Mass General Brigham

399 Revolution Drive, Suite 675
Somerville, MA 02145
T 857-282-5151
M 781-583-8750

February 28, 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 Determination of Need (DoN) Staff Report issued for the above application from Dana Farber Cancer Institute (DFCI). For the reasons detailed in this letter, we respectfully ask the Department of Public Health (DPH or the Department), including the Public Health Council (PHC), to amend the proposed conditions suggested by DoN staff to better address the risk the Proposed Project presents to the Commonwealth's cost containment goals.

In making these comments, we will not repeat the points we made in our comments on the independent cost analysis (ICA) but we request that the PHC consider both those comments and this response in making its determination. We write now to focus specifically on the consequences of approving this hospital construction as requested and to suggest a condition that may help mitigate the potential damage caused by the Proposed Project.

In summary, DFCI has not established that its Patient Panel needs a 300-bed cancer hospital, instead relying on the flawed assumption that all patients who receive cancer care at BWH will move to the new hospital. The reality is that we project more than half of the patient volume filling these new beds will come from community hospitals and lower-cost AMCs. DFCI's Proposed Project will destabilize those hospitals, which are currently providing high quality cancer care in their patients' communities. Further, if built as planned, DFCI's Proposed Project will lead to increased healthcare costs, increased labor costs, and financial losses for other hospitals providing cancer care.

<u>DFCI has not established that it needs a 300-bed hospital to meet the needs of its Patient Panel.</u>

Although DFCI provides several different ways to describe their physicians' interactions with patients at BWH, none of them demonstrate that DFCI needs a 300-bed hospital to meet their needs. To establish Patient Panel need for a 300-bed hospital, DFCI asserts that all of the patients in Brigham and Women's Hospital's (BWH) beds who are seen by a DFCI attending oncologist are part of DFCI's Patient Panel and will seek inpatient care at the new hospital.[1]

[1] DPH defines Patient Panel as 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." This definition does not help identify need for the proposed 300-bed hospital because currently cancer care at BWH is provide in an integrated way with DFCI and BWH working together to treat patients. The patients currently receiving care at the Cancer Center are on the Patient Panel of both DFCI and BWH. The question for determining need is whether those patients will seek care at the DFCI hospital or continue their care at BWH.

This assumption is not supported by the reality of how patients with cancer are referred to inpatient care when needed. The affiliation of a patient's physician is an important factor in their choice of hospital. In fact, the most common pathways into the Dana Farber/Brigham and Women's Hospital Cancer Center (Cancer Center) start with a referral from a primary care provider or specialist.[2]

Further, BWH will continue to provide a full range of cancer care at BWH. It is important to note that although DFCI minimizes this, currently DFCI only provides medical oncology services when needed to BWH inpatients. BWH provides all inpatient care to Cancer Center patients other than medical oncology, including medical consultation, surgical care, radiation oncology, radiology, pathology, nursing, social work, and more. MGB provides an integrated model of cancer care, that is centered on the needs of the patient. BWH will add medical oncologists at BWH, and BWH patients who need cancer care will continue to be able to receive all necessary care at BWH or within the MGB system. Therefore, DFCI's prediction that 100% of the patients at BWH will move to DFCI is overinflated.

As noted in our comments on the ICA, MGB has a primary patient relationship with over 70% of patients seen at the Cancer Center. 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, and the integrated model of care at MGB, these patients will likely choose to continue to receive their cancer care at an MGB facility and no more than 30% of the BWH patient volume may shift to DFCI's proposed 300-bed hospital.

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%

In order to fill the rest of the beds at the proposed 300-bed hospital, some patients historically cared for at Beth Israel Deaconess Medical Center (BIDMC) will shift to the new hospital, necessitating that more than half of DFCI's new patients will come from other AMCs and community hospitals. These patients are not currently part of DFCI's Patient Panel and should not be included in a calculation of the appropriate number of beds at this new hospital.

The Health Policy Commission (HPC) released its preliminary Cost and Market Impact Review (CMIR) of the Proposed Project on February 27, 2025. In the CMIR, the HPC notes that it is difficult to assess the actual need for increased hospital capacity for oncology. Among the confounding factors, the HPC points

[2] As described in MGB's comments on the ICA, typically a primary care or specialist provider will identify a suspicious finding and refer the patient to the MGB 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. Alternatively, a primary care provider or specialist will directly refer a patient to a surgeon.

to the limits of their statistical modeling of oncology beds and the trend that medical oncology care can be provided in outpatient settings. The HPC also notes that MGB is currently increasing its oncology care

at Massachusetts General Hospital (MGH), based on a 2022 Determination of Need Approval, to meet the demonstrated need of its Patient Panel. The HPC concludes that it is unclear whether DFCI's Proposed Project is needed. See page 69 of the CMIR.

Since the HPC is unable to determine whether this project is needed by patients, MGB's analysis of the patients who are likely to leave BWH for the new DFCI hospital should weigh heavily on the determination of how many beds are actually needed at the proposed hospital. Although the Staff Report heavily defers to DFCI's assertions of need, those assumptions, as discussed, are based on flawed expectations of patient flow.

Based on the actual mechanisms by which patients are referred to a cancer hospital, and the detailed analysis shared in MGB's comments on the ICA, the number of beds needed to care for the patients who may shift from BWH and BIDMC to DFCI is 126, less than half of the proposed number of beds. As a result, DFCI will need fill the rest of the proposed 131 beds with patients from other sources, specifically from lower-cost hospitals that are currently providing high quality cancer care to their patients.

Table 2

Med Oncology

	Source Hospitals				Scenario				
	Cases	Days	ALOS	ADC	% Shift	Cases	Days	ALOS	ADC
MGH	4,248	33,460	7.88	92	0.0%	-	-	-	-
BWH	6,373	46,299	7.26	127	30.0%	1,912	14,357	7.51	39
MGB AMCs	**10,621**	**79,759**	**7.51**	**219**	**18.0%**	**1,912**	**14,357**	**7.51**	**39**
BIDMC	5,310	46,889	8.83	128	67.3%	3,576	31,576	8.83	87
Other AMCs	10,973	94,366	8.60	259	50.7%	5,559	47,805	8.60	131
All Academic	26,904	221,013	8.21	606	42.7%	11,046	93,737	8.49	257
MGB CH	1,620	8,387	5.18	23	50.6%	820	4,248	5.18	12
BILH CH	3,279	15,988	4.88	44	50.7%	1,661	8,101	4.88	22
Other CH	1,355	6,739	4.98	18	50.7%	686	3,414	4.97	9
All Community	6,253	31,115	4.98	85	50.7%	3,168	15,763	4.98	43
Total	**33,157**	**252,128**	**7.60**	**691**	**42.9%**	**14,214**	**109,500**	**7.70**	**300**

126

<u>If DFCI is permitted to build a cancer hospital with 300 beds, the project will damage the Commonwealth's cost containment goals.</u>

Since DFCI cannot establish that its theoretical Patient Panel needs more than 126 beds, the Applicant should not be permitted to build and license 300 inpatient beds.

If the Department permits DFCI to license so many additional inpatient beds, it will lead to increased healthcare costs and destabilization of the health care system. The shift of patients from community hospitals with lower relative prices (see Table 2 from MGB's Comments on the ICA) to DFCI for their inpatient care will lead to an increase in the Commonwealth's total medical expenditures. In addition to possible increases to inpatient costs (see MGB's Comments on the ICA for details), the HPC found that

the Proposed Project will lead to higher commercial outpatient prices of $39 million. See page 48 of the CMIR. The CMIR also predicts that hospitals other than BIDMC, BWH and MGH will lose a combined $60 million to $64 million in commercial revenue per year as oncology discharges shift to DFCI. See CMIR page 51. Even when accounting for any potential savings in commercial inpatient costs, the CMIR found that DFCI's proposed hospital will lead to an increase in commercial spending of between $10.7 and $17 million more annually on cancer care.

As described in MGB's comments on the ICA, the shift in patients will also lead to a critical worsening of ED capacity and boarding and a more expensive labor market. In order to operate this building, DFCI anticipates adding 2,400 new positions in the Boston Longwood area. This will create a market shock, driving up labor costs for all healthcare providers in the area or possibly the entire state. The CMIR discusses the possibility of increased labor costs for other providers based on this project as well. Both DFCI and the ICA underestimate the effects of this demand for healthcare workers.

The Staff Report includes a Condition that seems to be aimed at addressing the potential risk to the health care Cost Growth Benchmark established under M.G.L. c. 6D, §9, but this will not mitigate the damage this Proposed Project will cause to the Commonwealth's goals for cost containment.

As written, proposed Condition 5 looks narrowly at DFCI's future annual cost per inpatient (while omitting from the calculation the very costly pharmaceutical expenses for cancer treatment and related increases to outpatient costs) and compares that to the healthcare cost growth benchmark. The omission of pharmaceutical expenses and outpatient costs is particularly concerning given the CMIR's expectation that DFCI's Proposed Project will increase outpatient costs and that $26.5 million of the increase in commercial outpatient prices will be due to higher commercial prices for oncologic drugs at DFCI. This comparison does not address the DoN factors or the potential damage to the Commonwealth's health care system from this Proposed Project. The DoN factors require DPH to consider how a proposed project will contribute to the Commonwealth's cost containment goals for the entire Commonwealth, not just the costs at an individual facility (see Factors 2 and 4).

By looking at DFCI's percentage growth in annual revenue and comparing it to the health care cost growth benchmark for the year, DPH is looking only at the costs related to the new hospital and not to the overall effects the hospital has on the Commonwealth's total health care expenditures. To track whether the new hospital puts the Commonwealth's cost containment goals at risk, DPH should be looking at how the new hospital will impact statewide health care expenditures and therefore damaging the Commonwealth's ability to stay within the health care cost growth benchmark. Such a Condition would necessarily include DPH review of the increased costs due to the shift in patients from community hospitals to DFCI, increased outpatient costs related to this expansion, increased labor costs, and the increased costs due to additional strain on Emergency Departments.

Such a review is particularly important in this instance, where DFCI does not need a 300-bed hospital for its Patient Panel, so if built as proposed, the project will have a strong impact on total healthcare expenditures by shifting patients from community hospitals to fill the new DFCI beds.

In addition, even if this condition were properly aimed at helping DFCI satisfy Factors 2 and 4, the Staff Report proposes that if DFCI does increase its annual growth percentage, the solution is to require DFCI to develop a plan to make equity investments to increase health equity and access. That will not address the increased total health care expenditures (THCE) due to this project.

Instead, we suggest the Department impose a condition that limits the number of beds that DFCI can build out and license to reflect the actual established needs of DFCI's Patient Panel. The condition should permit DFCI to build out and license 126 inpatient beds. Prior to permitting any amendment to expand the approved number of beds, DPH should require DFCI to establish to the PHC's satisfaction that any expansion of its Patient Panel need for inpatient beds is not due to a shift in patients from community hospitals. 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.

Conclusion

DFCI has not established that it has Patient Panel need for 300 new cancer beds, and if the Department permits DFCI to build this project as proposed, it will irretrievably lead to increases in THCE, as well as destabilizing the hospitals that currently provide high quality cancer care. 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.

The risk of this approval cannot be mitigated by an after-the-fact plan to increase DFCI's investments in health equity and access. Instead, the Department should consider imposing a condition that is directed at addressing these possible risks by limiting the number of beds DFCI can open to the number needed by its Patient Panel, instead of approving more than twice than number of beds.

Sincerely,

Christopher Philbin

Christopher Philbin
Vice President, Office of Government Affairs