



THE GENERAL COURT OF MASSACHUSETTS
STATE HOUSE, BOSTON 02133-1053

To: Department of Public Health, Determination of Need Program
250 Washington Street, 6th Floor
Boston, MA 02108

CC: Mrs. Marylou Sudders, MSW, ACSW
Secretary of Health and Human Services
Commonwealth of Massachusetts

August 22nd, 2022

We write to request that the UMass Memorial Medical Center Determination of Need application related to creating 91 additional medical/surgical beds across multiple buildings be subject to an Independent Cost-Analysis (“ICA”). While we generally support the expansion plans of UMMC, there are a lot of questions that need to be answered. It is critical that any planned construction reduces capacity constraints and helps consumers save on costs. Keeping in mind the rebuttal of UMMC’s claims about other leading hospitals, the best way to determine if expansion will increase quality of care while lowering healthcare costs is via an unbiased third-party review.

The Greater Worcester region is already served by multiple low-cost, high-quality providers, so we have legitimate concerns as to whether the proposed \$144 million expansion will in fact bring down prices and benefit patients. UMMC claims that failure to approve the new beds will increase “the potential for patients to be transferred to higher cost hospitals outside of the service area.” St. Vincent Hospital has 51 licensed/medical surgical beds that have been temporarily closed on account of staffing shortages, and an additional 12 beds available for use at times of increased demand, totaling 63 beds able to be activated at short notice in the UMMC service area. Existing providers maintain the capacity to house any patients the UMMC is unable to hold. Therefore, we fear that this expansion will serve to take patients from UMMC’s satellite campuses to the Worcester flagship, referring these patients to higher cost physicians without any discernable quality of care benefit. Despite what UMMC says, we see this move having the potential to increase healthcare costs in Central Massachusetts, while also driving consumer traffic away from UMMC’s satellite campuses. While we want to ensure the Greater Worcester region has the highest quality medical care for our residents, given the facts of local hospital bed capacity, the UMMC claims of capacity constraints do not ring true.

We believe it is in the best interests of the DPH to mandate an independent review of the expansion to ensure costs will remain low and quality of care will be maintained at a high level. Only after this independent review confirms the veracity of the claims presented within the UMMC DoN application should the project move forward. There is a precedent of Independent Cost-Analysis in major hospital expansion. In 2021 Mass General Hospital was subject to an ICA for their proposal to create ambulatory

care centers in Westborough, Woburn, and Westwood. We believe it is imperative that the Commonwealth ensure every aspect of major hospital expansions are thoroughly vetted. The UMMC's \$144 million expansion proposes 91 additional medical/surgical beds and multiple renovations, and should certainly warrant this. It would be irresponsible to let a project of this scale advance without third-party verification. Again, we urge you to mandate an ICA for the UMMC DoN application, as only through impartial and independent studies can the Commonwealth best determine whether new projects are needed or beneficial.

Sincerely,

James J. O'Day
State Representative
14th Worcester District

Michael O. Moore
State Senator
2nd Worcester District

Harriette L. Chandler
State Senator
1st Worcester District

Sean M. Rose
Worcester City Councilor
District 1

Michael Soter
State Representative
8th Worcester District

Susannah Whipps
State Representative
2nd Franklin District

From: Rose, Sean M. <RoseS@worcesterma.gov>
Sent: Saturday, September 3, 2022 8:36 AM
To: McGeown-Conron, Ryan C (DPH); Kelley, Elizabeth D. (DPH)
Subject: UMASS Medical Center

CAUTION: This email originated from a sender outside of the Commonwealth of Massachusetts mail system. Do not click on links or open attachments unless you recognize the sender and know the content is safe.

Good Morning,

My name is Sean Rose and I am a District-1 Councilor in Worcester. My name was added to a letter to the Department of Public Health asking UMASS Medical Center to do an independent cost analysis. My name should not have been added. I had asked that my name not be put on until I was able to seek more information on the project. I do not support the request for this analysis to take place. Please disregard my name being added to this letter.

Respectfully,

Sean Rose

Sean Rose, M.Ed.
District 1 ~ City Councilor

From: Janet Wilder <janet.wilder@theshareunion.org>
Sent: Tuesday, August 23, 2022 8:02 PM
To: DPH-DL - DoN Program
Subject: In support of UMass Memorial Proposal to Add Beds

To Whom It May Concern,

My name is Janet Wilder. I'm an Organizer with the SHARE/AFSCME Union. SHARE represents more than 3000 healthcare workers at UMass Memorial Medical Center and UMass Memorial Marlborough Hospital. We are Nursing Assistants and Mental Health Counselors, Secretaries and Schedulers, Xray Technologists and Respiratory Therapists, and many more.

Thank you for the opportunity to voice SHARE members' serious concerns about the number of beds available for patients who need them at our hospital, and in support of the proposed bed expansion.

Other people's testimony will focus on the numbers: How under-bedded Central Mass is (20% lower), the number of hours that ED boarders wait for a bed on average (17), how many boarders we have every day (50 to 70). I want to give you a piece of the picture of what it's like to work at UMass Memorial's Emergency Department – the 2nd busiest in the state, with very high acuity patients.

We are soooo full. It's especially hard on the staff in the Emergency Room, where patients get stuck because there are no patient rooms available upstairs. One Cat Scan technologist was telling me that the demand for Cat Scans in the ED is so high they often have lots of beds in

the hallways outside of Cat Scan to accommodate the overflow – which means a long wait for the patients, no privacy, and delays. This past Saturday night was busy, with patients waiting 7 or 8 hours just to get a Cat Scan. The Technologists have a long list of in-house patients waiting for a Cat Scan, but they need to take the traumas and emergencies first. For example, UMass Memorial Medical Center is a Level 1 trauma center with Stroke certification, so stroke patients take precedence over everybody else waiting. SHARE members are proud to do this work – we are the only Certified Comprehensive Stroke Center in Central Mass. The staff clear the Cat Scan table when the stroke patient rolls into the ED, and hold it for them – we all know that “time is brain” for stroke patients.

But the ED staff feel awful making any patient wait, worried that the wait will affect their care. This technologist stayed late Saturday night til 1am, she didn’t feel she could leave. It's exhausting to work that way, always running and worrying about waiting patients.

That’s just one tiny glimpse of a picture of what staff, and the patients, are going through every day, every week, at UMass Memorial Medical Center. We need more CT scanners and more beds!

Janet Wilder
SHARE Organizer
c: 617-620-2127
www.theshareunion.org



CITY OF



Worcester
MASSACHUSETTS

JOSEPH M. PETTY
MAYOR

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Massachusetts Department of Public Health
Determination of Need Program
Attn: DoN Support
67 Forest Street
Marlborough, MA 01752
ATTN: Elizabeth D. Kelley, MBA, MPH, Director, Bureau of Health Care
Safety and Quality

Re: UMass Memorial Medical Center - DoN Application #UMMHC-22042514

Dear Ms. Kelley:

I am writing to support UMass Memorial Medical Center's application to add 91 new inpatient beds.

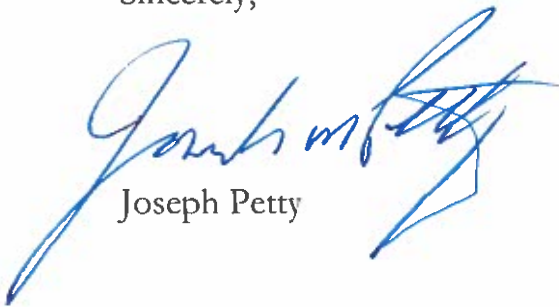
Residents of the City of Worcester are impacted by the Central Massachusetts bed shortage, especially as they seek care at our largest hospital, UMass Memorial Medical Center. With 20 percent fewer beds in this region than Western Massachusetts and 15 percent fewer than Eastern Massachusetts, residents of Worcester and surrounding communities do not share the equitable local access to care as their peers across the state.

It is important to note that UMass Memorial is legislatively mandated to provide "highly specialized clinical services" not available at other hospitals in Central Massachusetts and to be the safety net provider for "indigent patients" in the region. Among the highly specialized services it uniquely provides are the region's only Level 1 adult and pediatric trauma center, only Level 3 NICU, Pediatric ED, Pediatric ICU, liver and kidney transplant center, comprehensive advanced interventional stroke and cardiovascular center, bone marrow transplant and CAR-T cell therapy program. And, in terms of indigent patients it treats the largest volume of MassHealth/Medicaid patients in the entire region.

UMass Memorial provides a critical service in implementing this legislative mandate. However, its ability to fully meet the demand for highly specialized services and safety net care is severely impeded by the bed shortage. On a typical morning, 50 to 70 patients who have already been admitted to the hospital remain in the emergency department as boarders for an average of 17 hours before getting a bed. Additionally, over the past year the Medical Center has been forced to refuse literally thousands of transfer requests from community hospitals for high acuity patients who need specialized care unavailable in the hospital where they are. These patients mostly had their care substantially delayed while they awaited a transfer, or they were transferred to more distant tertiary care centers such as the Boston academic medical centers.

This problem is fixable and the proposal that is now before you is an important part of the solution. It is in the best interest of residents of Central Mass that this application be approved, and I therefore respectfully request your favorable review.

Sincerely,

A handwritten signature in blue ink, appearing to read "Joseph Petty", with a stylized flourish extending from the end of the signature.

Joseph Petty

JAMES P. McGOVERN
SECOND DISTRICT, MASSACHUSETTS

CHAIRMAN
COMMITTEE ON RULES

SENIOR DEMOCRATIC WHIP



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House of Representatives

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August 26, 2022

Massachusetts Department of Public Health
Determination of Need Program
Attn: DoN Support
67 Forest Street
Marlborough, MA 01752
ATTN: Elizabeth D. Kelley, MBA, MPH, Director, Bureau of Health Care Safety and Quality

Dear Director Kelley,

I write to you today in support of UMass Memorial Medical Center's application to add 91 new inpatient beds and respectfully request that the Department of Public Health recommend its approval.

Central Massachusetts has a significant bed shortage, with 20% fewer beds per-1,000 residents than Western Massachusetts and 15% less than Eastern Massachusetts. As the sole regional provider of many highly specialized services, UMass Memorial is instrumental in ensuring that residents of Central Massachusetts access the appropriate level of care locally, rather than traveling to distant tertiary care centers. Residents and community hospitals alike turn to the Medical Center for high acuity, tertiary care. For example, it has the region's only Level 1 adult and pediatric trauma center, only Level 3 NICU, Pediatric ED, Pediatric ICU, liver and kidney transplant center, comprehensive advanced interventional stroke and cardiovascular center, bone marrow transplant and CAR-T cell therapy program. As a result, Central Massachusetts residents who need these services must either get them at UMass Memorial or travel outside the region for care.

The urgency of the bed shortage becomes most apparent by considering its impact upon emergency department volume and waiting times, and how often the Medical Center must decline transfer requests from other hospitals because a bed is not available.

Emergency Department

The Medical Center's emergency department (ED) is the second busiest in Massachusetts and its patients have a high acuity level. But at the beginning of each typical day, approximately 50 to 70 *admitted* patients are "boarding" in the ED because a bed is not yet available for them. The average boarding time for these admitted patients is 17 hours – which equates to a total of 19 hours of post-admission waiting time, since one is only counted as a "boarder" 2 hours after admission. While the Medical Center provides excellent care, such delays create risks: numerous studies show that prolonged delays for high acuity patients increases their likelihood of adverse health outcomes, extended lengths of stay, and likelihood they will need costly post-discharge treatment.

Transfer Declines

Of the Commonwealth's 6 academic medical centers (AMCs), UMass Memorial is the only one located outside the City of Boston. Because AMCs offer the most highly complex tertiary care—care that is typically unavailable at other hospitals—this means that the Medical Center is the sole provider of a wide variety of highly specialized services for a large geographic region. As a result, it receives a very large volume of transfer requests from community hospitals for high acuity patients who need specialized care. But due to overcrowding, it consistently must decline transfers. **In fact, from February 2021 through February 2022, the Medical Center had to decline approximately 3,500 transfer requests.** These patients either face significant delays in receiving the appropriate care while they wait in a community hospital, or they are transferred to distant providers of highly specialized care, typically higher priced AMCs in Boston. (State data shows the Medical Center is the most consistently low-cost AMC in Massachusetts.)

This is an urgent situation that has obvious implications for access, health outcomes and cost. Among those most impacted are many of the most vulnerable members of our community. The Medical Center is designated by the state as a “High Public Payer” hospital and by the federal government as a “Disproportionate Share Hospital” due to its disproportionately high ratio of low-income patients who are either uninsured or on MassHealth/Medicaid (in addition to those on Medicare). For low-income patients, the burden of ED delays or transfers to AMCs in Boston instead of Worcester are substantial. They and their families face barriers to care such as lack of transportation, inability to take time off from work and, for some, lack of insurance. These are substantial hurdles even when they seek care locally, but they are magnified when these patients face lengthy ED delays or are transferred outside the region.

I am impressed that UMass Memorial – which, as a safety net system, faces fiscal challenges arising from low Medicaid reimbursement rates – has devised this innovative, cost-effective proposal to help address this public health challenge. In fact, I am so supportive that I am actively seeking \$1 million in Fiscal Year 2023 federal “community project funding” for the expansion.

UMass Memorial Medical Center has done an incredible job to support our community and provide high quality care to those who need it most—this expansion will allow them to continue to provide that care. I respectfully ask that the Department of Public Health likewise support this application by expeditiously recommending its approval. Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink that reads "James P. McGovern". The signature is fluid and cursive, with the first name "James" and last name "McGovern" clearly legible.

James P. McGovern
Member of Congress



VIA EMAIL DPH.DON@MassMail.State.MA.US

Massachusetts Department of Public Health, Determination of Need Program
67 Forest Street
Marlborough, MA 01752
ATTN: Elizabeth D. Kelley, Director, Bureau of Health Care Safety and Quality

Re: UMass Memorial Medical Center - DoN Application #UMMHC-22042514

Dear Ms. Kelley:

On behalf of the United Way of Central Massachusetts, I am writing to support UMass Memorial Medical Center's bed expansion application. The proposed 91 inpatient beds will be instrumental in narrowing the bed shortage in this region and better providing for the health care needs of residents.

The United Way of Central Massachusetts (UWCM) serves thirty municipalities, including the City of Worcester. We work every day to break the cycle of poverty and support programs and collaborative initiatives aligned with our strategic vision for a healthy community. Our sphere of work aligns almost perfectly with what is commonly described in healthcare as "social determinants of health." In implementing our strategic vision, UWCM has worked with UMass Memorial in ways that are truly too numerous to count.

As the safety net health provider for this region, UMass Memorial is deeply and consistently engaged in partnerships with community-based organizations, including UWCM, to maximize our collective impact on improving the health and wellbeing of the most vulnerable members of our community. Rather than recite a litany of examples, I'll use just one – the Worcester Together Working Group. On March 16, 2020, just before the COVID-19 lockdowns began, a group of Worcester leaders from nonprofit social, health, youth and human service agencies, city government, education, and the faith community convened to brainstorm how we could collaboratively align our work in response to an ominous pandemic that was quickly gaining steam and which we knew would be especially dangerous for the most vulnerable. UMass Memorial was at that first meeting, and now (2 ½ years later!) they remain at the table *each and every week* as Worcester Together continues to strategize, collaborate, and implement a coordinated response to emerging community needs.

Each organization involved in Worcester Together, from the smallest to the largest, brings a unique and impactful perspective that has enabled us to address pressing needs related to things such as food insecurity, housing instability, youth development, education, seniors, behavioral health and many more. As the largest institution

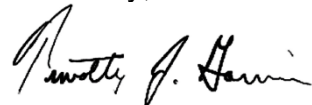
involved, and as the only academic medical center outside the City of Boston, the unique capacities that UMass Memorial brought have been very impactful. They continuously update the entire membership on population data relating to COVID positivity rates, vaccination rates and other health measures, all categorized to show trends by demographic and geographic factors such as race, ethnicity, age, and census tract. This has been instrumental in helping all of us respond in real time and target the community members and neighborhoods most in need of services. In addition, UMass Memorial has been on the front lines of directly providing healthcare in the community outside its four walls healthcare response, especially through its community based COVID testing and vaccination programs, which continue to this day.

I could go on with other examples, both related and unrelated to COVID, but the point is that UMass Memorial is deeply engaged in not only caring for community members when they are ill, but in efforts to keep them healthy in the first place.

But in terms of UMass Memorial's core missions of providing highly specialized care and acting as a safety net for the most vulnerable, we all know that the bed shortage is a major impediment. You no doubt have seen the data – 50 to 70 boarders in the emergency room every day; each waiting an average of 17 hours or more for a bed; 3,500 community hospital transfer requests that had to be denied in one year; the highest emergency department volumes in its history; etc. These are all compelling. But as the leader of a charity with a mission to serve the neediest, I respectfully ask you to consider the people behind those statistics. Consider each and every patient who lingers for hours on end as a boarder in the ER, each and every community hospital patient whose transfer is denied due to overcrowding, each and every patient transferred to a distant academic medical center because the local one can't accept them, and each and every family member who bears the stress of worrying about their loved ones confronting these barriers. And please also consider that, since UMass Memorial serves a disproportionate share of low-income patients, many of these patients and families have fewer resources to deal with the crisis than you or I. Considered from this perspective, when you consider the *people* behind the data and statistics UMass Memorial's application is not simply compelling. Instead, it's an absolute slam dunk.

I respectfully ask that the Department of Public Health support this application by expeditiously recommending its approval. Thank you for your consideration.

Sincerely,



Timothy J. Garvin
President & CEO
United Way of Central Massachusetts
484 Main Street, Suite 300
Worcester, MA 01608



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Michael F. Collins, MD, FACP
Senior Vice President for the Health Sciences
University of Massachusetts
Chancellor
UMass Chan Medical School
Professor
Population & Quantitative Health
Sciences and Medicine
T.H. Chan School of Medicine

September 1, 2022

Ms. Lara Szent-Gyorgyi
Director Determination of Need Program
Department of Public Health
250 Washington Street, 6th Floor
Boston, MA 02108
Email: dph.don@state.ma.us

RE: UMass Memorial Health's Application #UMMHC-22042514-HE) Determination of Need

Dear Ms. Szent-Gyorgyi:

On behalf UMass Chan Medical School, the Commonwealth's only public medical school, I write to express my support for UMass Memorial Health's Determination of Need Application (#UMMHC-22042514-HE) seeking to expand inpatient capacity by adding seventy-two beds on its University campus and an additional nineteen beds on its Memorial campus.

UMass Memorial Health's application documents a clear and compelling case for its request for ninety-one additional beds. A 35% increase in average daily Emergency Department visits in the past three years; an average daily census of 92% that frequently reaches 100%; and an average of between fifty to seventy patients boarding in the Emergency Department waiting for an open inpatient bed all demonstrate a critical need for additional capacity. These factors alone are enough to justify the proposed bed expansion. However, when taking into account the anticipated positive impact this proposed expansion would have on medical education and clinical research, this proposal becomes even more compelling and strategically important to the future of health care in the commonwealth.

Educating and training the next generation of the Massachusetts physician workforce is central to the mission of UMass Chan. As our primary clinical partner, UMass Memorial Health is critical to helping us fulfill this foundational mission. For the past quarter century, the unique public-private partnership between the commonwealth's medical school and its private nonprofit primary clinical partner, UMass Memorial Health has yielded tremendous benefits for the health care delivery system in Massachusetts. Expanding medical school class size is instrumental to increasing the state's physician workforce, but this is only possible with sufficient clinical training sites and opportunities for our medical students. The proposed new beds at UMass Memorial Health will not only increase training opportunities for our medical students but also will expand residency training programs for recent graduates and enable our internal medicine residency program to expand significantly. Unlike other Massachusetts-based medical schools, most of our students are residents of the state and opt to remain in the commonwealth to launch their careers in medicine. These outstanding medical students, residents and fellows truly are this state's future physician workforce.

UMass Memorial Health's bed expansion also will support the growth of translational and clinical research efforts undertaken by UMass Chan researchers, benefitting patients and their families throughout the region. This



research often involves novel, innovative clinical trials and treatment protocols that UMass Memorial Health is uniquely positioned to support and sustain as a result of its dynamic inpatient care capacity and volume. Collaboration between our medical school and the clinical system offers residents of Central Massachusetts with access to highly specialized clinical care and research trials that otherwise would not be available locally.

In summary, UMass Memorial Health's current inpatient capacity constraints and the corresponding delays in accessing care as evidenced by the Emergency Department's long boarding times are unsustainable. The additional ninety-one beds proposed will reduce this patient backlog and enhance cutting-edge clinical and translational research efforts, as well as physician training opportunities at a time when the commonwealth faces a growing physician workforce shortage. For these reasons and on behalf of UMass Chan Medical School, I strongly endorse UMass Memorial Health's proposal and recommend that the Department act favorably upon the clinical system's Determination of Need application.

Should you have any follow-up questions, please do let me know.

Sincerely,

A handwritten signature in black ink that reads 'Michael F. Collins'. The signature is written in a cursive, flowing style.

Michael F. Collins, MD, FACP
Senior Vice President for the Health Sciences, UMass
Chancellor, UMass Chan Medical School

September 2, 2022

VIA EMAIL: DPH.DON@massmail.state.ma.us

Determination of Need Program
Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108
Att: Elizabeth D. Kelley, MBA, MPH, Director, Bureau of Health Care Safety and Quality

RE: Determination of Need (“DoN”) Application #UMMHC-22042514-HE
Substantial Capital Expenditure
Substantial Change in Service
UMass Memorial Medical Center (“UMMMC”) by UMass Memorial Health Care, Inc. (“Applicant”) (the “Application”)

Dear Ms. Kelley,

The Saint Vincent Hospital Ten Taxpayer Group thanks you for holding a public hearing on August 23, 2022 (“Hearing”) regarding the Application, which proposes the following: (1) the renovation of a 6-story building adjacent to UMMC’s University Campus, located at 378 Plantation Street, Worcester, MA 01605, that will contain 72 additional medical/surgical beds, one additional computed tomography unit, and shell space for future build out to accommodate clinical services; (2) 19 additional medical/surgical beds on UMMC’s Memorial Campus; and (3) other renovation projects to improve the existing services and facilities at UMMC’s Memorial Campus (the “Proposed Project”).

We also appreciate the opportunity we had to speak at the Hearing (a copy of our testimony is attached as Exhibit 1), and to submit these written comments following the Hearing.

During the Hearing, we heard the Applicant and several supporters of the Proposed Project describe an overcrowded Emergency Department (“ED”), high levels of ED boarding, and an inability to accept requests for patient transfers to UMMC. These are problems that need to be resolved in order to best serve patients in Central Massachusetts and we certainly are in favor of doing so. However, we did *not* hear the Applicant or any supporter of the Proposed Project consider any alternative solutions, and adding beds to UMMC is not the only solution, but it is the most expensive one. Notably, we did *not* hear the Applicant or any supporter of the Proposed Project address the unnecessary and excessive health care costs that would burden the Commonwealth, patients and payors if the Proposed Project is approved. As detailed below in Section I, we are writing to re-emphasize that the Proposed Project: (1) is unnecessary in light of existing, local, lower-cost alternative market capacity, (2) would needlessly increase Massachusetts health care costs, and (3) would not add measurable public health value or quality of life. For these reasons, the Proposed Project is antithetical to the purpose and objective of the Determination of Need (“DoN”) Program (intended to ensure that a project addresses a demonstrated need), as well as the Department’s goals for health care cost-containment and improved public health outcomes, and the Department should disapprove the Application.

In the event that the Department is not prepared to disapprove the Application at this time, we continue to urge the Department to require the Applicant to undergo an Independent Cost-Analysis (“ICA”).

Furthermore, because the Proposed Project is a Material Change, contrary to the Applicant's assertion in the Application, the Applicant is required to file a Material Change Notice ("MCN") with the Massachusetts Health Policy Commission ("HPC"), and we urge the Department to await the HPC's evaluation of the Proposed Project before taking any action other than disapproval. Our reasoning pertaining to the ICA and MCN is detailed below in Sections II and III.

I. DoN Program and Department Goals

I. Need

The Applicant's testimony (and that of its supporters) focused on the need to increase UMMMC bed capacity solely for the purpose of treating high-acuity patients who require specialized services that cannot be treated elsewhere. This need is not at all aligned with the Proposed Project. The Proposed Project does not request the addition of 91 high-acuity beds. Rather, the Proposed Project requests the addition of 91 low-acuity beds ("New Beds").¹ There is no need for the New Beds when current market capacity is available to absorb and treat those low-acuity patients (and at a lower cost). As explained in our August 3, 2022 comments ("Initial Comments"), Saint Vincent Hospital ("SVH") has 63 available low-acuity beds ("SVH Available Beds") and currently has the capability to treat 100% of the Primary Diagnoses (defined in footnote 1) UMMMC anticipates treating in its 91 New Beds, as SVH provides such care each and every day. As noted in our Initial Comments, SVH is located 0.6 miles from UMMMC Memorial Campus and 1.9 miles from UMMMC University campus, making ambulance transport to SVH and general community access just as easy as transport and access to the proposed 72 bed Plantation Street tower, which is not physically connected to any UMMMC hospital. Moreover, the Applicant's affiliate hospitals in the suburbs ("Affiliate Hospitals")² also could provide additional alternative capacity. While the Applicant testified that the recent census increased at each of the Affiliate Hospitals³, each Affiliate Hospital continues to operate at an occupancy rate that is under 65%⁴. The Applicant's reference at the Hearing to increased census, without

¹ The Application states: "The Proposed Project includes the licensure of a new inpatient facility on the UMMMC license through the renovation of an existing building recently purchased by the Applicant. ***The additional 72 medical/surgical beds will provide UMMMC additional capacity to focus on lower acuity inpatients.*** UMMMC anticipates the most prevalent diagnoses of patients admitted to the new inpatient building will be Septicemia/Severe Sepsis, Chronic Obstructive Pulmonary Disease, respiratory infection, pneumonia, heart failure, and pulmonary edema [{"Primary Diagnoses"}]. By centralizing the care of patients with similar diagnoses and acuity levels, the Applicant anticipates patients will experience improved care delivery and coordination, as well as an improved care experience." and "As noted above, ***the proposed building will accommodate lower acuity patients who are unlikely to require tertiary level of care,*** but who may require CT imaging during their inpatient admission." (emphasis added). The other 19 medical/surgical beds will be added to UMMMC's Memorial Campus, where low-acuity patients typically are treated.

² We are including the following in "Affiliate Hospitals": Clinton Hospital, Marlborough Hospital, and Harrington Hospital.

³ As reported at the Hearing, census increased as follows: Clinton Hospital - 8%, Marlborough Hospital - 13%, Harrington Hospital - 16%.

⁴ 2020 American Hospital Association data for patient admissions and licensed beds show the following capacity rates: Clinton Hospital - 58%; Marlborough Hospital - 57%; Harrington Hospital - 44%. See Exhibit 2. The analysis for Exhibit 2 is based on inpatient visits per bed calculated as total admission divided by total licensed beds using the following sources: American

acknowledging continued significant additional capacity within its Affiliate Hospitals, is misleading.⁵ Between the SVH Available Beds and the available beds at the Affiliate Hospitals, there is more than adequate capacity to address ED boarding. Proper utilization of lower acuity bed capacity at SVH and the Affiliate Hospitals will leave UMMC with the capacity it needs for patients who need highly specialized care.

The Applicant's testimony (and that of its supporters) referred to a shortage of beds in Central Massachusetts compared to the number of beds in Eastern and Western Massachusetts.⁶ However, the Applicant and its supporters failed to recognize that currently, Worcester County has approximately 1.17 medical/surgical beds per 1,000 people, which is already 9% higher than the national average and 4% higher than the Massachusetts average.⁷ There is unused capacity in the region that can be utilized to provide high-quality care at a lower cost, making the New Beds unnecessary and the reference to regional differences within Massachusetts irrelevant.

The Applicant stated during the Hearing that the Applicant has done everything it can to ease ED boarding, yet the Applicant failed to acknowledge that UMMC's Observed to Expected (O/E) Length of Stay (LOS) ratio is 1.27, which means that UMMC acute inpatients stay 27% longer than expected.⁸ As explained in our Initial Comments, if UMMC were to invest a fraction of the capital costs, or a fraction of the incremental operating costs, needed to implement the Proposed Project in reducing its O/E LOS to meet the national academic medical center average (O/E LOS of 1.22), UMMC would increase its bed capacity by 28 UMMC beds.⁹ Those 28 beds, coupled with SVH's 63 Available Beds, equal the 91 New Beds proposed by the Applicant, without even taking into consideration the available bed capacity at the Affiliated Hospitals. If UMMC were to further reduce its O/E LOS to meet the first quartile O/E LOS average of 1.06 for academic medical centers nationwide, UMMC would increase its bed capacity by 123 beds.¹⁰ Even the most minimal effort by UMMC to reduce its O/E LOS, together with use of the beds available at SVH, and/or greater utilization of Affiliate Hospital beds, would completely eliminate the need for New Beds. While the Applicant may have engaged in some performance improvement activity, clearly there is significant room for additional improvement to bring its operations in alignment with national averages. There are reasonable alternatives to increasing capacity without constructing New Beds, and the Applicant has not even considered them.

Hospital Association at: <https://www.ahadata.com/aha-annual-survey-databasedata> (Tabs AHA 2012 – 2020 and Inpatient beds AHA); and UMass Memorial Health System Statistics at <https://www.ummhealth.org/about-us/system-statistics> (UMass licensed bed statistics). The increases cited in FN3 would bring capacity rates to the following: Clinton Hospital – 63%; Marlborough Hospital – 64%; Harrington Hospital – 51%.

⁵ The Applicant also has not addressed the option to convert one of its Affiliated Hospitals to a facility that solely treats the Primary Diagnoses. This is an alternative to the Proposed Project that would alleviate the need for the New Beds, and provide the same care contemplated by the Proposed Project but at a much lower health care cost.

⁶ As reported at the Hearing, Central Massachusetts has 15% fewer beds than Eastern Massachusetts and 20% fewer beds than Western Massachusetts, per 1,000 residents.

⁷ See Exhibit 3. American Hospital Association at: <https://www.ahadata.com/aha-annual-survey-databasedata> (Tabs AHA 2012 – 2020 and Inpatient beds AHA); CMS LDS data (Medicare FFS) at www.cms.gov.

⁸ In contrast, the SVH Available Beds operate at a significantly reduced O/E LOS of only .99. See Exhibit 4.

⁹ See Exhibit 5.

¹⁰ See Exhibit 6.

Central Massachusetts does not need the New Beds. Rather, health care providers in the region need to work collaboratively to utilize existing market capacity (as they did during the pandemic), and the Applicant needs to work towards operational improvements at UMMMC as well as more efficient use of its Affiliate Hospitals. Together, these strategies will yield 91 low-acuity medical/surgical beds and likely even more. There is no evidence that the Applicant has considered these alternatives. The Applicant has not explained, through its Application or during the Hearing, why these alternatives would not solve its capacity problems, even though the Applicant has a regulatory obligation to provide sufficient evidence that the Proposed Project is superior to alternative and substitute methods for meeting patient needs.

2. *Cost-Containment*

The Applicant's testimony (and that of its supporters) focused primarily on the current need to transfer patients to Boston-based providers and other high-cost providers outside of the service area due to capacity constraints at UMMMC. The result of these transfers, as reported at the Hearing, is that patients unnecessarily pay more for their care, as UMMMC is a lower-cost academic medical center than the academic medical centers treating the transferred patients. While this may be true, as noted above, there is no need to transfer these patients out of the service area when there are high-quality, lower-cost available beds in the region where providers can treat the lower acuity patients the Applicant contemplates treating in the New Beds. Furthermore, the Applicant and its supporters wholly fail to acknowledge that UMMMC is the highest cost provider in the region. UMMMC has a commercial payor reimbursement rate that is 9% higher than the Massachusetts average and 14% higher than SVH's reimbursement rate, and approximately 14%-17% higher for treatment of Primary Diagnoses.¹¹ In addition, the Applicant already has a 51% market share in the region; approving an expansion through the Proposed Project, especially when coupled with the Applicant's proposed addition of Heywood Hospital and Athol Hospital, will only increase this disparity in reimbursement rates, further strengthening the Applicant's near monopolistic pricing power.¹² Furthermore, the Applicant plans to operate each New Bed at a cost of approximately \$1.3M per year, which is excessively high, given that the average operating cost for a medical/surgical bed in Massachusetts is \$900K-\$950K per year and the operating cost for a medical/surgical bed at SVH is \$880K per year.¹³ The high cost of the proposed New Beds is due in part to the infrastructure of a large academic medical center as well as

¹¹ See Exhibit 7. Source: Statewide commercial payer RP data, CMS IPPS Web Pricer.

¹² The Applicant's market share, following its acquisition of Harrington Hospital in 2021, was 51.5%. In contrast, SVH's market share at that same time was 15.8% (based on Medicare - traditional surgical volume). See Exhibit 8. Trilliant All-Payor Surgical Data Sample (October 2020 – September 2021), accessed March 2, 2022. See *Heywood Hospital in talks to join UMass Memorial Health*. Boston Globe. May 3, 2022.

¹³ See Exhibit 9. Analysis is based on data from the following: American Hospital Association at <https://www.aha.org/statistics/fast-facts-us-hospitals>; Kaiser Family Foundation 2020, fully loaded costs at <https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; Average length of stay in community hospitals at <https://www.statista.com/statistics/183916/average-length-of-stay-in-us-community-hospitals-since-1993/>; Massachusetts government at <https://www.mass.gov/doc/command-center-hospital-capacity-charts/download>; Massachusetts Adult Care Hospital Inpatient Data at <https://www.chiamass.gov/assets/docs/r/pubs/2020/CMSR-HIDD-FY2019-Report.pdf>; 2018-2021 CMS LDS data (Medicare FFS) at www.cms.gov.

the added cost of the proposed 72-bed tower, which needlessly duplicates infrastructure and ancillary services given that it is not physically connected to any existing UMMMC hospital.¹⁴

The Affiliate Hospitals also are lower-cost providers than UMMMC. However, the Applicant fails to sufficiently staff those hospitals with the specialists needed to retain patients in their communities, which results in unnecessary and expensive transfers to UMMMC. In particular, the Applicant fails to provide call coverage after 5pm for specialties such as gastroenterology and urology at those hospitals. Instead the Applicant transfers patients to the higher-cost UMMMC facilities in Worcester. The Department can expect that this will not only continue to occur, but will occur to a greater degree, if the Applicant adds 91 New Beds to UMMMC.

We agree that reducing transfers to high-cost providers in Boston and out-of-state, and providing care in a timely manner, are critical aspects of cost-containment. But to promote cost-containment to the fullest, we should utilize the existing bed capacity that lower-cost, high quality providers in the region can offer. In other words, while patients may pay less for health care if they are treated at UMMMC instead of a Boston-based or out-of-state academic medical center, those patients will realize even greater cost savings if they are treated at SVH or at an Affiliate Hospital instead of UMMMC. The difference is significant, which is particularly important for the large volume of low-income and other vulnerable patients served in the region, who suffer disproportionately when they are transferred outside the region.¹⁵ As noted in our Initial Comments, 59.3% of the population in the region have an income that is under 400% of the Federal Poverty Level.¹⁶ These are the residents who will be negatively impacted most severely. Treating low acuity patients in the New Beds at UMMMC, as contemplated by the Proposed Project, when there is available capacity to treat these same patients at lower-cost providers such as SVH and the Affiliated Hospitals, runs contrary to the Commonwealth's goal of cost-containment.

The Applicant has not addressed any of these issues, either through its Application or during the Hearing. It is clear that the Proposed Project will unnecessarily increase health care costs to patients, payors, employers and the Commonwealth. The Proposed Project is in direct opposition to the Commonwealth's goal of cost-containment.

¹⁴ During the Hearing, the Applicant mentioned the use of a pneumatic tube at the proposed tower. While we have no doubt that such technology will be helpful, it will by no means eliminate the need for duplicative ancillary services or delays caused by travel time for UMMMC's clinicians.

¹⁵ SVH, like UMMMC, is a high public payer hospital as designated by the Center for Health Information and Analysis: SVH – 68% (FY20); UMMMC – 66% (FY20). See Massachusetts Center for Health Information and Analysis website at <https://www.chiamass.gov/high-public-payer-hospitals/>.

¹⁶ See Exhibit 10. Analysis is based on data from the following: 2021 Massachusetts Health Policy Commission Annual Healthcare Cost Trends Report at <https://www.mass.gov/doc/2021-health-care-cost-trends-report/download>.

3. *Improved Public Health Outcomes*

The Applicant's testimony (and that of its supporters) focused primarily on the benefits of reducing transfers outside the region and treating patients in their own communities in a timely manner.¹⁷ We agree that there is tremendous value in reducing transfers and keeping patients in Central Massachusetts for their medical care, and in providing timely access to such care. However, the region does not need the New Beds to accomplish these goals. Rather, we can keep patients in their communities for timely treatment by utilizing existing market capacity. Additionally, we could accomplish this goal to an even greater degree if, as discussed above, the Applicant were to use its Affiliate Hospitals more efficiently and appropriately, and make operational improvements at UMMC. These operational improvements will have a far more significant impact on reducing patient falls and pressure ulcers (two of the three public health outcomes that the Applicant cited in its Application in support of the Proposed Project) than adding the New Beds.

If the Department were to rely on the Proposed Project to reduce transfers outside the region and treat patients in their own communities in a timely manner, the region would not see improvement in public health outcomes until 2024 or later. The better approach is to begin working towards these public health goals now, and the New Beds are not needed to proceed. SVH is committed to doing its part by opening its 63 available medical/surgical beds to help alleviate the problems the Applicant has identified and improve public health outcomes, starting right now. We heard multiple times during the Hearing that the Applicant is dedicated to, and works collaboratively with, its community. Now is the time to expand those efforts, and SVH stands ready to work together towards improving public health outcomes in the most immediate and cost-effective manner.

* * * * *

In summary, patients in the Greater Worcester region deserve high-quality and timely care in their community at the lowest possible cost. The Proposed Project will not accomplish this. Instead, the Proposed Project will unnecessarily create 91 new beds at a cost that is much greater than the cost of care that could be provided by existing high quality, lower-cost providers with unused capacity.

There is no need for 91 new beds. There is no need to increase health care spending in the region. There is no need to jeopardize the ability of lower-cost providers to continue to operate, leaving the highest-cost provider as the only alternative. Operational improvements, more efficient and appropriate use of the Affiliate Hospitals and utilization of current market capacity would more easily solve the problems—and at a lower cost—than the Proposed Project claims to solve. Until all of the beds in Central Massachusetts are open and reach a certain critical occupancy, no bed expansions should be approved.

¹⁷ The Applicant also referenced its engagement in the local community to improve health. While we appreciate the Applicant's efforts, they have no bearing on whether the Proposed Project itself will add measurable public health value.

II. Independent Cost-Analysis (ICA)

In accordance with the DoN statute, the Department, in making any determination of need, must “encourage appropriate allocation of private and public health care resources and the development of alternative or substitute methods of delivering health care services *so that adequate health care services will be made reasonably available to every person within the commonwealth at the lowest reasonable aggregate cost*” (emphasis added).¹⁸ We question how the Department could issue a Determination of Need when the Applicant has not demonstrated, through the Application or during the Hearing, why or how the cost of care will result in attaining the “lowest reasonable aggregate cost”. Further, we question how the Department could determine that costs will **not** increase in connection with the Proposed Project, especially in light of the Applicant’s status as the highest-cost provider in the region and given its near-monopoly pricing power, without an independent third party review of whether the Proposed Project supports the Commonwealth’s cost-containment goals. To-date, there is no evidence to suggest that the Proposed Project will yield adequate health care services that will be made reasonably available to every person within the Commonwealth *at the lowest reasonable aggregate cost*. For this reason, we hereby respectfully request that the Department reconsider its decision and proceed by requiring the Applicant to undergo an ICA.

The absence of an ICA in connection with the Department’s consideration of the Proposed Project is inconsistent with the Department’s prior actions. From 2017 to-date, each time a Ten Taxpayer Group requested an ICA in connection with a proposed project involving a substantial capital expenditure, the Department exercised its discretion to require the applicant to undergo an ICA, thereby enabling the Department to determine objectively whether the proposed project was consistent with the Commonwealth’s cost-containment goals.¹⁹ Notably, except for one of the applications, none²⁰ of the requests for an ICA were supported by any demonstrative data or evidence to support the request, yet the Department exercised its discretion to require the ICA.²¹

We note that the Estimated Total Capital Expenditure (“TCE”) for one of the applications described above (\$150M) was only \$7M more than the TCE for the Proposed Project (\$143M), and in that same case, the Maximum Incremental Operating Expense (“MIOE”) (\$12M), was \$107M *less* than the Applicant’s MIOE (\$119M). In another application described above, the TCE (\$224M) and the MIOE (\$155M) also are comparable to the TCE and MIOE for the Proposed Project (a difference of \$80M and \$36M, respectively). These differences certainly are not significant enough to justify an ICA in those cases but no ICA with

¹⁸ MGL c. 111, Section 25C(g).

¹⁹ There has been only one DoN application since 2017 with respect to which a request for an ICA was made but the Department did not exercise its discretion to require an ICA. In that case, the application pertained to DoN-required equipment (an MRI) – that is, a discreet project pertaining to a single MRI unit. The initial capital expenditure for the proposed MRI was \$2,292,401 and the annual operating costs to support the proposed MRI was \$552,168. Such proposed project is clearly not comparable to the Applicant’s Proposed Project, as they are substantially different in scope and cost.

²⁰ The one exception – UMass Memorial submitted a substantive request for an ICA in connection with a MassGeneral Brigham DoN application.

²¹ Of further note, in one other instance, no ICA was requested, yet the Department exercised its discretion and required the applicant to undergo an ICA.

respect to the Application. The Proposed Project requires a TCE that exceeds \$143M – a substantial expenditure that should be reviewed in terms of its impact on cost-containment, especially given that UMMC is a State-funded institution that would be expending the Commonwealth’s public funds and taxpayer dollars to implement the Proposed Project.

In light of the substantive comments we submitted to the Department on August 3, 2022, raising objective material concerns that the Proposed Project is antithetical to the Commonwealth’s goal of cost-containment, together with demonstrative data and support, the substantial TCE associated with the Proposed Project, and the potential for waste of the Commonwealth’s public funds, we find the absence of an ICA requirement puzzling and concerning. There is no downside to requiring an ICA – only an upside – one that would enable the Department to evaluate the Proposed Project more closely through an independent third party objective analysis to ensure that the Department’s cost-containment goals truly would be met with respect to the Proposed Project. Again, we urge the Department to reverse its decision and require the Applicant to undergo an ICA to ensure that the Proposed Project will not increase health care spending and ensure that public tax payer funds are not misused in connection with the Proposed Project.

For ease of reference, we have provided a link to all materials described above in Exhibit 11.

III. Material Change Notice (MCN) and Health Policy Commission (HPC) Review

Based on the Applicant’s response to Item 1.7 in the Application, the Applicant asserts that the Proposed Project does not require the filing of an MCN with the HPC. We disagree.

The HPC’s Notices of Material Change and Cost and Market Impact Reviews Regulations (“HPC Regulations”) define “Material Change” to include an affiliation (such as employment of Health Care Professionals) of or by a Provider (such as multiple Health Care Professionals from the same Provider) that would result in an increase in annual Net Patient Service Revenue of the Provider of ten million dollars or more, or in the Provider having a near majority of market share in a given service or region.²²

The Proposed Project, which will require approximately 500 new FT positions – that is, the employment of Health Care Professionals – does both, and therefore is a “Material Change”. First, the employment of the additional Health Care Professionals in connection with the Proposed Project will lead to an increase in the Applicant’s annual Net Patient Service Revenue of \$10M or more.²³ Second, the Applicant already has greater than a majority of market share in the region²⁴, and the employment of the additional Health Care Professionals in connection with the Proposed Project will further increase the

²² 958 CMR 7.02

²³ This statement is based on the fact that the Applicant plans to spend approximately \$118M/year to operate the New Beds. In light of the fact that the Applicant anticipates a positive profit margin in connection with the Proposed Project, the Applicant’s annual Net Patient Service Revenue will be increased by at least \$10M.

²⁴ The Applicant’s market share, following its acquisition of Harrington Hospital in 2021, was 51.5%. In contrast, SVH’s market share at that same time was 15.8% (based on Medicare - traditional surgical volume). See Exhibit 8. Trilliant All-Payer Surgical Data Sample (October 2020 – September 2021), accessed March 2, 2022.

Applicant's dominant market share. Because the Proposed Project constitutes a "Material Change" under the HPC Regulations, the Applicant is required to file an MCN with the HPC.

Furthermore, one of the HPC's primary responsibilities is to "examine significant changes in the health care marketplace and their potential impact on cost, quality, and market competitiveness", including "tracking and analyzing the number, type, and frequency of material changes to the governance or operations of health care providers (MCNs)" and "evaluating the impact of significant provider transactions on the competitive market and on the state's ability to meet the health care growth benchmark (CMIRs)".²⁵ As a matter of public policy, the Proposed Project falls squarely within the purview of the HPC and an MCN is necessary to enable the HPC to fulfill its responsibilities with respect to health care spending and maintaining market equilibrium. For this reason, too, the Department should require the Applicant to file an MCN with the HPC. Any issuance of a Determination of Need prior to HPC review would be untimely.²⁶

Alternatively, the Department should consider the Application to be withdrawn, pursuant to 105 CMR 100.430(B), because the Applicant failed to provide requested information – that is, documentation of its Notification of Material Change.

* * * * *

Due to the concerns and issues described above, we urge you to disapprove the Proposed Project (or consider it to be withdrawn). Alternatively, at a minimum, we urge you to require the Applicant to undergo an Independent Cost-Analysis and file a Material Change Notice with the Health Policy Commission.

Thank you for your consideration of our comments. If you have any questions or would like to discuss our concerns further, please contact me at Carolyn.Jackson@stvincenthospital.com or 508-363-6504.

Sincerely,

Carolyn Jackson
Chief Executive Officer of Saint Vincent Hospital
Representative of the Saint Vincent Hospital Ten Taxpayer Group

²⁵ Massachusetts Health Policy Commission website: <https://www.mass.gov/market-oversight>. Accessed on 8.25.22.

²⁶ The Applicant must file an MCN at least 60 days prior to the effective date of the proposed Material Change. 958 CMR 7.03. The HPC will need to determine whether a Cost and Market Impact Review is required, and a Notice of Determination of Need, if issued, cannot go into effect until 30 days following HPC's completed Cost and Market Impact Review. 105 CMR 100.310(A)(2).

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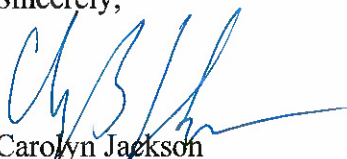
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EXHIBIT 1

SAINT VINCENT HOSPITAL TTG PUBLIC HEARING TESTIMONY

Opening Statement

Good evening. My name is Carolyn Jackson, and I am the Chief Executive Officer of Saint Vincent Hospital in Worcester, and the representative of the Saint Vincent Hospital Ten Taxpayer Group, which is registered as a party of record.

The Department should not approve the Proposed Project for three primary reasons, all of which were more fully explained in our previously submitted written comments to DPH which are currently posted on the DON website:

One, there is no need for the Project because the Greater Worcester region is already well-served by existing high-quality, lower-cost providers with enough unused capacity to total or even exceed the 91 requested med/surg beds;

Two, the Project is counter to the Commonwealth's goal for cost-containment, and in fact, if DPH approves the Project, health care costs and spending will needlessly increase; and

Three, better and less expensive alternatives exist to improve the public health outcomes identified in the Application.

I will address each of these three points separately.

Need

There is no community need for UMass's proposed 91 new beds. Saint Vincent Hospital, a tertiary hospital, located 0.6 miles from UMass Memorial and 1.9 miles from UMass University, has 63 available med/surg beds today that can be opened without construction or capital outlay. In fact, Saint Vincent is opening those beds now to help with the need that UMass has identified. Saint Vincent is capable of treating and does currently treat 100% of the types of patients that UMass anticipates treating in the proposed new beds. Additionally, UMass's own Affiliate Hospitals (Clinton, Marlborough and Harrington) have available capacity.

In addition , if UMass redirected a fraction of the proposed funding for the new beds toward reducing its excessive observed-to-expected length of stay, it could create its own additional bed capacity without any construction. UMass is ranked in the third quartile for large academic medical centers nationwide with an observed-to-expected length of stay of 1.27, which means patients stay an average of 27% longer at UMass than they should. If UMass were able to improve its operations to equal the average of the national second quartile, it would effectively create 64 new beds without swinging a hammer or spending any capital.

Through existing market capacity and operational improvements at UMass, Central Massachusetts could easily add many more than 91 additional med/surg beds.

Cost-Containment

As an initial matter, we want to express our disappointment that DPH failed to require an Independent Cost Analysis. We

raised very serious objective concerns about the Project being antithetical to DPH's goals for health care cost-containment. DPH should have obtained an independent, objective, and complete analysis of the Project to measure the cost increase it will cause. We were surprised by DPH's decision, as each time a TTG has requested an Independent Cost Analysis in connection with a substantial capital expenditure, DPH has agreed that the applicant should undergo an ICA. We implore DPH to reconsider.

As detailed in our written comments, the Project will increase health care costs to patients, payors, employers, and the Commonwealth and will counteract DPH's cost-containment goals. UMass is the highest cost provider in the region. For commercial payors, UMass is reimbursed 9% higher than the Massachusetts average and 14% higher than Saint Vincent. UMass's Affiliate Hospitals are also lower-cost providers, but rather than add specialists to enable more patients to be cared for at those hospitals, UMass requires the transfer of patients from the lower cost Affiliates to the higher cost Memorial and University campuses.

Further, UMass's cost structure and operational inefficiencies promote wasteful spending. The proposed new beds have an operating cost of \$1.3M per bed per year, which far exceeds the per-bed per-year national average of \$600K, the Massachusetts average of \$950K, and the SVH cost of \$880K. The high cost of the proposed new beds is due in part to the infrastructure of a large academic medical center as well as the added cost of the proposed 72-bed tower, which needlessly duplicates infrastructure and ancillary services given that it is not physically connected to any existing UMass hospital.

Additionally, UMass already has 51% market share in the region, so approving an expansion, especially when coupled with the proposed addition of Heywood and Athol Hospitals, would further increase UMass's near-monopolistic pricing power, potentially weakening the financial viability of local, lower-cost hospitals. This is not an acceptable outcome and is not consistent with DPH's regulations or the purpose of the DoN program.

Improved Public Health Outcomes

The Project will not improve public health outcomes in the manner UMass promotes, but the alternatives will actually better improve health outcomes. ED boarding can be immediately addressed by utilizing available beds at Saint Vincent and UMass Affiliate Hospitals. Together, these resources provide more than adequate capacity to meet the need described by UMass and do so in a manner that promotes cost containment while keeping patients in their own communities. Additionally, reducing length of stay at the UMass University and Memorial campuses will do more to reduce patient falls and pressure ulcers than adding more beds will.

Closing Statement

Patients in the Greater Worcester region deserve high-quality and timely care in their community at the lowest possible cost. The Project will not deliver this. Instead, the Project will create 91 new beds at a cost that is much greater than the cost of care that could be provided by existing high quality, lower-cost providers with unused capacity.

There is no need for 91 new beds. There is no need to increase health care spending in the region. There is no need to jeopardize the ability of lower-cost providers to continue to operate, leaving the highest-cost provider as the only alternative. Operational improvements, more efficient and appropriate use of UMass's Affiliate Hospitals and utilization of current market capacity would more easily solve the problems—and at a lower cost—than the Project claims to solve. Until all of the beds in Central Massachusetts are open and reach a certain critical occupancy, and until UMass is able to improve its excessive observed to expected length of stay, no bed expansions should be approved.

We appreciate the opportunity to present to DPH tonight and appreciate DPH's close review of the Proposed Project and our previously provided written comments.

EXHIBIT 2

Occupancy rate (licensed beds)

Source: AHA data, UMass licensed bed statistics, SVH Data by YR provided by Tenet Strategy Team

Healthcare System	Inpatient Days (#)		Licensed Beds (#)		Occupancy Rates (%)	
	2019	2020	2019	2020	2019	2020
UMass Memorial Medical Center	208,648	211,706	733	747	78%	78%
UMass Memorial HealthAlliance-Clinton Hospital	34,881	32,276	152	152	63%	58%
Heywood Hospital	21,772	21,220	134	134	45%	43%
Harrington Hospital*	20,727	20,743	129	129	44%	44%
UMass Memorial-Marlborough Hospital	16,571	16,472	79	79	57%	57%
Athol Hospital	3,340	3,446	21	21	44%	45%
SVH**	69,441	66,819	290	290	66%	63%

* Harrington Hospital licensed beds not available in AHA data; licensed beds found in 2022 UMass statistics report on licensed beds

(<https://www.ummhealth.org/about-us/system-statistics>)

** SVH licensed beds provided by Tenet (Carolyn Jackson)

EXHIBIT 3

Inpatient beds per 1,000

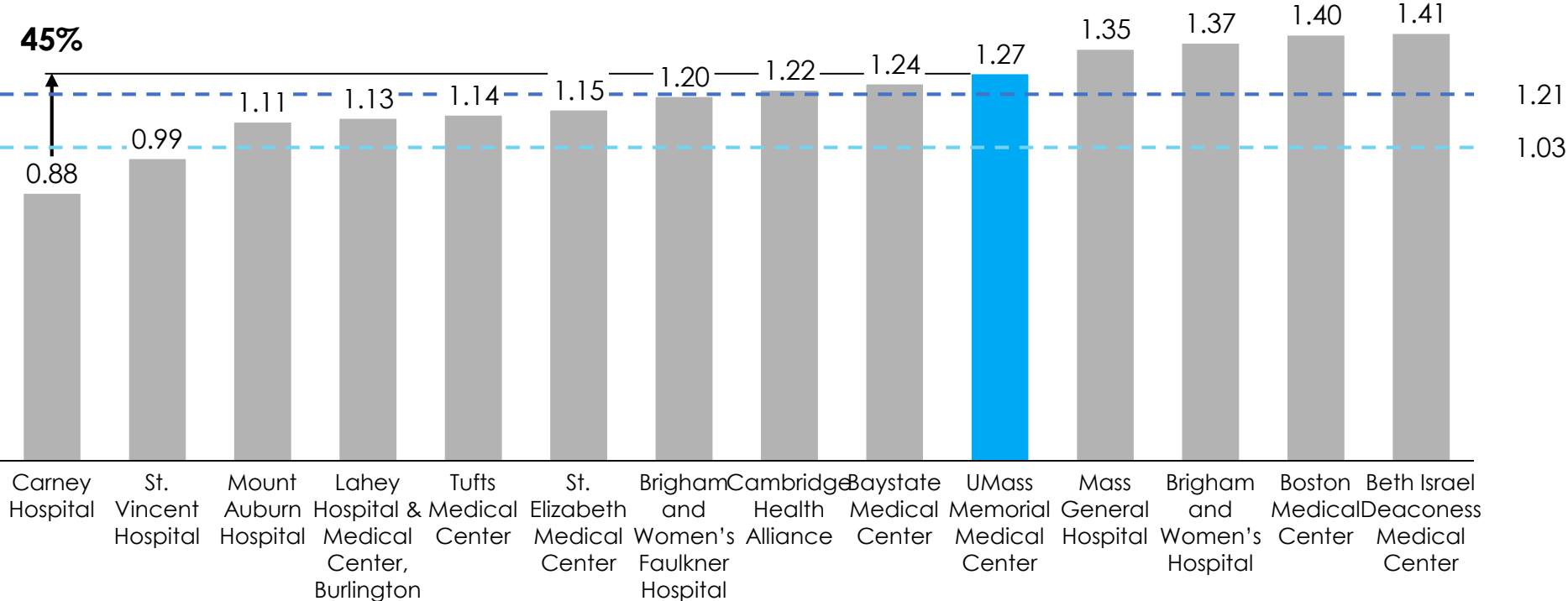
Source: AHA & CMS LDS data (Medicare FFS)

County	Med / surg staffed beds per 1,000
Plymouth, MA	0.27
Essex, MA	0.50
Norfolk, MA	0.50
Hampshire, MA	0.57
Franklin, MA	0.67
Middlesex, MA	0.80
Nantucket, MA	0.89
Bristol, MA	0.90
Dukes, MA	1.03
Worcester, MA	1.17
Barnstable, MA	1.27
Hampden, MA	1.54
Berkshire, MA	1.55
Suffolk, MA	3.47
Massachusetts avg	1.13
National avg	1.07

EXHIBIT 4

UMass is in the bottom third of teaching hospitals and AMCs in MA for O/E LOS ratio

Q1-Q2 2021 inpatient Medicare O/E length of stay (LOS) for teaching hospitals and AMCs in MA, excluding psych and newborn



- O/E ratio >1 indicates acute inpatient days are often longer than expected days²
- UMass O/E is 1.27, indicating average acute inpatient stays are 27% longer than expected
- UMass is outperformed by 9 peers in MA and has an O/E 45% higher than top performing Carney Hospital

1. Average O/E performance across top 4 hospitals (Carney, St. Vincent, Mount Auburn, Lahey)
2. Expected days assessed per reason for hospitalization and patient factors (e.g., age, comorbidities, etc)

EXHIBIT 5

2021 O/E LOS (excluding psych and newborn)

Source: Medicare FFS LDS data & AHA licensed beds for UMass

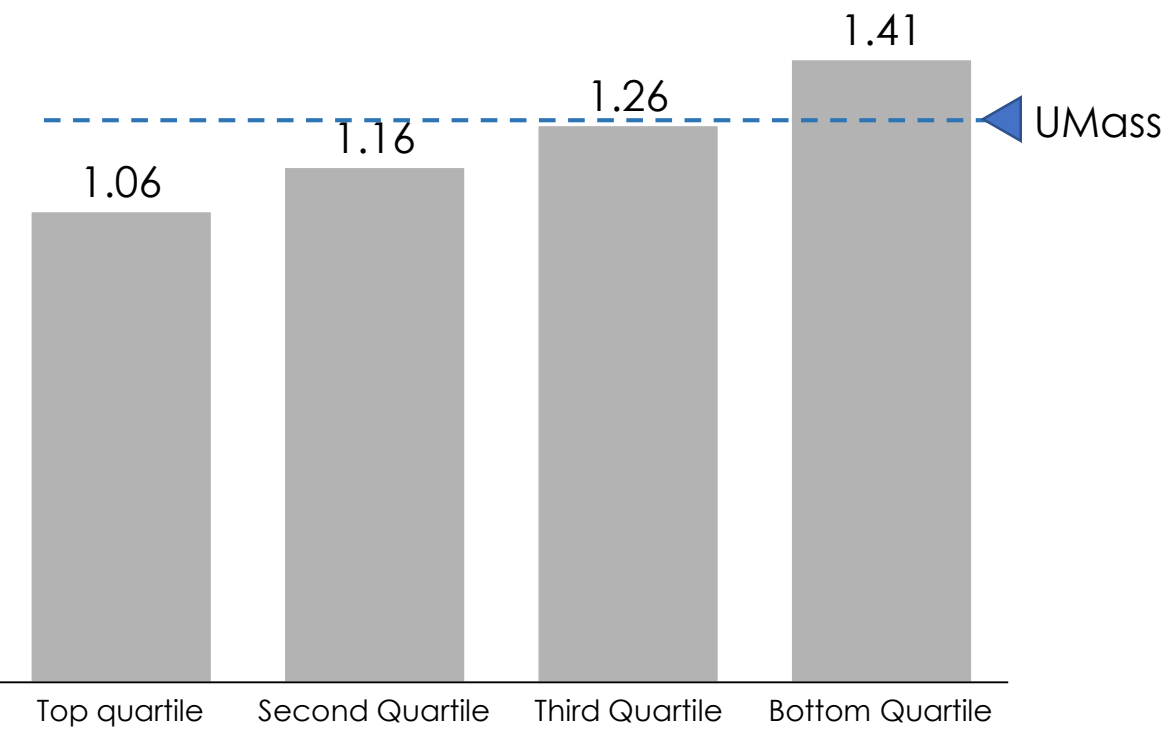
O/E	Comparison	Inpatient beds	# reduced from current state	Source
1.27	UMass current state O/E	747	0	2021 CMS LDS data (Medicare FFS) for academic medical centers in MA, AHA licensed beds data for UMass
1.22	National AMC average	719	28	2021 CMS LDS data (Medicare FFS) for national academic medical centers

EXHIBIT 6

UMass could potentially create additional capacity by improving O/E LOS performance compared to other comparable AMCs

Q1-Q2 2021 inpatient Medicare O/E length of stay (LOS) for comparable AMCs¹

O/E = Observed LOS / expected LOS per discharge²



UMass could potentially create additional bed capacity by matching Second Quartile or Top Quartile performance at comparable AMCs

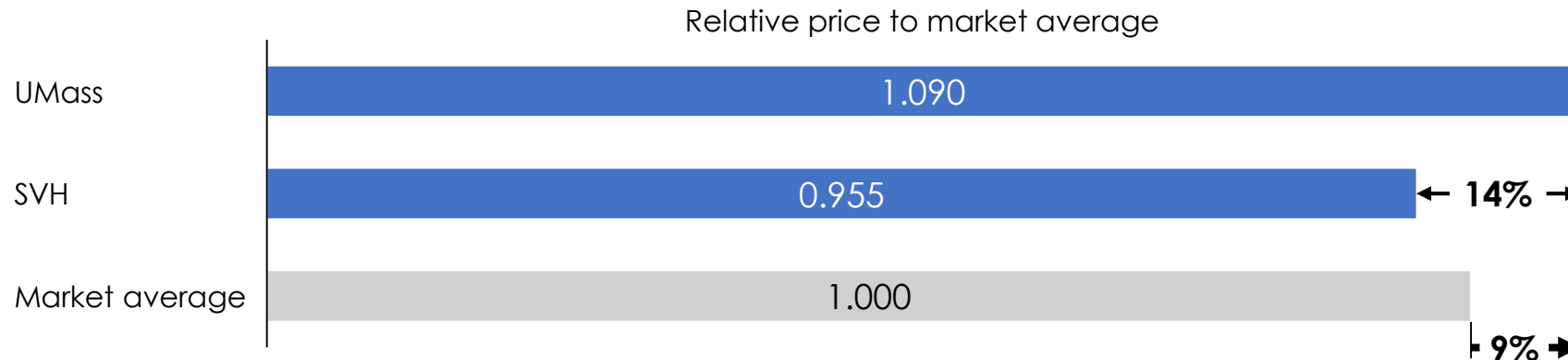
O/E comparison	O/E ratio	Necessary inpatient beds	Potential capacity created
UMass - current state	1.27	747	N/A
Second Quartile Average	1.16	~683	~64
Top Quartile average	1.06	~624	~123

1. Comparable AMCs defined as CMI (>1.8), Teaching level (>25% residents per total beds), Bed size (>350)
2. Expected days assessed per reason for hospitalization and patient factors (e.g., age, comorbidities, etc)

EXHIBIT 7

Adding capacity may result in regional increases to cost of care

Commercial relative price at UMass Medical Center and SVH compared to market average



Medicare FFS reimbursement at UMass Medical Center and SVH for DRGs representative of the service lines stated by UMass

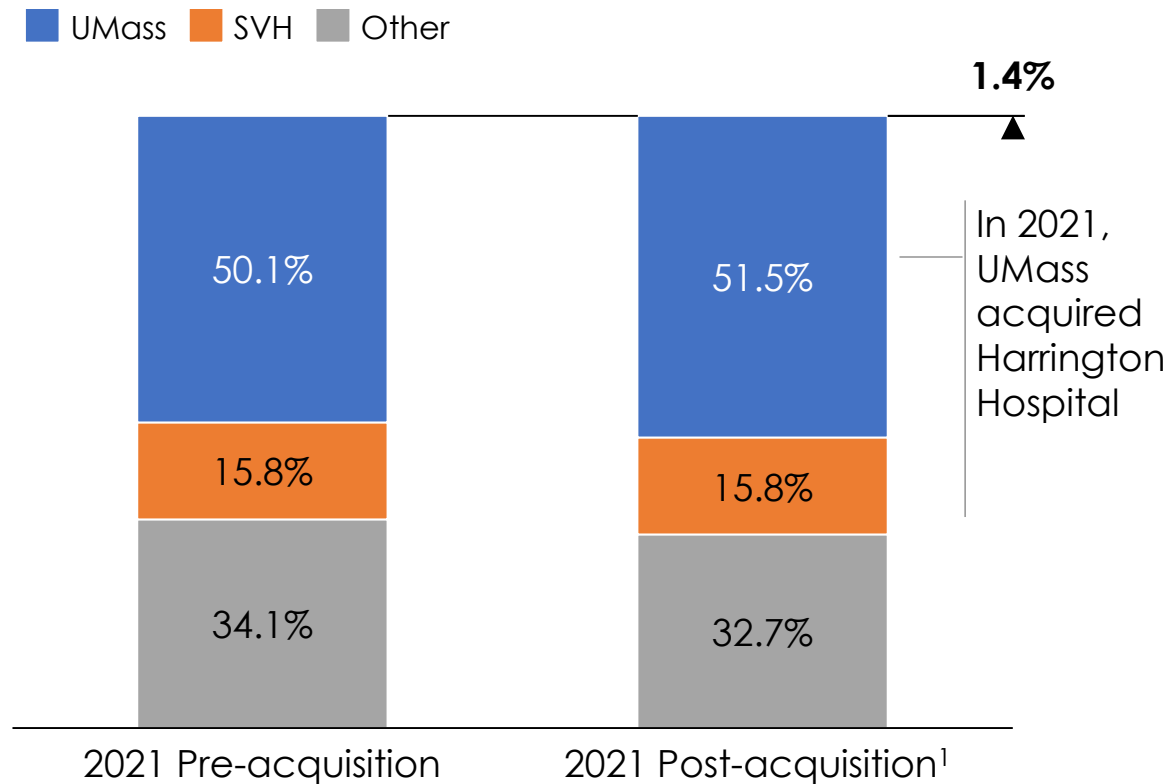
Service type	DRGs	Differential (SVH compared to UMass)	
Septicemia / severe sepsis	870, 871, 872	▼	14.1%
COPD	190, 191, 192	▼	17.4%
Heart failure	291, 292, 293	▼	16.9%
Pneumonia	193, 194	▼	15.9%
Pulmonary edema	189, 208	▼	16.2%
Respiratory infection	177, 178, 179	▼	16.2%

- For commercial payers, UMass is ~9% above Massachusetts market average and ~14% above SVH costs
- For DRGs of service lines in UMass' filing, UMass is ~14-17% more expensive than SVH for Medicare FFS
- Due to their relatively high cost of care, introducing additional beds at UMass could potentially increase regional costs

EXHIBIT 8

Adding beds will likely further increase UMass market share, potentially further reducing competition in the region

2021 Market share based on inpatient surgery volume for SVH SSA, Medicare FFS only



- Prior to its 2021 acquisition, UMass held the highest market share at 50.1% after acquiring Harrington Hospital, UMass' market share increased by 1.4% to 51.5%
- With the acquisition, other area hospitals lost market share while SVH's remained at 15.8%
- UMass' proposal for additional beds may further decrease market share of other local health systems

1. UMass acquired Harrington Hospital in June 2021

EXHIBIT 9

Estimated operating costs for med/surg beds should be measured against national and Massachusetts average

Estimated
annual cost of
inpatient bed

=

Inpatient
admissions

X

Average
length of
stay

X

Average
cost per IP
day

of staffed IP beds

Metric	National average	Massachusetts average
# of inpatient admissions	~33.4M	~809K
Average length of stay	~5.5	~4.9
\$ per inpatient day	~\$2,873	~\$3,462
# of staffed inpatient beds	~921K	~15,000
Estimated annual cost per inpatient bed	~\$550-600K	~\$900-950K

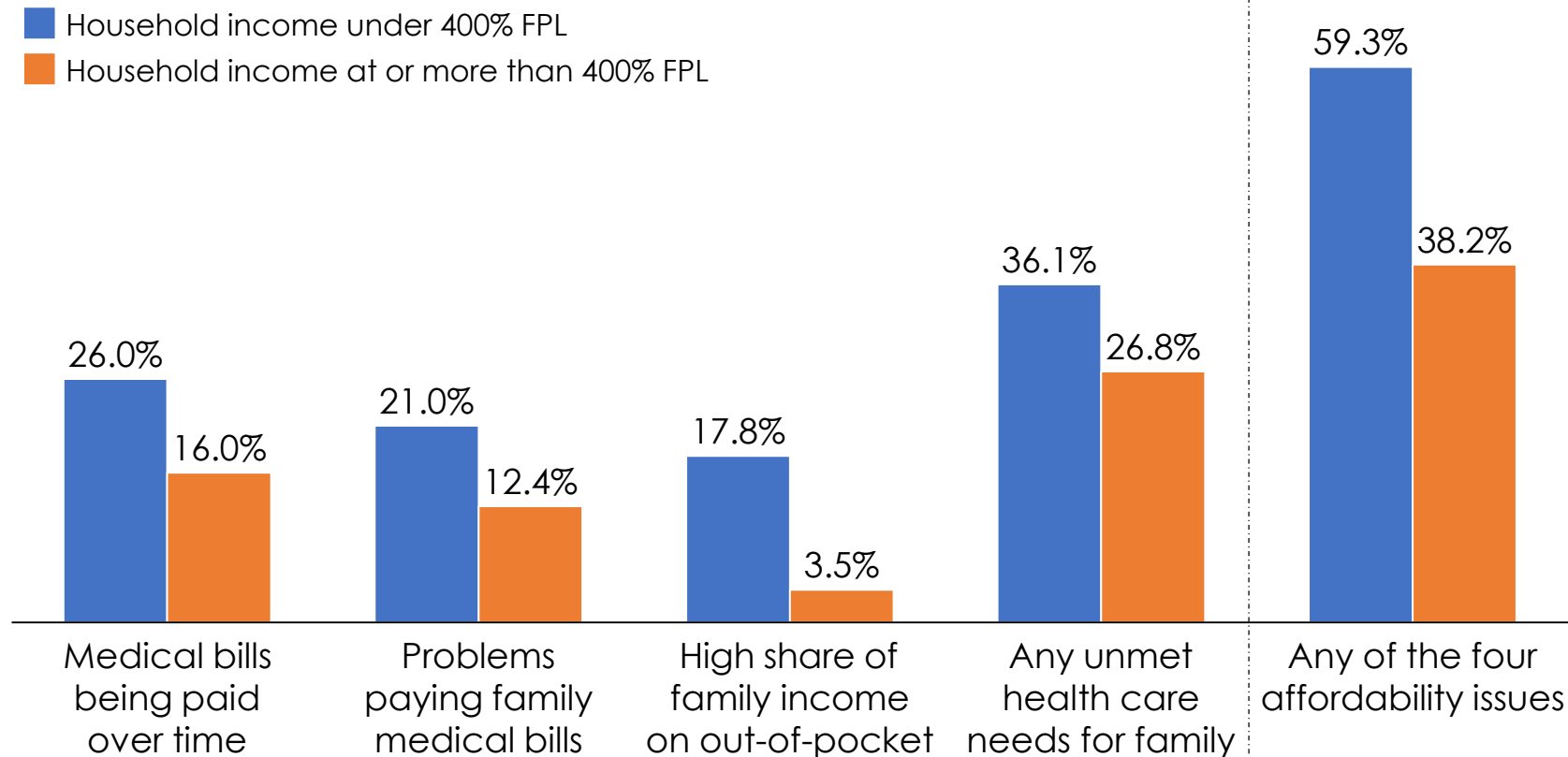
- National estimated operating cost for a med/surg bed is ~\$600K annually
- In Massachusetts, estimated operation costs for a med/surg bed is ~\$900K annually

Source: [American Hospital Association](#), [Kaiser Family Foundation 2020, fully loaded costs](#), [Average length of stay in community hospitals](#), [Massachusetts government](#), [Massachusetts Adult Care Hospital Inpatient Data](#), 2018 – 2021 CMS LDS data (Medicare FFS)

EXHIBIT 10

Increasing medical costs may continue to disproportionately impact households under 4x FPL

2021 Massachusetts Health Policy Commission Annual Healthcare Cost Trends
Report on affordability (% surveyed experiencing affordability issue)



- Increasing regional costs will also impact patients; with 59.3% under 400% FPL and 38.2% above 400% FPL with commercial insurance citing challenges to affordability of healthcare
- Increasing costs to healthcare greater impact on lower income adults across all affordability issues, and rises to regional costs may negatively impact affordability of care

EXHIBIT 11

Pending DoN projects in 2022: <https://www.mass.gov/info-details/don-pending-projects-and-applications>
Completed DoN project from 2017-2022: <https://www.mass.gov/info-details/don-completed-projects#2020->

Determination of Need application and related materials for Mass General Brigham BWFH-MGB-20121716-HE in connection with a substantial capital expenditure: <https://www.mass.gov/lists/don-mass-general-brigham-incorporated-bwfh-mgb-20121716-he>

- Shields request for ICA: <https://www.mass.gov/doc/shields-health-care-group-bwfh/download>
- Wellforce request for ICA: <https://www.mass.gov/doc/wellforce-bwfh/download>
- Center for Diagnostic Imaging request for ICA: <https://www.mass.gov/doc/center-for-diagnostic-imaging-cdi-bwfh/download>
- Department letter requiring ICA: <https://www.mass.gov/doc/independent-cost-analysis-request-letter/download>

Determination of Need application and related materials for Mass General Brigham MGB-20121612-HE in connection with a substantial capital expenditure and substantial change in service, including the addition of 94 beds: <https://www.mass.gov/lists/don-mass-general-brigham-incorporated-mgb-20121612-he>

- Shields request for ICA: <https://www.mass.gov/doc/shields-health-care-group-mgh/download>
- Wellforce request for ICA: <https://www.mass.gov/doc/wellforce-mgh/download>
- Citizens' request for ICA (Tam): <https://www.mass.gov/doc/tam/download>
- Citizens' request for ICA (Leung): <https://www.mass.gov/doc/leung/download>
- Center for Diagnostic Imaging request for ICA: <https://www.mass.gov/doc/center-for-diagnostic-imaging-cdi-mgh/download>
- Ten Taxpayers Alliance (Freeman) description of general concern for “skyrocketing” health care costs associated with the addition of 94 new beds: <https://www.mass.gov/doc/ten-taxpayer-alliance-cchers-inc-mgh/download>
- Department letter requiring ICA: <https://www.mass.gov/doc/independent-cost-analysis-request-letter-0/download>

Determination of Need application and related materials for Mass General Brigham – Multisite – 21012113-AS in connection with Substantial Capital Expenditure, Ambulatory Surgery, DoN-required equipment: <https://www.mass.gov/lists/don-mass-general-brigham-incorporated-multisite-21012113-as>

- Shields request for ICA: <https://www.mass.gov/doc/shields-health-care-group-multisite/download>
- City of Marlborough request for ICA: <https://www.mass.gov/doc/city-of-marlborough-ttg/download>
- Marlborough Economic Development Corporation request for ICA: <https://www.mass.gov/doc/marlborough-economic-development-corporation/download>
- Wellforce request for ICA: <https://www.mass.gov/doc/wellforce-4/download>
- Worcester Regional Chamber of Commerce request for ICA: <https://www.mass.gov/doc/worcester-regional-chamber-of-commerce/download>
- SHARE request for ICA: <https://www.mass.gov/doc/the-share-ttg/download>
- MelroseWakefield Healthcare request for ICA: <https://www.mass.gov/doc/melrosewakefield-healthcare/download>
- The Surgery Center request for ICA: <https://www.mass.gov/doc/the-surgery-center/download>
- UMass Memorial Physicians request for ICA: <https://www.mass.gov/doc/ttg-umass-mds/download>

- UMass Memorial Health Care request for ICA (raising objective material concerns that the proposed project is antithetical to the Department's cost-containment goal): <https://www.mass.gov/doc/umass-memorial-health-care-multisite/download>
- Center for Diagnostic Imaging request for ICA: <https://www.mass.gov/doc/center-for-diagnostic-imaging-cdi-multisite/download>
- Department letter requiring ICA: <https://www.mass.gov/doc/ica-request-letter/download>

Determination of Need application and related materials for The Children's Medical Center Corporation – Hospital/Clinic Substantial Capital Expenditure Application Number BCH-21071411-HE:
<https://www.mass.gov/lists/the-childrens-medical-center-corporation-hospitalclinic-substantial-capital-expenditure>

- Department letter requiring ICA: <https://www.mass.gov/doc/ica-request-letter-1/download>

Determination of Need application and related materials for Shields Healthcare Cambridge, Inc. application for DON-Required Equipment (MRI) Application Number NONE-22020311-RE:
<https://www.mass.gov/info-details/shields-healthcare-of-cambridge-inc-don-required-equipment>

- Citizens' request for ICA (Sanginario): <https://www.mass.gov/doc/mass-general-brigham-incorporated-0/download>

Determination of Need application and related materials for Applicant: <https://www.mass.gov/info-details/umass-memorial-hospital-hospitalclinic-substantial-capital-expenditure>

- Saint Vincent Hospital TTG requests for ICA: <https://www.mass.gov/doc/saint-vincent-hospital-pdf-umass-memorial-hospital-hospitalclinic-substantial-capital-expenditure/download> and <https://www.mass.gov/doc/public-comments-saint-vincent-hospital-pdf/download>