Mass General Brigham

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February 13, 2025

Dennis Renaud, Director
Department of Public Health
Determination of Need Program
67 Forest Street
Marlborough, MA 01752

Dear Director Renaud,

Re: Application # DFCI-2304915-HE (Application)

On behalf of the Mass General Brigham Ten Taxpayer Group (MGB), we write to provide comments with respect to the recently completed independent cost-analysis (ICA) for the above-referenced Determination of Need Application filed by Dana Farber Cancer Institute (DFCI) with the Department of Public Health (Department or DPH). The ICA was completed by FTI Consulting, Inc. (FTI). Consistent with the DoN statute and regulation, the Department requested that FTI provide an analysis to demonstrate that the Application is consistent with the Commonwealth's efforts to meet the health care cost-containment goals established by the Health Policy Commission (HPC). The Department asked FTI to consider the impact of the Proposed Project on utilization, capacity, prices, competition, equitable access, and healthcare costs of the services contemplated by the Proposed Project and to assess the bearers of any cost impacts. As a Party of Record to the Application, we are providing comments pursuant to 105 CMR 100.405(D) and request the Department to review and consider these comments in issuing its staff recommendation.

As further detailed in this letter, the ICA is based on a flawed assumption about how patients are referred for cancer care, incorrectly assigning Brigham and Women's Hospital (BWH) patients to DFCI, which leads to an underestimation of the increased healthcare costs that will result from the Proposed Project. Because of this flawed assumption regarding patient referral patterns, the analysis fails to recognize that the new hospital proposed by DFCI will inevitably need to draw a large number of patients from other AMCs and community hospitals in order to be financially viable, ultimately driving up the costs of cancer care and burdening existing hospitals that provide cancer services. In addition, the ICA significantly underestimates the impact on Medicare reimbursement due to the costs for the care to operate a 300-bed hospital. The analysis also fails to account for the financial and operational impact on existing emergency departments, which are already over capacity, fails to account for the impact of the project on healthcare labor costs, and fails to account for a proposed over-resourcing of the area with new imaging and radiation therapy equipment.

**The Patient Panel established in the ICA does not reflect how patients are referred for cancer care.**

The ICA's analysis is based in the flawed assumption that most of the volume at the new DFCI hospital will come primarily from Brigham and Women's Hospital's (BWH) existing Patient Panel. The methodology used in the ICA to support this assumption (matching patients based on their attending physician during their inpatient admission at BWH in BWH licensed beds) does not account for how patients are typically referred for cancer care, that is: through the patient's primary care and/or specialty provider. In addition, referrals for many types of cancers go directly from a patient's primary or specialty care provider to surgical or radiation oncology.[1] This is particularly relevant to the ICA because DFCI does not propose to have any surgical oncology at the new hospital, only medical oncology, and therefore MGB patients who need surgical oncology will continue to be referred to and treated at BWH or another MGB facility, while other cancer patients who need surgery will be referred to BIDMC or another facility with surgical capacity.

The ICA asserts that the patients currently at BWH will instead receive inpatient care at the new DFCI facility. The basis for this assertion is that physicians with privileges at DFCI will direct patients to the new facility. From a roster of 1,764 physicians with privileges at DFCI, provided by DFCI to FTI, the ICA labels as DFCI physicians any who have at least five discharges from BWH and at least 25% of their inpatient discharges are for neoplasm patients. As shown in Table 4 of the ICA, for 2022, based on this identification of physicians, FTI attributes 6,434 inpatient cancer care discharges from BWH beds to DFCI. This is based on the flawed theory that because these patients were treated in a BWH licensed bed by an attending physician with privileges at DFCI, these patients are DFCI patients. What the ICA does not recognize is that there are nuances that need to be considered in assigning patients to a particular provider and it is not as straightforward as asserting that a physician is a DFCI provider based on having some treatment relationship with a patient admitted to BWH. Under the existing DFCI/BWH arrangement, almost all the MGB attending physicians treating cancer patients at BWH also have privileges at DFCI. FTI identifies these physicians as "DFCI providers" but they are not. Instead, these physicians are based at and employed by BWH[2] and therefore, these patients should be attributed to BWH, not DFCI. Attributing these patient discharges to DFCI erroneously and exponentially increases the number of patients allocated to DFCI in the ICA. It is also worth noting that the ICA mischaracterizes the beds at BWH. DFCI leases 30 beds from BWH. The remaining beds in which DFCI attending physicians treat patients are for patients at BWH and are not leased to DFCI. These are BWH-licensed beds, and as such the patients in these beds are admitted to and are patients of BWH and are treated by BWH providers.

MGB agrees that a cancer patient's physician is an important factor in their choice of hospital but disagrees with how the ICA allocates patients. Instead of looking at the affiliation of the attending physician for an episodic inpatient visit, the ICA should look at the primary care and specialty provider relationships since they hold and maintain the long-term provider-patient relationship and are the most frequent referrers of patients to BWH for cancer care.[3] MGB has a primary patient relationship with over

[1] To illustrate this, we provide two examples from the experience within the MGB system. Currently, approximately 30% of patients diagnosed with cancer are referred directly to surgical oncology. Over a 17-month period from 2017-2019, a cancer registry analysis showed that 75.6% of new cancer patients treated at BWH started at BWH.
[2] These physicians work for the BWH Physicians Organization or for the hospital.
[3] Although there are multiple pathways into the cancer center, typically, a primary care provider or specialist will identify a suspicious finding and refer the patient to the Early Detection and Diagnostics Clinic. The patient will then be referred to a surgeon, medical oncologist, or radiation oncologist based on the results and treatment needs. Another pathway involves a primary care provider directly referring a patient to a surgeon, who will conduct a

70% of patients seen at Dana Farber/Brigham and Women's Hospital Cancer Center at BWH. Of those patients, 25% have a primary care relationship with an MGB provider, and the remainder have an MGB primary specialist (over 50% from the following specialties: Cardiology, Urology, Orthopedics, Internal Medicine, Gastroenterology, and Thoracic Surgery). See Table 1. Due to these relationships, these patients will likely choose to continue to receive their cancer care at an MGB facility.

Table 1

| MGB Primary Relationship for Oncology Patients | |
|---|---|
| Total Discharges from BWH FY24 from Oncology, Bone Marrow Transplant, or DFCI beds | 7,654 |
| Unique Patients from those discharges | 4,659 |
| Patients with Primary Care Physician in MGB Epic Registration | 1,149 |
| Ratio of Primary Care Patients | 25% |
| Patients with Primary Care OR Specialist with Chronic Care Management | 3,372 |
| Ratio of patients with MGB Physician Care | 72% |

Due to the ICA's flawed assumption about provider attribution to DFCI and the lack of recognition of the origination of patient referrals for cancer care, the ICA incorrectly assumes that the majority of BWH cancer patients receiving care at BWH will move to the proposed DFCI hospital. When taking these factors into consideration, MGB believes that a more accurate assumption is that no more than 30% of the BWH patient volume will shift to DFCI.

**The ICA does not adequately reflect the potential impact of a new 300 bed cancer hospital on lower cost academic medical centers (AMCs) and community hospitals.**

Due to the ICA's flawed premise about the source of patients receiving care at the proposed hospital (that is, the majority of BWH patients will not become patients of the new hospital), DFCI will need to obtain patients from other sources to operate a financially viable 300 bed hospital. The likely source of patients therefore will come to the proposed DFCI hospital from AMCs other than BWH or MGH and from community hospitals, therefore the ICA underestimates the cost impacts of the Proposed Project.

DFCI is requesting 300 inpatient beds at the proposed new hospital. Based on DFCI's estimates of average length of stay, this creates capacity for 14,000 discharges a year. MGB estimates that 30% of the BWH patients currently receiving cancer care at BWH may move to the new DFCI facility. This is based on the calculation that over 70% of the current patients receiving cancer care at BWH have a primary patient relationship with MGB and therefore their cancer care will be referred to MGB facilities, including BWH's existing beds. This means that slightly over 1,900 discharges a year that may shift from BWH licensed beds to the new hospital. Based on the projections in DFCI's DoN Application, approximately 3,600 discharges a year will come from patients who would otherwise be treated at Beth Israel

thorough evaluation, often including a biopsy. If the biopsy results are positive, the patient is then referred to the cancer center's multidisciplinary team for further management. If a patient presents to the Emergency Department with a suspicion of cancer, the established pathways mentioned above are followed. If the patient's condition is acute, they are admitted, and the inpatient teams will conduct a thorough evaluation to determine the diagnosis and treatment pathway.

Deaconess Medical Center (BIDMC).[4] That leaves DFCI with the need to find patients from other sources to make up the remaining 8,000-9,000 projected discharges. DFCI predicts that approximately 20% of its patients will be from out of state or out of the country. Assuming that number is correct, DFCI will still need to draw approximately 5,000 discharges to fill its beds, and the likely source will be from other lower-cost AMCs and community hospitals. This is supported by BWH patient data; a large number of patients outside the greater Boston area already come to Boston Longwood Area hospitals for cancer care. If there are 300 new beds added to the Longwood Medical Complex (as a result of the proposed DFCI hospital) patients who are currently receiving care in community hospitals will come to DFCI to fill those beds, leading to higher costs for care and destabilization of the community hospitals.

For these calculations, MGB used the Center for Health Information and Analysis (CHIA) "Relative Price and Provider Price Variation in the Massachusetts Commercial Market" databook issued July 2024, which provides data for 2022[5]. Relative price allows comparisons of average provider prices across hospitals, while accounting for differences in patient acuity, types of service providers, and different insurance product types. The numbers used in this response are based on CHIA's blended relative price, which enables comparison of acute hospital prices across all commercial payers.

Using these data, MGB identified that BWH has a blended inpatient[6] relative price of 1.29, BIDMC has a relative price of 1.18, and DFCI has a relative price of 1.09.

Even if DFCI does not use its increased market share to negotiate higher rates, there will still be an increase in the Commonwealth's total medical expenditures (TME) due to the shift of patients from community hospitals with lower relative prices. While all Massachusetts community hospitals have lower cross-payer statewide relative prices than DFCI, Table 2 provides some examples of community hospitals that are vulnerable to patients shifting to DFCI.

Table 2

| **Hospital** | **Data Year** | **Cross-payer Statewide Relative Price (S-RP)** |
|---|---|---|
| Emerson Hospital | **2022** | 0.91 |
| Heywood Hospital | **2022** | 0.73 |
| Holy Family Hospital | **2022** | 0.95 |

[4] The number of medical oncology cases transitioning from BIDMC was derived from numbers provided by DFCI in its Application. The DoN Application provided an Average Daily Census at BIDMC of 86.7 (Page 20). Multiply this by 365 days = 31,6465 patient days divided by 8.6, the Average Length of Stay provided in Table 11 (Page 21). This comes out to 3,679 cases.

[5] The ICA uses 2021 data from CHIA and Medicare Inpatient claims data to calculate the relative prices of DFCI, BIDMC and BWH but notes that the methodology closely mirrors CHIA's approach in calculating relative price in the Massachusetts commercial markets. For purposes of this response, MGB is using the most recent CHIA data published, which is from 2022. The numbers are effectively similar.

[6] CHIA publishes inpatient data by facility and by payer. To aggregate to the facility level, MGB used its own payer mix as a proxy for the proposed DFCI hospital. This mix is 52% BCBSMA, 16% Harvard Pilgrim, 7% Tufts, and 25% all other payers.

| | | |
|---|---|---|
| Lawrence General Hospital | **2022** | 0.84 |

**The ICA's assumptions regarding reimbursement for a new 300 bed cancer hospital underestimate the potential impact on healthcare costs.**

The ICA reviews various reimbursement scenarios for Medicare and commercial reimbursement, but they are unrealistically low. In particular, the ICA's estimate of DFCI's future Medicare reimbursements are faulty. DFCI receives an enhanced Medicare reimbursement for its services due to its status as a Medicare PPS-Exempt Cancer Hospital, and its reimbursement is cost-based. By underestimating the costs of running a standalone cancer hospital in Boston, the ICA underestimates DFCI's future Medicare payments. If the proposed project goes forward as planned, DFCI's cost-per-discharge for Medicare patients will increase, which would increase its Medicare reimbursement.

DFCI has the unique status of being one of only 11 Medicare Prospective Payment System (PPS)-Exempt Cancer Hospitals in the country. This status provides for reimbursement that is based on the actual cost of care provided, while hospitals without this status (i.e., hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS)) receive set rates of reimbursement that are generally lower than the actual cost of providing care. Essentially, a PPS-Exempt Cancer Hospital such as DFCI is made whole for the care it provides to Medicare beneficiaries. In calculating DFCI's costs, however, the ICA relied on DFCI's current cost structure of providing care in 30 leased beds at BWH; the costs of running a full hospital with 300 beds will be higher. A freestanding hospital has many additional expenses for additional staffing and other overhead needs that are not reflected in the expense of operating 30 beds within another hospital. MGB estimates that the true cost structure for a cancer hospital will be 37%-42% higher than the existing costs for DFCI's 30 leased beds. The lower bound of 37% is based upon BWH's current cost structure for inpatient beds, and the 42% upper bound is based upon the GAO report cited below.

The ICA models two scenarios for possible increased Medicare prices. The first simply assumes that Medicare reimbursement will match the average of BWH and BIDMC levels. There is no support for this assumption.[7] The second scenario attempts to address the reality that DFFCI will incur increased costs when running a 300-bed standalone facility, increasing DFCI's Medicare prices to match the median reimbursement increase over estimated IPPS payments among other PPS- Exempt cancer hospitals, based on data from a U.S. Governmental Accountability Office (GAO) report.[8] However, this median Medicare reimbursement, which blends costs from several markets across the nation, does not account for the high labor costs in Eastern Massachusetts, which makes it of limited use in predicting the Medicare payments to a 300-bed stand-alone cancer hospital in Boston. Further, the GAO report notes that PPS-Exempt cancer facilities receive, on average, 42% more in Medicare inpatient payments relative to what an IPPS facility would be paid. Using the GAO average to model the future Medicare

[7] It is worth noting that Medicare often reimburses IPPS hospitals such as BWH below the cost of providing care to patients. See, e.g. https://www.aha.org/2024-01-10-infographic-medicare-significantly-underpays-hospitals-cost-patient-care. The costs to run a 300-bed cancer hospital will, in any circumstance, be higher than the average of BWH and BIDMC's IPPS reimbursements.

[8] *See* GAO-150199, Medicare: Payment Methods for Certain Cancer Hospitals Should be Revised to Promote Efficiency. https://www.gao.gov/assets/gao-15-199.pdf.

reimbursement rates produces a predicted Medicare reimbursement rate of $91.5M or 42% higher than current DFCI reimbursement.

Further, the ICA does not reflect the very real potential for increased labor costs that will further drive up DFCI's costs and therefore drive up DFCI's Medicare payments. In its response to DoN staff questions, DFCI confirms that it anticipates the new DFCI Cancer Center will require significant hiring (2,400 new full-time equivalent positions), which will put upward pressure on current costs of delivering care. Eastern Massachusetts is significantly challenged with staffing shortages and high labor costs.[9] Increased demand for staff in the Longwood area will push labor costs higher for all area providers, and consequently to providers throughout Massachusetts.[10]

The ICA's pricing scenarios discussed above also address commercial payers, but the modeling includes flawed assumptions about negotiating leverage at DFCI and BWH. In its highest scenario, the ICA assumes DFCI will agree to a price point midway between DFCI's current price and BWH current price. . However, DFCI's Proposed Project will result in a hospital with an average daily census (ADC) of up to 265 patients. The ICA notes that ADC statewide is 1380 (See Table 7 of the ICA). That will give DFCI a 19% statewide share of patient days, and an even higher share in the Boston area. It is likely that as a result of higher costs due to labor challenges and a high share of cancer care market that DFCI will pursue rates in alignment with the top of the market.[11]

Table 3 illustrates the impact on costs given the anticipated patient movement from BWH, BI, and AMC and Community Hospitals described above. Even if DFCI does not use that leverage to negotiate a large increase in its commercial rates, small increase in commercial rates for DFCI, in addition to increased Medicare payments and the movement of patients from lower-cost hospitals into the new DFCI hospital, will result in at least a 14% increase in total medical expenses. This estimate assumes a commercial rate level (1.19) at the mid-point between the MGB AMC relative price as determined through the most recent 2022 CHIA reporting (1.29) and the estimated DFCI relative price for inpatient services blended by BWH commercial payer mix (1.09). This blended estimate is taken from the ICA, and we believe it is conservative. The actual increase in costs will be even higher, given the shift in patients from community hospitals that will occur.

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[9] As a reference point, in the current market BWH's recent agreement with MNA will result in 20% to 30% increases in pay to nurses over the next 2.5 years (see MNA press release https://www.prnewswire.com/news-releases/brigham-and-womens-hospital-nurses-vote-to-ratify-new-contract-that-averted-potential-strike-and-seeks-to-improve-nurse-staffing-and-patient-care-conditions-302244515.html).

[10] Of note, newly enacted changes to the DoN statute, which take effect on April 8, 2025, will require the Department to consider the impact of a proposed project on the workforce of surrounding healthcare providers. This provision indicates the Legislature's concern about the impact of new facilities on the Commonwealth's healthcare workforce challenges.

[11] The ICA also does not account for likely increases in BIDMC's rates for surgical oncology. A significant proportion of DFCI's medical oncology patients will need surgery, which DCFI intends to refer to BIDMC. This will require BIDMC to hire additional surgeons, which will likely necessitate giving surgeons an increase in pay. In addition, by having many more surgeons, BIDMC will have more leverage to negotiate higher rates as the main cancer surgery provider for the new DFCI hospital. The combination of increased pay to surgeons and increased leverage for BIDMC will likely lead to increased reimbursement for surgical oncology. These costs should have been included in the ICA's calculations as part of the increase in costs due to supply-induced demand, as they will be a result of the increased number of cancer patients seeking care in the Boston Longwood Area instead of their local facilities.

Table 3

| Current State | | Health Care Spending | | | Future State | Health Care Spending | | | Change $ | | | Change % | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Medical | Surgical | Total | | Medical | Surgical | Total | Medical | Surgical | Total | Medical | Surgical | Total |
| Commercial | | $ 407.2 | $ 64.7 | $ 471.9 | | 437.5 | 54.7 | 492.2 | $ 30.3 | $ (10.1) | $ 20.2 | 7% | -16% | 4% |
| Government | Medicare incl Mgd | $ 217.8 | $ 66.0 | $ 283.8 | Medicare incl Mgd | $ 309.3 | $ 66.0 | 375.3 | $ 91.5 | $ - | $ 91.5 | 42% | 0% | 32% |
| | Medicaid incl Mgd | $ 35.9 | $ 7.5 | $ 43.5 | Medicaid incl Mgd | $ 35.9 | $ 7.5 | 43.5 | $ - | $ - | $ - | 0% | 0% | 0% |
| | Subtotal | $ 253.8 | $ 73.5 | $ 327.3 | Subtotal | $ 345.3 | $ 73.5 | 418.8 | $ 91.5 | $ - | $ 91.5 | 36% | 0% | 28% |
| | Total | $ 661.0 | $ 138.2 | $ 799.2 | Total | $ 782.8 | $ 128.2 | $ 910.9 | $ 121.8 | $ (10.1) | $ 111.7 | 18% | -7% | 14% |

The blue shaded 'current state' reflects actual costs for Full Year 5/1/23-4/30/24 for the combined Dana Farber Brigham and Women's Cancer Center. In the Orange 'future state' section, the same patients are translated to a notional healthcare ecosystem where there is a new 300 bed cancer center, and projects future spending based upon patient migrations and relative costs (described above in this document).

The ICA also incorrectly ascribes supply-induced demand to the BWH as well as underestimates the potential price increases from supply-induced demand from the DFCI. The ICA provides an upper bound to the supply-induced demand of 2.7% to 3.1% per year attributed to backfill at the BWH. This analysis mischaracterizes the source of the supply-induced demand. As discussed, the existing beds at BWH will continue to be available to MGB patients who need inpatient cancer care or other inpatient care. Rather it is the new beds at the proposed DFCI facility that will create new supply-induced demand in order to fill the beds, likely drawing patients from lower cost AMCs and community hospitals affiliated with BILH, and also patients who might not otherwise receive inpatient cancer care. This will increase costs due to supply-induced demand at a larger rate than that identified in the ICA. Since DFCI has not established a patient panel to support need for more than the current 30 beds, the new facility will need to find additional patients to fill the remaining 270 new beds in the market.

Further, the ICA falsely assumes that there is no likelihood for supply-induced demand at the proposed facility because it is projected to be immediately capacity constrained. However, this is based on the flawed assumption that all BWH patients will move to the new facility. The ICA assumes that BWH and BIDMC would "backfill" newly available capacity, and that would be equivalent from a cost impact to no patient shift and the new DFCI beds are filled by patients not currently receiving inpatient care. Given the high occupancy rates for MGB hospitals, including BWH, it is clear that patients continue to choose to receive care at BWH and other MGB hospitals. This means the estimated costs outlined in Tables 20 and 21 of the ICA are likely, rather than speculative and transitory, and these increases in costs should be accounted for in the ICA's estimate in increased costs due to this Proposed Project.

**The ICA does not recognize that lack of an Emergency Department at the new hospital will increase the cost of care.**

The lack of an Emergency Room as part of the DFCI cancer proposal is concerning, as a significant number of current DFCI/BWH patients require emergency services during their treatment and are admitted to hospitals across MGB's system.

Currently, approximately 11% of patients treated at DFCI return to an MGB Emergency Department (ED) within one year of discharge. If the Proposed Project is fully built, it can accommodate 14,000 patients annually. If 11% of those patients need ED care, that would be an increase of 1500 patients seeking ED care, in EDs that are already crowded beyond capacity. While some of these patients will seek care in the BIDMC ED and, if necessary, be admitted to the DFCI hospital, others will seek care at an MGB ED. This will be particularly likely if the patient's primary care provider is affiliated with MGB. This will also lead to highly fragmented care for patients who come to the BWH ED but cannot be cared for by their DFCI oncologist who is practicing at the DFCI hospital.

Massachusetts has among the longest ED wait times in the United States, ranking 49$^{th}$ nationally. The EDs at BWH and BIDMC, as at all Massachusetts acute hospitals, are already beyond capacity. For example, in 2024 BWH had a total of 16,552 boarders (defined as waiting in the ED two hours after the decision to admit), which is 96% of all admissions. The average time spent boarding in the ED was 21.4 hours, with a median time of 14.3 hours. Non-admitted patients spent an average of 7.8 hours in the ED, with a median time of 5.6 hours. This capacity crisis also means that 56% of patients in the BWH ED spent some amount of time getting their care in a hallway. BIDMC has similar challenges, as do all Massachusetts EDs. The strain of adding additional patients will further burden the Commonwealth's hospitals, damaging the quality of the care being provided. Further, the increased demands on the EDs at BIDMC, BWH and other hospitals will cause increased labor costs, which will be directly attributable to the addition of 300 hospital beds at the new DFCI hospital without additional ED beds.

**Additional linear accelerators are duplicative and will increase costs.**

The ICA's projections for linear accelerator (LINAC) need are based on its flawed assumption that patients will move from receiving their care at BWH and other MGB facilities to the new DFCI hospital. The ICA projects a need for 10 LINACs in the Longwood Area, including the existing LINACs at BWH. Presently, there are 11 LINACs in Longwood (3 at DFCI, 3 at BIDMC and 5 at BWH) and one total body irradiator at BWH. The ICA's assumption that DFCI will retain 100% of its current volume and capture nearly 80% of BWH's LINAC volume overstates the likely migration of patients and therefore inflates the need for LINACs in the Boston Longwood Area.

In addition, the existing LINACs at BWH primarily treat BWH surgical patients, who are not expected to shift to DFCI for their oncology care. Since DFCI will not be providing surgical oncology treatment at the new facility, oncology patients who have surgery or other medical care at BWH and need LINAC treatment will continue to receive this care at BWH.

Therefore, the addition of 3 new LINACs which are not needed to address the patient needs in the Longwood area will increase the supply-induced demand for these services. There will continue to be demand for LINAC treatment at BWH for their existing patient panel and therefore DFCI will need to find patients from other sources, most likely other low-cost AMCs and community hospitals. Therefore, the additional LINACs at the new DFCI facility will, as the ICA notes, lead to increases in TME for outpatient imaging. Any increase in need for LINACs is more likely to occur in the communities and not in the Boston Longwood Area, which is well supplied for the demands of its patients.

Finally, the ICA does not take into account the particular challenges of hiring radiation technicians. There is a shortage of radiation technicians, and by adding unnecessary LINACs to the Longwood area, DFCI will exacerbate this labor shortage, driving up labor costs for radiation technicians even higher.

**Conclusion**

The ICA's assumptions are flawed, leading to unrealistically low estimates of the potential increase in healthcare costs from the creation of a new 300 bed cancer hospital in the Longwood Medical Area. The ICA makes assumptions about DFCI's potential patients, because DFCI does not currently have sufficient patients to demonstrate need for the addition of 270 beds in Massachusetts solely dedicated to inpatient cancer care. Because these beds are not needed by DFCI's Patient Panel, the Proposed Project will destabilize the Commonwealth's health care system. If built as proposed, the new hospital will lead to increased healthcare costs, a more expensive labor market, a damaging shift of patients from community hospitals that currently provide cancer care, and a critical worsening of ED Capacity and boarding, which is already at a crisis level.

Because the ICA is based on a fundamental misunderstanding of the origin of the patients who will fill the beds of the new facility, the Proposed Project should be reevaluated based on more realistic data about patient origin and therefore a more realistic analysis of the potential for increased costs. Such a reevaluation would demonstrate that the proposed project is inconsistent with the Commonwealth's cost-containment goals.

Any approval of the proposed project should be conditioned to limit the number of beds to reflect the actual established needs of DFCI's Patient Panel. Prior to permitting any amendment to expand the approved number of beds, DPH should require DFCI to establish that its Patient Panel is not due to a shift in patients from community hospitals or AMCs other than BIDMC. This condition is necessary because as currently proposed, the DFCI project is inconsistent with the Commonwealth's cost-containment goals and will raise healthcare costs in the Commonwealth by building capacity that its Patient Panel does not need.

Thank you for your thoughtful consideration of these comments. We are available to answer any questions you may have regarding the analysis and concerns contained herein.

Sincerely,

Christopher Philbin

Christopher Philbin
Vice President, Office of Government Affairs