in payer networks, and one with widely recognized quality, brand, resources, and incumbent insurance contracts – not a new independent competitor entering the markets of Westborough, Woburn, and Westwood. Moreover, MGB's high prices (even at 50% of its downtown hospital prices) are unlikely to dissuade consumers attracted by the MGB brand. Consumers who shift their care to MGB providers generally do not pay the additional cost of that care. Instead, the extra costs associated with more expensive provider choices are paid by everyone through increased health insurance premiums.[4]

Third, the ICA does not account for the costs associated with new MGB patient volume that will fill (1) MGB's inpatient beds as the system moves procedures from inpatient to outpatient sites, or (2) MGB's hospital outpatient departments as the system moves some hospital-based ambulatory surgery and radiology patients to the new ambulatory sites. If the capacity created by MGB's shift of hospital-based care to its new ambulatory sites is backfilled by volume that is currently treated by MGB's lower-cost competitors, this is likely to increase overall health care expenditures, even if overall utilization stays constant. MGB has not announced plans to decrease hospital inpatient or outpatient capacity commensurate with the new proposed capacity at the ambulatory sites. Instead, MGB is seeking to expand two of its hospitals' (Massachusetts General Hospital and Brigham and Women's Faulkner Hospital) inpatient and outpatient services in connection with separate pending DoN applications. The ICA did not consider any of this increased hospital volume from new ambulatory center patients in its analysis of the cost impacts of the DoN.

II. Access to Health Care Services

The ICA does not account for the impact on access to services – particularly low margin services and services for publicly-insured patients – that may arise from MGB's acquisition of commercial market share and its engagement of health care workforce needed to operate the new sites. First, in examining the capacity of Massachusetts providers to render needed services, the ICA does not account for the health care system's reliance on cross-subsidization across services and payers to achieve sustainable margins. The ICA's model projects that the proposed sites will draw ambulatory surgery and high-tech imaging away from providers like UMass Memorial, Wellforce, Boston Medical Center, and Steward, but does not analyze the impact of this loss of revenue on the lower-priced providers' ability to maintain service offerings despite serving significantly higher

[3] MA Attorney General's Office, Examination of Health Care Cost Trends and Cost Drivers (November 17, 2021), *available at* https://www.mass.gov/doc/2021-examination-of-health-care-cost-trends-and-cost-drivers/download.

[4] *See* MA Attorney General's Office, Examination of Health Care Cost Trends and Cost Drivers (October 13, 2016), *available at* https://www.mass.gov/doc/2016-examination-of-market-health-care-cost-trends-and-cost-drivers/download (finding that health insurance premiums socialize across a shared risk pool not only the risk of getting sick but also the higher costs of some members' use of high-priced providers).

percentages of MassHealth patients than MGB.[5] This limitation in the ICA is significant given that the services it focuses on – imaging and ambulatory surgery – generate some of the highest commercial margins in health care.[6] Health care providers rely on the higher commercial margins generated by services like high-tech imaging and ambulatory surgery to subsidize the provision of lower or negative public payer margins for services like behavioral health, pediatrics, primary care, and women's health services. Even small percent decreases in the highest margin services and commercial patient volume could harm those providers' ability to provide low-margin services or to cater to MassHealth patients – which in turn could threaten access to health care services, increase costs in ways that are hard to model or predict, and further deepen inequities in the health care options available to the affluent and the poor.

Second, the ICA's analysis of the health care labor force does not reflect current market conditions or the impact that staffing the proposed sites is likely to have on access to services in other health care settings. Nearly two years into the Covid-19 pandemic, health care staffing in Massachusetts is in crisis.[7] The ICA, however, relies on the CMS database of all providers with a registered provider ID to estimate the supply of workers, noting that this database provides an "upper bound" on the number of providers as it may include individuals who are no longer in clinical practice. For health professionals like nurses for whom the CMS database may generate an undercount (because they do not typically bill claims directly), the ICA looks to state licensure data and Bureau of Labor Statistics estimates. None of these sources gives a fair representation of the number of people currently in clinical practice. More timely indicators of current health care workforce conditions, such as current unfilled postings for health care staff positions or Massachusetts hospital beds currently offline due to staffing shortages, go unmentioned. The ICA also does not account for literature projecting significant health care staffing shortages in Massachusetts.[8] The ICA concludes that anticipated staffing needs for ACCs would "almost never comprise more than two percent of the existing labor supply" and finds without further explanation that such an increase in demand for staff would be "de minimis."[9] The ICA suggests ample health care workforce availability based on data sources relevant only to authorization of clinical practice and billing. The reality of health care workforce conditions in Massachusetts points to a severe shortage. At a time of health care staffing crisis in Massachusetts and around the country, this analysis fails to account for the impact across the health care market if 447 health care workers[10] left their current positions to staff the three new centers.

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[5] Hospitals associated with these systems serve significantly higher percentages of MassHealth patients than MGB hospitals. According to FY2019 data from the Center for Health Information and Analysis, MGB hospitals had a weighted average inpatient and outpatient MassHealth payer mix of 13%. The corresponding percentage for UMass Memorial hospitals is 24%, Steward 22%, Wellforce 24%, Boston Medical Center 52%.

[6] According to pre-filed testimony submitted by MGB in connection with the 2019 Health Care Cost Trends Hearing, ambulatory surgery and high-tech imaging accounted for almost 20% of the total commercial margin for Massachusetts General Hospital and Brigham and Women's Hospital. 2019 Pre-Filed Testimony, Partners HealthCare System, Inc., AGO Provide Exhibit 2, *available at* https://www.mass.gov/doc/partners-healthcare-system-2019-pre-filed-testimony-ago-provider-exhibit-2/download.

[7] Carey Goldberg and Jonathan Levi, *Vaccine mandates hit amid historic health care staff shortage*, THE BOSTON GLOBE (Oct. 2, 2021), *available at* https://www.bostonglobe.com/2021/10/02/business/vaccine-mandates-hit-amid-historic-health-care-staff-shortage.

[8] *See, e.g.,* US Healthcare Labor Market, Mercer (2021), *available at* https://www.mercer.us/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf (study projecting MA will be among the worst five states in the country in terms of shortages of nurses and shortages of medical assistants/home health aides in next five years).

[9] ICA ¶ 181.

[10] The ICA reports that MGB estimated that it would need 110 full-time-equivalent workers at the Westwood

III. Health Equity

The cost and access issues raised in this comment must also be considered through a health equity lens. As health care becomes increasingly unaffordable and safety net community providers lose staff and shutter services, these burdens are not felt equally across the Commonwealth. The proposed MGB ambulatory sites are in higher-income, predominantly white communities with access to private transportation. As MGB noted in its response to DPH's questions, MGB considered local payer mix – meaning the percent of the local population covered by commercial health insurance – of the siting communities when selecting where to locate the new ambulatory centers.[11] This makes sense in terms of maximizing revenue and return on investment, as commercial health insurers pay higher rates than public payers. However, this strategy raises questions about access and equity for lower income communities with MassHealth coverage, especially because people of color disproportionately have MassHealth, rather than commercial insurance. This expansion proposal is poised to increase access for a population that already has disproportionately high access to care. And any resources (such as commercial patients, high margin services, or staff) that these new sites draw away from lower-cost health care systems will harm access for low-income patients and patients of color.

In our 2020 report entitled "Building Toward Racial Justice and Equity in Health: A Call to Action," the AGO highlighted the health disparities facing communities of color and connected those longstanding inequities to the disparate effects of COVID-19 and the urgency of the nationwide racial justice movement.[12] Consistent with this call, we urge consideration of the equity impacts of proposed changes to the health care delivery system.

Thank you for your consideration of these comments.

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MAURA HEALEY

Eric Gold
Division Chief, Health Care Division

Proposed Site, 163 at the Westborough Proposed Site, and 174 at the Woburn Proposed Site. ICA ¶ 176.

[11] Mass General Brigham Incorporated – Multisite – Responses to DoN Questions, p. 8, *available at* https://www.mass.gov/doc/mass-general-brigham-incorporated-multisite-responses-to-don-questions-1/download.

[12] MA Attorney General's Office, Building Toward Racial Justice and Equity in Health: A Call to Action, *available at* https://www.mass.gov/doc/building-toward-racial-justice-and-equity-in-health-a-call-to-action/download.