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January 27, 2022

Via Email:

Lara Szent-Gyorgyi, MPA

Director, Determination of Need Program

Department of Public Health

67 Forest Street

Marlborough, MA 01752

Re: Application No. MGB-20121612-HE: Independent Cost Analysis

Director Szent-Gyorgyi:

On behalf of the Massachusetts General Hospital (MGH), I am pleased to provide comments about the recently completed independent cost analysis (ICA) for the above-referenced Mass General Brigham (MGB) application. Consistent with regulations, the scope for this ICA was defined by the Department of Public Health's (DPH) Determination of Need (DoN) Program as was the selection of Charles River Associates as the independent economist. The charge of the ICA focused on determining whether the proposed project would be consistent with Massachusetts' health care cost containment goals. The analysis also required an evaluation of the MGH's calculation of need.

The ICA affirmed that the project is consistent with health care cost containment goals and is needed to serve our patient panel, offering the following conclusions:

- Significant growth in demand for all services in the proposed project is predicted for the next five to ten years and will be driven by projected population growth of MGH's service area and the aging of the population.
- MGB's influence or "shares associated with the proposed project are modest and unlikely to meaningfully change the system's bargaining leverage with health insurers."
- Allowing capacity-constrained health care providers to expand has been demonstrated to put "downward pressure on health care prices and reduce expenditures on health care services."
- Although the proposed project will increase expenditures for services provided to patients who switch to MGH, the overall increase in expenditures across all services in the proposed project is "only 0.2 percent."

While the DPH must consider the HPC's comments, it should not give those comments greater weight than the ICA and the DPH's own analysis of the factors within the DoN application. The ICA was a carefully scoped analysis, and the DPH accepted the final report because it was complete, comprehensive, and consistent with the charge. The ICA and the HPC's conclusions, however, do not align, and the DPH should recognize the context

and limitations of the HPC's approach. The HPC conclusions are speculative and raise scenarios that it could not substantiate through independent data. Also, the HPC analysis did not review the DoN application from a patient access or need perspective. In fact, MGH cannot meet its current demand for inpatient care, a problem that negatively affects access, quality, and patient experience. In addition, the HPC ignored future demographics and utilization trends, and without new capacity, patient choice and access would effectively be rationed by the state.

Forcing MGB patients to go outside of the system of care they had selected because another provider has capacity is contrary to the Commonwealth's prioritization of care continuity as evidenced by its promotion of ACOs. Indeed, Mass General Brigham has embraced population health as a strategic initiative and has a robust MassHealth ACO. And while MassHealth beneficiaries may not be the highest proportion of patients cared for within the MGB system, it is important to recognize that MGB cares for more MassHealth patients than any other provider in the Commonwealth. It is misleading, therefore, to focus on overall payer mix without considering actual patients.

The HPC's role is narrow – to contain monetary health care costs. The HPC does not consider the benefits of a project from the access or quality perspectives. But that is, in fact, DPH's role, and it is critical that the DPH not lose sight of its broader purpose in determining what is needed for the good of public health. Additionally, the HPC does not consider the non-monetary costs if a project is not allowed to go forward. As an internationally recognized academic medical center, the MGH is a vital health care resource for the state and the nation. This teaching hospital has long been at the forefront of research and care delivery that improves patient outcomes and quality of life. The MGH has helped define this state as the epicenter for the highest quality medical care and research.

The proposed MGH project will focus on cancer and cardiac care not generally available in the community setting. For example, MGH is a leader in developing applications of the life-saving technology CAR-T that benefits certain cancer patients today with tremendous promise for new applications. Those individuals who are candidates for this and other novel therapies require access to specialized inpatient beds and highly trained staff to support the complex recovery from such their treatments. Similarly, MGH has a robust cardiac surgery program, including transplant and ECMO services – again, services not provided by community hospitals. Moreover, the proposed advanced imaging planned as part of the project will primarily serve inpatients, a nuance that the HPC failed to recognize in its conclusions regarding imaging costs. As the DPH is aware, imaging for inpatients is not separately reimbursed and is part of the global inpatient stay payment.

Contrary to the HPC assertion, MGH's need for additional capacity does not affect wealthy, commercially insured patients only. In fact, MGH serves as the community hospital for families in Chelsea, Revere and Everett as well as those who live in many neighborhoods in Boston. These communities, in fact, are not wealthy, and many of their residents are MassHealth beneficiaries. People who live in the communities around this hospital rely on the MGH Emergency Department and residents from these neighborhoods represent a significant percentage of inpatients at MGH. In addition, MGH's affiliate Salem Hospital, is the community hospital for the cities of Lynn and Salem, and MGH serves as the tertiary and quaternary care provider for these communities. MGH has long recognized its role in providing care to underserved by operating health centers that offer care and services right in those communities. MGH also provides millions of dollars in financial support annually to community and public health partners to address the social determinants of health.

While the HPC has acknowledged the impact of the pandemic, it failed to acknowledge that the capacity problems we are now seeing existed long before the pandemic arrived. The pandemic did, however, serve to shine a bright light on the increased capacity constraints hospitals have faced. There is a long-standing ED boarding problem in Massachusetts, and specifically at the MGH, there are so many patients waiting for extensive periods of time in its

ED that it is often on Capacity Disaster, meaning there are no available beds and MGH cannot accept transfers of critically ill patients from other hospitals – patients for whom the MGH represents the best hope.

Moreover, 72% of MGH’s inpatient beds are in double rooms and a significant portion of care is provided in facilities constructed 50-80 years ago. Compare this to the MGH’s peer institutions across the country that have 100% single rooms – the standard of high-quality care. Single-bed rooms are the DPH requirement for any new bed construction. The goal for the new building is to decommission beds in aged buildings, convert double rooms into private rooms, and enable some net new bed capacity for flexibility in the future. Completion of this plan would still not get MGH to reach the goal of all private rooms as there would be over 100 beds in double occupancy rooms.

Based on the application and the ICA, the DPH should conclude that the proposed project has met all of the DoN factors of review. Therefore, it should approve MGB’s application and ensure citizens of the Commonwealth have access to MGH’s highest-quality services. Without more single-room inpatient beds at MGH, the hospital may be unable to respond effectively to the next pandemic, to the next surge in demand. Clearly, this project is needed now more than ever. The MGH remains committed to providing the highest standard of care for all – for being the last and best hope for the sickest patients in our region, and for being a comfortable, supportive, and responsive place of care and healing for our surrounding communities.

We urge the DPH to take favorable and timely action to allow the project to move forward. We appreciate the DoN Program’s time and thoughtful review of the Application.

Sincerely,

A handwritten signature in black ink, appearing to read 'David F. M. Brown', written in a cursive style.

David F. M. Brown, M.D.
President, Massachusetts General Hospital

cc: R. Rodman, Esq.
T. McNamara
E. Kelley