

In The Matter Of:
*Partners Healthcare System, Inc., Determination of
Need Application #PHS-19093011-HS*

*Department of Public Health
Vol. I
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**DORIS O. WONG
ASSOCIATES, INC.**

C O U R T R E P O R T E R S

50 Franklin St., Boston, MA 02110
Phone (617) 426-2432

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COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF PUBLIC HEALTH
DETERMINATION OF NEED PROGRAM

PUBLIC HEARING RE:

Partners Healthcare System, Inc., Determination of
Need Application #PHS-19093011-HS

Substantial Change in Service
Determination of Need Required Equipment
Massachusetts General Physicians Organization

BEFORE:

Margo Michaels, MPH
Director, Determination of Need Program

Held at:
Holiday Inn, Bunker Hill
30 Washington Street
Somerville, Massachusetts
Wednesday, November 20, 2019
5:59 p.m.

Alexander K. Loos,
Registered Diplomate Reporter

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1 P R O C E E D I N G S

2 MS. MICHAELS: Hello. Good evening,
3 everyone.

4 Welcome to the public hearing for the
5 Massachusetts Department of Public Health
6 Determination of Need program. My name is Margo
7 Michaels. I'm the director of the program.

8 And the purpose of tonight's hearing,
9 according to state regulation, is to allow any
10 person to make their views known with respect to an
11 application before the Department. This hearing is
12 not one where we'll be reviewing evidence or hearing
13 arguments. Rather, it's a public forum for the
14 presentation of any comments that might be relevant
15 to the consideration of an application.

16 For some background, although the applicant
17 will come up first, Partners Healthcare System has
18 filed a notice of Determination of Need for a change
19 of service in the Massachusetts General Physicians
20 Organization, which is a multispecialty group, and
21 its affiliated organization of MGH. These
22 physicians provide various services at MGH licensed
23 facilities and operate as licensed clinics providing
24 freestanding imaging services in Waltham and

1 Chelsea.

2 The proposed project is for the expansion
3 of this clinic through the addition of three 3T
4 magnetic resonance imaging units to be located at
5 Assembly Row here in Somerville.

6 We look forward to hearing comments from
7 the public as well as members of two taxpayer groups
8 that have formed on this specific application. The
9 application has been posted on the DPH website as
10 well as our questions to applicant. Tonight's
11 hearing is being recorded, and a transcript of this
12 recording will also be posted on our website.

13 In order for everyone to have the
14 opportunity to speak, I would like to ask for
15 comments to be limited to three minutes, and we're
16 going to have one of my colleagues here with little
17 signs to tell you when your minutes are up. I will
18 call each person up in the order that they have
19 signed in. To save time, I'll also ask the next
20 person to come up so they can sit in the front,
21 although it looks like we're not going to be
22 jostling for crowd control. Written comments will
23 also be accepted as part of tonight's hearing.

24 Finally, before we take action, final

1 action on any application, we must consider any
2 comments or specific recommendations presented here
3 or submitted to us. Any person and any ten taxpayer
4 group may provide written or oral comment any time
5 during the first 30 days following the filing date
6 of an application or, in this case, during the first
7 ten days after a public hearing. So if you would
8 like to comment, and you will not do so tonight, we
9 need to hear back from you by November 29th. And
10 Lucy, we have cards with our e-mail address and
11 regular address if you want to send it snail mail.

12 So with that, I would like to ask the
13 applicant to come up and give a presentation on the
14 application.

15 DR. ROSMAN: Thanks so much. Thank you,
16 Director Michaels and guests.

17 My name is David Rosman. I'm a staff
18 radiologist at Mass. General Hospital and service
19 chief for outpatient imaging. I'm pleased to be
20 here today on behalf of our patients and our -- my
21 colleague physicians who serve them to talk about
22 their urgent need for better access to timely,
23 cost-effective imaging. We hope to provide that for
24 them at a physician-owned -- as you heard -- and

1 operated imaging satellite to be located at Assembly
2 Row here in Somerville.

3 I want to thank the Department of Public
4 Health for holding this public hearing. Thank you
5 all for being here and -- and look forward to the
6 conversation today.

7 I have some written remarks, and I will
8 submit them, but I'll try and summarize tonight.

9 As a service chief of outpatient imaging,
10 I'm responsible for the development and delivery of
11 outpatient services for patients served at Mass.
12 General Hospital and across Mass. General Physicians
13 Organization's imaging centers. I speak for our
14 entire team of clinicians, radiologists, nurses,
15 technologists and care coordinators when I say that
16 our mission to improve the health and well-being of
17 our patients by delivering excellence in patient
18 care and advancing that through innovation is a
19 foundation for all we do. When we think about why
20 we're here, why we're building this site, we're
21 trying to serve our patients better.

22 The proposed project will improve the
23 health and well-being of our patients by reducing
24 our current backlog and by improving access for our

1 current patients to low-cost, high-quality MRI
2 services.

3 Across all our locations, we're operating
4 at capacity. I think it's probably worth describing
5 why that's happening. MRI technology has really
6 advanced, even in my career. We are using MRI now
7 to solve problems we never used to. We can now
8 characterize lesions -- I'm an abdominal imager --
9 that we used to have to biopsy or operate on. We
10 don't have to do that anymore. We know what it is,
11 and, as a result, more MRIs means less operations.
12 We follow patients with cancer more closely because
13 we can see subtle changes one way or the other in
14 their care. And what that means is a patient who is
15 on a chemotherapeutic regimen, which can cost 200-,
16 \$300,000 a year -- a crazy place where we are in the
17 world right now -- we can change their direction of
18 care and say, "Stop using this \$200,000 drug. It's
19 not working." Or, "Change to a different one that
20 works." That changes everything, and the reason
21 that we can do that is why we're using so much more
22 MRI than we used to.

23 Well, what that results in is very full
24 capacity. So, for example, if you wanted to get an

1 MRI at MGH on main campus right now during normal
2 business hours, you'd be waiting about seven weeks
3 to book it.

4 Now, if you were -- had a pacemaker and
5 wanted an MR, most patients with pacemakers can't be
6 seen in almost any location, MR location, and we see
7 the majority of them at Mass. General, although
8 other sites do perform this, but we perform the
9 majority at Mass. General, and our next available
10 slot for a pacemaker MRI, at least as of last week,
11 was May 2020.

12 So if you think about -- I mentioned
13 before, "normal working hours." We don't operate
14 normal work hours anymore. At least our working
15 hours are different from normal. We open our doors
16 at 5:45. Some of our MRs on campus operate 24 hours
17 a day, but we open our doors at 5:45 for almost all
18 of our locations. We see our first patient at 6:00
19 and the last one out the door around eleven o'clock.
20 Even then, we're seeing waits of four weeks at the
21 extreme hours of the day.

22 And I ask you to put yourself in their
23 shoes. Faced with a possible cancer diagnosis --
24 you went and saw your doctor; they saw something

1 worrisome, and you might need an operation, or you
2 might need chemotherapy -- the time you want to know
3 is now. Right? Or maybe tomorrow, but certainly
4 not January, right? Or several months away. So if
5 we wouldn't want it, everyone here, right, we know
6 we need to do better for our patients, and that's
7 why we're trying to do this.

8 It's important to note that we wish to open
9 these centers not to capture new patients, but
10 rather to serve our own. We need to move our
11 ambulatory imaging from campus to off campus, not
12 only because it's the right thing to do, frankly, to
13 lower total medical expense -- and I'll get there in
14 a minute -- but also to open up space on campus for
15 vulnerable, complex and sick patients, patients who
16 need procedures, et cetera, that we can't get done
17 on campus because the waits are so long. We need to
18 make sure that we open capacity to see them and move
19 the ambulatory patients where they should be seen,
20 off campus in an ambulatory, lower-cost setting.

21 The proposed project will help to alleviate some of
22 the volume at Mass. General Hospital's main campus,
23 and as those people are seen that way, then we open
24 up that capacity on campus.

1 I want to emphasize the important --
2 importance of and the benefits of offering
3 community-based outpatient care. Outpatient
4 settings such as the proposed MRI clinic at Assembly
5 Row are often preferred by patients, and their
6 families, to be much more accessible, and we have
7 some commentary from patients that indicate that.
8 We all know getting into downtown is even more
9 difficult than -- than getting here tonight, and
10 then trying to park in large complexes, getting into
11 the hospital, it's difficult; it's onerous. And
12 when you are sick, when you are elderly, when you
13 are debilitated, that is difficult. It's not the
14 way that you want to get your care. And so if we
15 can offer that to them at a more convenient
16 location, that's what we are trying to do.

17 In addition to creating convenient access,
18 the proposed Assembly Row MRIs are going to be a
19 cost-effective setting for care. Specifically, this
20 isn't a hospital-licensed service. Imaging is going
21 to be at a physician-owned, physician-operated site,
22 and thus will be reimbursed at the lower rates of
23 reimbursement available to physician practices.
24 That's better for the community cost. It's better

1 for our patients. We've been doing that in Chelsea
2 and Waltham since 1999, and -- and wish to extend
3 that out, and the physician care at the MPFS price
4 point that people have seen.

5 Finally, I want to take a moment to
6 highlight the continuity of care benefits for our
7 patients that will come with this proposed project.
8 It's what sets our services apart. All MRI results
9 will be within our system. They'll go to our PACS;
10 they will go to our system and -- medical record.
11 And not only that, but they'll be seen by our
12 subspecialty radiologists. So you know that your
13 breast imaging is going to be read by a breast
14 radiologist. Your head and neck tumor will be read
15 by a head and neck radiologist.

16 That subspecialty care does two different
17 things: One for the patient, and for the physician
18 it's piece of mind of where they are going. But for
19 the healthcare system, it's actually less cost.
20 We've seen Walmart actually now demand that their --
21 or incentivize, at least, that their patients go to
22 subspeciality imaging practices for exactly that
23 reason. They've seen 25 to 35 percent decreases in
24 cost, of downstream medical costs because of

1 accurate diagnosis up front.

2 In closing, this is a project designed to
3 help and serve our current patients. We are trying
4 to solve an access problem. Our physician referrers
5 are concerned with the impact of wait times for
6 imaging on their patients, and our patients are
7 suffering physically and emotionally, waiting too
8 long for the image that they need. We've proposed
9 this project to meet the demands of our current
10 patient panel for more timely access to MRI imaging
11 and provide increased access to high-quality,
12 low-cost services in a community-based outpatient
13 care setting that is more convenient for many of our
14 patients.

15 For these reasons, I respectfully ask the
16 DPH to recommend approval for this proposed project.
17 And again, I thank you very much for your time.

18 MS. MICHAELS: Thank you.

19 Now I would like to call Mary-Theresa
20 Shore.

21 MS. SHORE: Good evening, everyone.

22 My name is Mary-Theresa Shore, and I'm the
23 senior director of clinical operations and the
24 director of quality and safety for the Department of

1 Radiology at Mass. General Hospital.

2 In my role, I'm responsible to ensure
3 high-quality, safe and timely imaging for all of our
4 patients in radiology. One of the biggest
5 challenges we face today is providing access to MRI
6 services in a timely manner.

7 As previously described by my colleague,
8 Dr. Rosman, despite our best efforts by expanding
9 operational hours into the wee early mornings of the
10 hours and the late, late evenings, the demand for
11 MRI services continues to increase. Patients are
12 forced to take scheduled appointments that are not
13 convenient for them at all. Many of the patients
14 who take our 5:45 a.m. slots leave their homes at
15 four o'clock in the morning to make sure that they
16 can arrive for their appointment on time and have
17 their imaging performed. And the same remains true
18 for those patients who have appointments late in the
19 evening, traveling home at eleven o'clock or
20 twelve o'clock at night. Many of these patients are
21 elderly or very sick, but they will take any
22 appointment available to them to get their scan
23 done.

24 I personally receive many phone calls every

1 day from patients, physicians, administrative staff
2 asking me can I do them a favor? Can I squeeze them
3 in? Can I find a gap in the schedule? Anything
4 that I could do.

5 Because of these escalating requests, the
6 department did develop a program called urgent, or
7 expedited, imaging to assist in finding gaps in
8 schedules to help accommodate these patients that
9 simply just cannot wait seven weeks for an
10 appointment. Although helpful to a small subset of
11 these patients, it does not solve our other overall
12 problem for access for MRI services.

13 And those are just services for our
14 outpatients. MGH is a thousand-bed hospital with ER
15 visits exceeding 100,000 and inpatient admissions
16 exceeding 50,000 annually. A large percentage of
17 those patients would benefit from MR imaging, but
18 given the current MRI access restrictions, when
19 emergency or inpatients exceed our capacity in those
20 resources, outpatients will be delayed, in many
21 instances hours from their scheduled appointment.
22 Inpatients are often needed to be scanned late in
23 the evening or in the middle of the night. That
24 causes challenges for our nursing staff but, more

1 importantly, it causes challenges for the care of
2 that patient and the well-being of that patient
3 being brought down at one o'clock in the morning for
4 their MRI scan. It's a delicate balancing act to
5 ensure all patient types can be accommodated based
6 on the acuity of their imaging needs.

7 By expanding services to Assembly Row,
8 those patients who do not require hospital services
9 can obtain appointments in a timely manner as well
10 as reducing the chance that they will be delayed
11 once they actually arrive for their appointment.
12 They will not have to worry about traffic and
13 congestion of downtown Boston and also navigating
14 the expansive campus at MGH.

15 Once we can triage patients to the
16 appropriate locations for their imaging based on
17 their condition and their clinical needs, new
18 interventional procedures using MRI can be
19 implemented. These procedures can profoundly have
20 an impact on the quality of so many patients' lives.

21 For these reasons, I respectfully ask the
22 Department of Public Health to recommend approval
23 for this project.

24 Thank you.

1 MS. MICHAELS: Thank you.

2 Now I would like to ask, is it Eleanor
3 Moresco?

4 DR. MORESCO: Moresco, yes.

5 MS. MICHAELS: Moresco.

6 DR. MORESCO: Thank you.

7 Good evening. My name's Eleanor Moresco.
8 I'm a primary care physician who's practiced for the
9 last 33 years in the Medford community, and I'm here
10 on behalf of the physicians, the community
11 physicians affiliated with MelroseWakefield
12 Healthcare, what was originally known as Hallmark
13 Health Systems.

14 You may or may not be aware that over the
15 past three years our community hospital, our
16 physicians and our collaboration and partnership
17 with Tufts Medical Center have started to create a
18 really gelling and effective low-cost healthcare
19 network located on the North Shore of Boston. This
20 started at the end of 2016 when our hospital went
21 into partnership with Tufts Medical Center, and, as
22 a result of that partnership and joint venturing
23 between our hospital, MelroseWakefield Hospital, and
24 Tufts Medical Center, Tufts has sent their tertiary

1 providers out into our community, not only with the
2 convenience of providing care and visits for those
3 patients in their own community, but these
4 specialists are actually doing the patient surgeries
5 and procedures and hospitalizing these patients at
6 MelroseWakefield Hospital whenever this is possible.

7 As the result of this collaboration between
8 Tufts and our own hospital, the physicians, the
9 independent practice association of physicians
10 affiliated with the hospital also decided at the end
11 of 2016 to leave their contracting affiliation with
12 Partners Healthcare network and join an alternative
13 contracting network that was also centered around
14 Tufts Medical Center as a very high-quality,
15 high-patient-care mixed acuity and a very low-cost
16 tertiary care hospital in the Boston area. It is
17 actually the lowest of the tertiary care hospitals
18 in cost, and for every hospital event that we move
19 to Tufts Medical Center away from events that are
20 happening in the Partners network, there's about a
21 30 to 40 percent cost savings to the healthcare
22 system.

23 As part of getting involved -- as part of
24 our support in getting into this new contracting

1 network, the physicians have taken on and accepted
2 very aggressive pay-for-performance contracts.
3 We're being held to extremely high standards of
4 quality performance, but extremely high metrics for
5 lowering the cost of health care in our patient
6 populations.

7 One of the incredible successes of this
8 joint venturing and this collaboration between
9 physicians, our hospital and Tufts Medical Center in
10 this lower-cost contracting network, is that we have
11 reduced our overall tertiary care hospitalizations
12 for certain medical conditions and disease states by
13 keeping those patients in our community for all
14 parts of their care; and, in addition, we've shifted
15 34 percent of our patients out of the Partners
16 network and into Tufts Medical Center as their
17 tertiary care hospital, which has created a huge
18 savings in the healthcare economy in our population.

19 So that brings me to the second thing that
20 I would like to talk to you about tonight, which is
21 that, as a community physician, I have a concern
22 that licensing this huge site with three powerful
23 magnets in what has traditionally been considered
24 our own primary and secondary service area could

1 become a destabilizing force to our emerging
2 low-cost healthcare network. My concern as a
3 physician leader is that this magnet is not just an
4 issue of diagnostics and access, but it may
5 represent the leading edge of a larger programmatic
6 approach to the community where subspecialists who
7 rely heavily on MRI for the diagnosis and management
8 of patients will be brought out to the community
9 into subspecialty clinics. Those are
10 traditionally -- those types of subspecialties are
11 particularly very procedure-based specialties, like
12 orthopedics, cancer care, spine surgery,
13 neurosurgery. The concern is that our patients will
14 be looking to access based on availability and
15 branding, will be looking to access this facility
16 for care, and rather than staying in the community
17 and getting their total care in the community, or at
18 our lower-cost tertiary care partner, that their
19 inpatient care will be channeled into the
20 higher-cost Boston facility for their surgeries, for
21 their procedures and their hospitalizations.

22 So finally, this brings me to the third
23 thing that I would like to say.

24 MS. MICHAELS: Please wrap it up.

1 DR. MORESCO: Pardon me?

2 MS. MICHAELS: Please wrap it up.

3 DR. MORESCO: Yes. It's the last thing I'm
4 going to say.

5 Which is that I would -- what the
6 physicians in the community would request of the DPH
7 is that before you grant this license, that you
8 please inquire and investigate into the long-term
9 plans that MGH has for developing other healthcare
10 facilities on this site.

11 Thank you very much.

12 MS. MICHAELS: Thank you.

13 Next we have Natalie Egan.

14 Oh, Jeremy Herrington and then Natalie?
15 Okay.

16 MR. HERRINGTON: Thank you to all in
17 attendance tonight.

18 Good evening. I'm Jeremy Herrington,
19 clinical director of MRI and off-campus imaging at
20 Massachusetts General Hospital. In my current role,
21 I oversee the daily operations of all MRIs at the
22 main campus as well as the ambulatory care centers
23 in Chelsea and Waltham. In my role, I ensure that
24 there is MRI access within an appropriate time frame

1 based on the acuity of care, site to site.

2 Year over year, it has become more
3 challenging to provide this care within a reasonable
4 time frame for our inpatients, ED patients,
5 outpatient -- and our outpatient population.
6 Furthermore, some of our outpatients with implanted
7 devices, such as pacemakers, require additional
8 services in order to perform their exam, and thus
9 must be performed at the hospital.

10 At MGH and through the MGPO, we have
11 internally increased access to MRI through expanding
12 hours and reducing time slots through -- for our
13 imaging through new technologies. We currently open
14 our doors at 4:45 in the morning and receive
15 outpatients on the main campus, with the last
16 outpatient appointment at 10:15 at night. All of
17 this, while managing higher-acuity inpatients and ED
18 patient care in the safest manner possible.

19 MRI has increasingly become a vital
20 diagnostic tool for inpatients and ED patients, and
21 we must provide access to this tool within a
22 reasonable time frame in the increase in length of
23 stay at the hospital. As inpatient volume
24 increases, we have been left with little choice but

1 to open sporadic overnight shifts to meet the
2 inpatient MRI demand.

3 Ultimately, achieving high-priority care
4 for our inpatients and ED patients inherently limits
5 the number and type of outpatient appointments the
6 hospital can offer. As access channels continue to
7 grow, managing the MRI schedules has become
8 increasingly untenable.

9 Within the department local MRI managers
10 and supervisors receive constant calls to assist
11 with patients who need an MRI but cannot wait
12 through our current backlog. Systematically local
13 managers must triage outpatient appointments based
14 on acuity, safety screening and care coordination.

15 As a clinical director, myself and the MRI
16 leadership team receive phone calls and pages
17 related to urgent add-on requests or requests that
18 must be done sooner than the first available
19 appointment at the main campus. Clinicians and
20 patients alike are astounded when they discover the
21 wait times, which often lead to frustration and
22 dissatisfaction.

23 This topic is particularly true with regard
24 to management of pacemakers and other

1 electronically-implanted devices that require
2 oversight during imaging. Based on our current
3 access, as of today, we are booking patients who
4 need MRI and have a pacemaker in May 2020.

5 In addition to the hospital, we are fully
6 booked at our off campus sites. Our Chelsea and
7 Waltham sites operate 16 hours a day, seven days a
8 week. There are currently no urgent or immediate
9 appointments available across all off-campus sites.
10 As a result, this leads to frustration for patients,
11 clinicians and staff looking for semi-urgent patient
12 care or -- or to potentially avoid an admission to
13 the ED.

14 In conclusion, the MRI leadership team has
15 performed heroic efforts, but as the acuity of
16 patients and the complexity of medical implants
17 increases, scanning routine outpatients at the
18 hospital continues to become increasingly
19 challenging. The scanners at Assembly Row will
20 allow us to reduce our outpatient backlog while
21 further assisting with managing the more acute cases
22 at the hospital in a timely manner.

23 I want to thank the Department of Public
24 Health for holding this hearing and considering this

1 important DoN request on behalf of Massachusetts
2 General Hospital and the Massachusetts General
3 Hospital Physician Organization.

4 MS. MICHAELS: Thank you. I keep doing
5 that every single time. Thank you.

6 Now Natalie Egan. Thank you.

7 MS. EGAN: Jeremy's tall.

8 Thank you, Director Michaels, for allowing
9 me to speak tonight.

10 My name is Natalie Egan, and I am a
11 practice support manager for Mass. General imaging.
12 I'm the liaison between the referring offices, their
13 physicians and staff, and the department of
14 radiology. I'm their advocate.

15 The biggest challenge I face, which you
16 probably know, is MRI access. It affects nearly
17 every group at MGH. I hear stories every day from
18 my offices. When they call me, it's my job to help
19 them solve their problem.

20 I'm not going to repeat what's already been
21 said. Rather, I'm just going to tell you about a
22 situation that really affected me as a practice
23 support manager.

24 I received a call from my pediatric

1 neurosurgery office. A patient, who was about ten
2 years old -- and my son was ten at the time, so it
3 really struck me -- he came to the physician's
4 office with headaches and vision changes. The
5 physician told the mom that they suspected a brain
6 tumor and wanted to get an urgent MRI. Of course
7 the parents were very nervous, very concerned, and
8 their entire world had been turned upside down.

9 I got a call, and the scheduler said,
10 "Natalie, these patients are right" -- "the parents
11 are right in front of me. Is there anything you can
12 do?"

13 There was nothing available. Of course, I
14 had to call the MRI operations manager and my MRI
15 staff and say, "Hey, is there anything you can do?
16 Can you squeeze this patient in, please?"

17 The parents had to go home. There was no
18 MRI appointment. There was no follow-up physician
19 appointment. They basically had to go home with
20 this child that was potentially diagnosed with a
21 brain tumor.

22 After a few calls, the MRI staff worked
23 their magic. They were able to get this patient an
24 appointment, and it was great. The patient had the

1 MRI. Fantastic. Unfortunately, it didn't align
2 with when the physician was available for their
3 appointment. So they had to go home again, no
4 results, and they had to come back for their
5 physician's appointment to learn the fate of their
6 child.

7 I think that, you know, we need additional
8 MRIs. The only thing we can do -- like we're doing
9 everything possible to fit these patients in, but
10 the only thing that we can do at this point is add
11 more MRI machines. When we move a patient or
12 squeeze a patient in, we're adversely affecting
13 other patients. So somebody's getting bumped, or
14 someone's getting moved. And it's not fair. We
15 should be able to take care of our own patients.

16 And I'm not talking about this as a single
17 occurrence. I actually had at least, like, 15
18 examples I could have brought up. I could really go
19 on and on, but I'm not going to do that tonight.
20 I'm just going to respectfully ask that you consider
21 to add the additional MRIs to the Assembly Row area.

22 Thank you.

23 MS. MICHAELS: Thank you.

24 Okay. Next up we have Ryan Fuller.

1 DR. FULLER: Good evening. Thank you for
2 allowing me to submit my comments. I'll be
3 providing written comments as well.

4 Like Dr. Moresco, I have concerns about the
5 project's impact on existing community providers and
6 its ability -- and the applicant's ability to
7 compete on the basis of price, total medical expense
8 and provider cost, or meaningfully contribute to the
9 Commonwealth's goal of improved public health
10 outcomes and delivery system transformation.

11 Community providers like MelroseWakefield
12 Healthcare have continued to demonstrate that we
13 were committed to the communities that we serve by
14 relentlessly focusing on delivering high-quality
15 care and value-based health care. Two examples of
16 this: Our recently-approved ambulatory surgery
17 center where we are committed to providing
18 lower-cost surgeries in the communities that we
19 serve, in the communities that we live in, and our
20 increase in inpatient case mix over five percent
21 over the last two years by partnering with our
22 Wellforce colleagues, specifically Tufts Medical
23 Center.

24 This application, in addition to the

1 multiple other DoNs recently filed by Partners
2 Healthcare, threaten work and access to high-value
3 community health care. I would like to focus my
4 remarks tonight on the ways in which the application
5 fails to provide sufficient data to illustrate the
6 need for three MRIs in Somerville.

7 In its application, Partners Healthcare
8 repeatedly states that the current fleet of MRIs is
9 operating near capacity. However, the application
10 does not provide enough evidence to support this
11 claim. At the very least, the Department should
12 consider asking for additional data. And my
13 remarks, that I will submit, outline those data
14 requests.

15 I believe this information will illustrate
16 that there is not a need for three MRIs, and new --
17 new, costly imaging machines to this market. I
18 believe that the Department should also inquire as
19 to whether Partners will be willing to repurpose any
20 of its existing more costly MRIs to serve the
21 application's stated purpose. As you know, a report
22 by HBC last year detailed how Massachusetts stands
23 out the fourth highest in -- highest in the nation
24 for spending on imaging services.

1 The application asserts that it will be
2 increasing the need for imaging services in the
3 growing population of people aged 65 and up. While
4 that logic makes sense, it fails to take into
5 account that Medicare, the predominant payer of
6 medical services to the elderly population, has been
7 highly critical of the skyrocketing rates for
8 imaging services, and is implementing the new
9 Medicare appropriate use criteria program. This
10 program is intended to curtail inappropriate
11 advanced diagnostic services provided to Medicare
12 beneficiaries and will undoubtedly curb the rate of
13 utilization in this population.

14 Furthermore, it is our understanding that,
15 if approved, Partners will have a total of 55 MRIs
16 across its system. Table 1 of the application
17 identifies 1.5 million unique patients. Using some
18 industry standards that -- using industry standards,
19 we believe that equals 150,000 scans per year. If
20 we assume one scan per patient, that would mean --
21 that would mean Partners would be running its
22 machines at 34 percent capacity.

23 Specifically to the Somerville market,
24 Table 3 of the application identifies only 9,139

1 unique patients in this service area. Assuming,
2 again, 8,000 scans as a capacity, the applicant is
3 far from demonstrating the need for three MRIs to
4 serve this patient panel.

5 In closing, I would like to thank the
6 Department for allowing me to raise my concerns.
7 Approval of these three additional machines within
8 the state's highest health -- highest-cost
9 healthcare system will undermine much of the hard
10 work that has gone into strengthening in the
11 existing community providers and ensuring patients
12 have access to lower-cost choices.

13 I appreciate the time and attention the
14 Department of Public Health is putting into the
15 rigorous analysis of this request. If this request
16 is truly necessary, actually beneficial to the
17 healthcare consumers and aligns with the state's
18 goals of lowering healthcare costs, enhancing access
19 to critical services throughout communities like
20 behavioral health and -- behavioral health and
21 primary care --

22 And I'm getting the hook. Thank you.

23 MS. MICHAELS: Thank you.

24 Next, and I believe last, is Abe Shoreland.

1 DR. SHORELAND: Good evening. Thank you,
2 Director Michaels, for the opportunity to speak.

3 My name's Abe Shoreland. I'm an orthopedic
4 surgeon working in the area. I practice on Montvale
5 Avenue in Stoneham, which is close to the site that
6 is proposed. I'm in a group of seven orthopedic
7 surgeons. We order a high volume of high -- of MRIs
8 daily of high quality. I personally have not
9 experienced any difficulty ordering imaging services
10 for my patients working with local providers.
11 Additionally, I do believe that my patients have
12 more than adequate access to high-quality, low-cost
13 follow-up care within the community.

14 If approved, I worry that Partners will use
15 these MRIs to funnel patients' care into their
16 high-priced downtown academic medical centers for
17 services that could otherwise be offered at a lower
18 cost to consumers in the community. As you know,
19 patients are often blind to the provider market
20 share and patient referral strategies. An expansion
21 of this type will only further guise those efforts
22 and leave patients feeling like they're without
23 choice in seeking more-convenient, less-costly
24 health care services.

1 As the state continues to focus on delivery
2 system transformation, I think specific attention
3 should be paid to ensure that well-funded,
4 high-priced providers are not creating an arms race
5 to build new, when there are existing providers in
6 the community that offer similar services. Without
7 this level of review, patients like mine have a
8 greater risk of getting pulled into higher-priced
9 systems without any benefits of increased quality or
10 convenience.

11 Thank you for the opportunity to speak.

12 MS. MICHAELS: Thank you. Oh, great.

13 Thank you. Next is Stephen Mackey.

14 And is there anyone else who would like to
15 speak after Mr. Mackey?

16 Okay. I'll give you one more shot when
17 he's done.

18 MR. MACKEY: Thank you, Dr. Michaels.

19 My name's Stephen Mackey. I'm president
20 and CEO of the Somerville Chamber of Commerce. I
21 want to thank the Department for coming here to
22 Somerville with this public hearing, and thank you
23 for the opportunity for brief remarks.

24 I am not a healthcare professional, but on

1 behalf of the Chamber of Commerce, and from our
2 perspective, we wanted to be here to point out what
3 a great addition to the community Partners
4 Healthcare has been, and we also want to offer a
5 little -- from our perspective, when you think about
6 site selection in Greater Boston, in the
7 metropolitan society in whatever dimension you think
8 of it -- whether it's business, or healthcare, or
9 education -- Somerville has taken advantage of and
10 been the beneficiary of the great urban resurgence
11 that's been going on in the world and in this
12 metropolitan area, and it's also been the
13 beneficiary of metropolitan and federal leaders
14 recognizing Somerville for its location.

15 We succeeded a few years ago in convincing
16 the powers that be in locating an Orange Line T
17 station at Assembly Square. That brought us our
18 great Partners Healthcare System and about a billion
19 dollars in other investments that have come in and
20 are coming along. Also our location convinced the
21 metropolitan planning organization and the MBTA to
22 invest a billion -- for the state to invest a
23 billion dollars and the federal government to invest
24 a billion dollars in establishing new stations along

1 the Green Line in Somerville. So from that
2 perspective, we would suggest that if it's serving
3 the society in metropolitan Boston in any way,
4 Somerville, and particularly Assembly Row, is
5 just an outstanding location. And also one that,
6 while we've been here for forever -- literally --
7 it's been discovered only recently. So it's really
8 been discovered and appreciated just recently.

9 Thank you very much.

10 MS. MICHAELS: Thank you.

11 All right.

12 With that, I have no more names on my list,
13 so I just want to ask if people want to speak.

14 Going once. Going twice.

15 Great. Thank you all for attending. I
16 appreciate it. If you have further comments, you
17 can send it to us in the next ten days. That would
18 be due back to us on November 29th.

19 Thank you.

20 (Whereupon, the proceedings were
21 concluded at 6:35 p.m.)
22
23
24

C E R T I F I C A T E

I, Alexander K. Loos, Registered Diplome
Reporter, do hereby certify that the foregoing
transcript, Volume I, is a true and accurate
transcription of my stenographic notes taken on
November 20, 2019.



Alexander K. Loos
Registered Diplome Reporter

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D I S C L A I M E R

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