SAINT VINCENT HOSPITAL
A COMMUNITY BUILT ON CARE

August 3, 2022

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

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 the opportunity to submit written comments regarding the Application, which proposes the following: (1) the renovation of a 6-story building adjacent to UMMMC'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 UMMMC's Memorial Campus; and (3) other renovation projects to improve the existing services and facilities at UMMMC's Memorial Campus (the "Proposed Project").

As you know, by letter dated July 22, 2022, we requested that the Department of Public Health ("Department") schedule one or more public hearings in connection with the Application, and that the Department require the Applicant to under an Independent Cost-Analysis ("ICA"). By this letter, we re-iterate those requests.

The Proposed Project is unnecessary due to existing, local, lower-cost alternative market capacity. It would needlessly increase Massachusetts health care costs and not improve health outcomes or quality of life for patients. We therefore urge the Department to closely analyze whether the Application meets the DoN criteria regarding need, cost containment, and public health outcomes. We believe the Application fails to do so, and accordingly, we encourage the Department to disapprove the Application.

Background and Summary

The Greater Worcester region is already well-served by existing lower-cost, high quality providers, which have unused capacity as it is, and adding the New Beds to UMMMC is unwarranted. The Applicant has asserted that it needs a total of 91 new beds (the "New Beds") to address capacity constraints that result in long wait times in the Applicant's Emergency Departments ("EDs"), high ED boarding rates, and an inability to accept transfers from area community hospitals. Operational improvements, more efficient and

appropriate use of Applicant's Affiliate Hospitals (as later defined), and using current market capacity would more easily solve the problems—and at lower cost—that the Proposed Project purports to solve.

For more than 100 years, Saint Vincent Hospital ("SVH") has provided high-quality health care to Worcester and surrounding communities. SVH is a tertiary care center offering cardiac surgery, complex cancer care and neurosurgery.[1] SVH has a total of 205 licensed medical/surgical beds. Of those beds, 51 were temporarily closed due to the national nursing shortage and reduced patient demand resulting from COVID-19. Additionally, there are another 12 beds at SVH that are used at times of high census when needed, totaling 63 available beds at SVH ("SVH Available Beds). SVH is reopening some of the temporarily closed beds to accommodate higher weekday volumes. The remainder of the temporarily closed beds, as well as the beds used at high census, can be opened and available at any time there is a need and available nurse staffing, without construction time (i.e., long before 2024, when the New Beds are expected to be operational), and without additional capital expenditures. Furthermore, in recent months, some of the 154 open medical/surgical beds at SVH are sometimes unoccupied and therefore available, as the current demand for healthcare in Central Massachusetts is not as strong as it was pre-pandemic. Occupancy often drops much lower on weekends. This flux in occupancy means that at any given time, SVH may have even more than 63 available medical/surgical beds. SVH currently has the capability to treat 100% of the types of patients UMMMC anticipates occupying its New Beds, as SVH handles such anticipated diagnoses[2] each and every day.

Notably, SVH is more conveniently located to public transportation than UMMMC because SVH is located closer to downtown Worcester than UMMMC. In addition, the proposed new UMMMC tower that will house 72 of the New Beds is not physically attached to either UMMMC's Memorial Campus or University Campus ED. Rather, it is located 0.6 miles from the University Campus ED and 1.9 miles from the Memorial Campus ED. In contrast, SVH is located within 2.4 miles of the University Campus ED and within 1 mile of the Memorial Campus ED, making ambulance transport to SVH and general community access just as easy without negatively impacting patient care or cost (See Exhibit 1). In addition, SVH, like UMMMC, is a high public payer hospital as designated by the Center for Health Information and Analysis[3].

The SVH Available beds are not the only alternative capacity available for patients. For example, the Applicant's affiliate hospitals in the suburbs ("Affiliate Hospitals")[4] also could provide additional alternative capacity. Currently, it is our understanding that the Affiliate Hospitals often have available medical/surgical beds[5], yet the Applicant fails to sufficiently staff those hospitals with the specialists needed to retain patients

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[1] We note that the Applicant erroneously states in its Narrative to the Application that UMMMC is the "only tertiary hospital" in the region.

[2] The Applicant states the most prevalent diagnoses to be treated in 72 of the New Beds will be septicemia/severe sepsis, COPD, respiratory infection, pneumonia, heart failure, and pulmonary edema ("New Bed Diagnoses").

[3] SVH – 68% (FY20); UMMMC – 66% (FY20). See Massachusetts Center for Health Information and Analysis website at https://www.chiamass.gov/high-public-payer-hospitals/.

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

[5] 2019 American Hospital Association data for patient admissions and licensed beds show the following capacity rates: Clinton Hospital – 63%; Marlborough Hospital – 57%; Harrington Hospital – 44%. 2020 American Hospital Association data for patient admissions and licensed beds show even greater capacity, as Clinton Hospital's capacity rate dropped to 58% (Marlborough and Harrington Hospitals' capacity rates were unchanged). 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 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).

in their communities. 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 Proposed Project, of course, will likely further encourage that strategy in order for UMMMC to fill its New Beds. If the Applicant were to invest a fraction of the capital identified in its Application for the Proposed Project and use a portion of the projected $118M increased annual operating expense to increase specialty care at its Affiliate Hospitals, the Affiliate Hospitals would be able to utilize existing, unoccupied beds ("Affiliate Hospital Available Beds") to treat patients needing specialty care in the community where they live. This would eliminate the need to transfer those patients to UMMMC—at higher cost—and further reduce the need for the New Beds. SVH Available Beds and Affiliate Hospital Available Beds (and any other available beds at surrounding community hospitals, "Other Available Beds") can and should be used to address the Applicant's cited capacity constraints before New Beds are added to the health care system in Central Massachusetts.

Furthermore, the addition of the New Beds to UMMMC will increase health care costs. UMMMC is the highest cost provider in the region.[6] Patients in SVH Available Beds would receive the same high-quality treatment at a lower cost than if treated in a New Bed (a range of 14%-17% savings for New Bed Diagnoses).[7] The Affiliate Hospitals also are lower-cost providers than UMMMC. Additionally, the Applicant is the largest health care system in Central Massachusetts. It includes UMMMC, Clinton Hospital, Marlborough Hospital and Harrington Hospital (that is, ten campuses across four hospitals), and it is looking to grow with the addition of Heywood and Athol Hospitals[8] (making it twelve campuses across five hospitals).[9] As a result, the Applicant has a dominant market share in the region.[10] Adding the New Beds to UMMMC would further increase the Applicant's dominant market share, strengthen its near-monopoly pricing power, and weaken the financial viability of local, lower-cost health care providers. Jeopardizing the ability of lower-cost providers to continue to operate, leaving the highest-cost provider standing, is not an acceptable outcome.

In summary, in light of lower-cost, local, alternative capacity in the market for both tertiary and lower acuity care, the Proposed Project: (i) simply is not needed; (ii) would adversely impact the Commonwealth's efforts to contain cost; (iii) would not add measurable public health value or quality of life; and (iv) would be a misuse of public funds, as the Applicant is a publicly funded institution. Accordingly, we urge the Department to disapprove the Application in its entirety. Until all of the beds in Central Massachusetts are open and reach a certain critical occupancy, no bed expansions should be approved.

Determination of Need Factors[11]

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[6] For commercial payors, UMMMC is reimbursed at a rate that is 9% higher than the Massachusetts average (and 14% higher than SVH). See Exhibit 3. Source: Statewide commercial payer RP data, CMS IPPS Web Pricer.

[7] See Exhibit 3. Source: Statewide commercial payer RP data, CMS IPPS Web Pricer.

[8] *Heywood Hospital in talks to join UMass Memorial Health*. Boston Globe. May 3, 2022.

[9] The Applicant also includes Worcester and Shrewsbury EMS and Lifeflight helicopter ambulance.

[10] 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 4. Trilliant All-Payor Surgical Data Sample (October 2020 – September 2021), accessed March 2, 2022.

[11] To assist the Department with its review, we have attempted to track the Application's structure where appropriate while also tracking the applicable regulatory standards at 105 CMR 100.210 *et seq*.

Pursuant to 105 CMR 100.210, the Applicant must clearly and convincingly demonstrate that the Proposed Project meets ***each*** Determination of Need Factor. The Applicant has failed to do so with respect to at least the following Factors:

Factor 1: Applicant Patient Panel Need, Public Health Value, and Operational Objectives.

(a) The Applicant has demonstrated sufficient need for the Proposed Project by the Applicant's Patient Panel.

(ii) Provide supporting data to demonstrate the need for the Proposed Project.

The Applicant seeks to ensure patients receive care in their community, in the right care setting, and in a timely manner, address ED boarding, meet the growing demand for inpatient services, and ensure timely access to tertiary care. The Applicant asserts that the Proposed Project is needed to improve access to inpatient medical/surgical services, which will improve ED throughput and reduce ED boarding, improve the timeliness of care delivery, improve patient satisfaction, increase the number of patients who are able to receive tertiary care, and improve health outcomes.

The Proposed Project is not needed to achieve these goals. As stated above, the objectives of the Proposed Project can be met by operational improvements by the Applicant, more efficient and appropriate use of Applicant's Affiliate Hospitals, as well as utilization of the SVH Available Beds, the Affiliate Hospital Available Beds, and Other Available Beds. These alternative options for addressing medical/surgical bed capacity would also result in delivery of care at a lower operating cost than the Proposed Project[12] and without capital expenditure or delay, and would serve more than 100% of the patients anticipated to occupy the New Beds. Existing community capacity is more than adequate to improve access to inpatient medical/surgical services, which will improve ED throughput and reduce ED boarding, in a manner that promotes cost containment and eliminates the unnecessary spending associated with the Proposed Project. As a result, there is no need for the New Beds.

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[12] The Application reports a Maximum Incremental Operating Expense from the Proposed Project in the amount of $118,577,591.00 per year, which is greater than $1.3M/year for each New Bed. In contrast, SVH's average cost per medical/surgical bed is $880K, the estimated national average cost per medical/surgical bed is approximately $550K-$600K/year, and the estimated Massachusetts average cost per medical/surgical bed is approximately $900K-$950K/year. See Exhibit 5. 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.

(iii) Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending.[13] When responding to this question, please consider Factor 4, Financial Feasibility and Reasonableness of Costs.

The Applicant states that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending because it will enable UMMMC to provide more timely access to inpatient services, which will reduce ED boarding, in turn improving health outcomes and maximizing overall hospital efficiency. The Applicant also states that the Proposed Project competes on the basis of price because the new inpatient facility will be the result of renovating an existing healthcare building, rather than constructing a new facility. The Applicant concludes that the Proposed Project: (i) will improve access to inpatient services (which will reduce wait times for an inpatient bed, in turn reducing ED boarding), and (ii) is necessary to ensure timely access to tertiary care unavailable elsewhere in the region (ignoring SVH), and that therefore, the Proposed Project will not negatively impact overall health care costs.

For multiple reasons, the Application fails to satisfy this Factor.

First, the Proposed Project will do nothing to reduce the cost that patients, payors, employers and the Commonwealth will incur relating to the New Beds or the Applicant's existing beds. Frankly, UMMMC is not committing to lowering its cost or pricing nor could it in order to fund the unnecessary New Beds. In fact, the additional capacity from the New Beds will help the Applicant maintain market dominance, enabling the Applicant to protect its higher pricing and negotiate even higher managed care reimbursement, thereby negatively impacting patients, payors, employers and the Commonwealth.

In other words, the Proposed Project actually will increase health care spending. The Applicant is the highest cost provider in the region[14], and the Proposed Project would compound the higher costs across more inpatient days. The Applicant reports an ever-increasing Average Length of Stay ("ALOS") for its medical/surgical beds as follows: 4.7 days in 2019, 5.1 in 2020, and 5.7 in 2021 and 5.8 in years 1 through 5 of the Proposed Project, yet a less efficient operation than its current operation.[15] Furthermore, UMMMC's Observed to Expected (O/E) Length of Stay (LOS) ratio is 1.27, indicating that acute inpatients stay 27% longer than expected, which also contributes to their high cost of care.[16] Adding more dollars-per-day to

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[13] See 105 CMR 100.210(A)(1)(f).

[14] See Footnote 7.

[15] For point of reference, UMMMC's CMI adjusted LOS for non-psych inpatients is as follows: 3.3 in 2018, 3.1 in 2019, 3.5 in 2020 and 3.5 in 2021 – a growth of 5.6% over that period of time. In contrast, SVH's CMI adjusted LOS for non-psych inpatients is as follows: 2.8 in 2018, 2.7 in 2019, 2.7 in 2020 and 2.9 in 2021 – a growth of 4.4% over that period of time. UMMMC's CMI adjusted LOS for non-psych inpatients is 20% higher than SVH's, and UMMMC's increase over time is 1.3 times the increase at SVH over that same period of time. See Exhibit 6. Analysis is based on data from the following: 2018-2021 CMS LDS data (Medicare FFS) for UMass at www.cms.gov.

[16] Observed days are the actual inpatient days and are compared to expected inpatient days which are assessed per diagnosis and patient factors (e.g., age, comorbidities, etc.). An O/E LOS ratio that is greater than one indicates actual acute inpatient days are longer than expected days. For a point of reference, we note that UMMMC is outperformed by SVH, which has an O/E LOS of 0.99 and UMMMC's O/E LOS is in the third quartile of all comparable academic medical centers nationwide. See Exhibits 7 and 8.

more days does not compete on the basis of price, total medical expenses, provider costs, or other recognized measures of health care spending.[17]

By contrast, SVH's O/E LOS is currently 0.99 – that is, at SVH patients stay approximately as long as they should while patients at UMMMC stay 27% longer than they should, which is costly and can lead to adverse outcomes.[18] And SVH's cost is lower. Using fewer dollars-per-day for fewer days *does* compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. Furthermore, the Application reports a Maximum Incremental Operating Expense from the Proposed Project in the amount of $118,577,591.00 per year. The Application does not specify the allocation of incremental operating expense between New Beds and other aspects of the Proposed Project. In order to accurately evaluate whether the incremental operating expense related to the New Beds competes on the basis of price, the Department should require an ICA.[19] In the absence of further detailed information, we have estimated that the operating cost of each New Bed is approximately $1.3M per year, which is considerably higher than the average operating cost for a medical/surgical bed in Massachusetts ($900K-$950K per year) and substantially higher than the operating cost for a medical/surgical bed at SVH ($880K per year).[20] In fact, the operating cost for the New Beds is up to $420,000 per bed per year more than the operating cost for a medical/surgical bed at SVH. The higher cost is due in part to the fact that UMMMC is an academic medical center with a higher cost structure and is due in part to the inefficiencies associated with a standalone 72-bed tower, which will require its own infrastructure that is duplicative of the Applicant's existing infrastructure.

Second, the Applicant fails to consider and compare local alternatives to the Proposed Project to demonstrate how the Proposed Project "competes" in terms of health care spending. That is, the Applicant neglects to consider that total medical expenses and provider costs would be

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Analysis is based on data from the following: 2021 CMS LDS data (Medicare FFS) for academic medical centers in Massachusetts at www.cms.gov; 2021 CMS LDS data (Medicare FFS) for academic medical centers at www.cms.gov.

[17] As an aside, we note that increased efforts by UMMMC to reduce its O/E LOS ratio would yield additional bed capacity at UMMMC. For example, if UMMMC could reduce its O/E LOS to meet the national academic medical center average (O/E LOS of 1.22), UMMMC would increase its bed capacity by 28 UMMMC beds. See Exhibit 9. If UMMMC could further reduce its O/E LOS to meet the first quartile O/E LOS average of 1.06 for academic medical centers nationwide, UMMMC would increase its bed capacity by 123 beds. See Exhibit 8. Such efforts, together with use of SVH Available Beds and/or more efficient operation of its Affiliate Hospitals would completely eliminate the need for New Beds. Analysis is based on data from the following: 2021 CMS LDS data (Medicare FFS) for academic medical centers at www.cms.gov; 2020 AHA data for UMass licensed beds at: https://www.ahadata.com/aha-annual-survey-databasedata (Tabs AHA 2012 – 2020 and Inpatient beds AHA).

[18] UMMMC's current O/E LOS of 1.27 exceeds not only SVH's O/E LOS of 0.99, but also the Massachusetts median O/E LOS of 1.21. See Exhibit 7. Analysis is based on data from the following: 2021 CMS LDS data (Medicare FFS) for academic medical centers in Massachusetts at www.cms.gov.

[19] An important aspect of the ICA will be an analysis of UMMMC's proposed operating costs per bed compared to the National average, the Massachusetts average and SVH's average, as noted in Footnote 12.

[20] See Exhibit 5. 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.

lower if the patients UMMMC anticipates treating in the New Beds were instead treated in the SVH Available Beds, the Affiliate Hospital Available Beds, or Other Available Beds. We will address these issues below and further under the Relative Merit factor.

Third, the Applicant states 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". However, the Applicant neglects to consider that the combination of the SVH Available Beds, more efficient use and sufficient staffing of the Affiliate Hospitals, and tighter management of the Applicant's existing beds would alleviate the need to transfer patients to "higher cost hospitals". Simply put, the SVH Available Beds and the Affiliate Hospital Available Beds (and potentially Other Available Beds) could, at lower operating cost and without capital expenditure or delay, serve more than 100% of the patients anticipated to occupy the New Beds. And the SVH Available Beds and Affiliate Hospital Available Beds can do so within the service area. Utilizing all of these alternative beds for low-acuity patients will reduce the costs paid by those patients, their payors, their employers, and the Commonwealth of Massachusetts, increase capacity at UMMMC for high-acuity patients, reduce or eliminate the need to transfer patients to higher cost hospitals, and therefore reduce overall health care spending.

Fourth, the cost savings that may be attributable to renovating an existing healthcare building, rather than constructing a new facility misses the point. Renovating an existing building to add the New Beds still requires a lot of capital. Inefficiently operating the New Beds still requires a lot of operating expense. Renovating an existing building rather than utilizing existing community capacity still has zero impact on cost-containment and competitive health care spending. Adding an undefined "other renovation projects to improve the existing services and facilities at Memorial Campus" still does not clearly or convincingly establish that the Proposed Project competes on the basis of price. Furthermore, because the Plantation Street building is not physically connected to either UMMMC Campus, any efficiencies that UMMMC might achieve in terms of renovating an existing building rather than constructing a new building are far outweighed by the costs associated with the duplicative ancillary services and infrastructure required for a separate, standalone location—renovated or new. To determine whether the Proposed Project is "competitive", the Applicant is not required to compare a renovation to new construction. Rather, the Applicant must (but does not) consider and compare local alternatives to the Proposed Project to demonstrate how UMMMC "competes". The SVH Available Beds can be made available as soon as needed without time required for construction, any additional capital expenditure, or any duplication of infrastructure or ancillary services. Lastly, the Applicant fails to acknowledge that patients can be treated in the SVH Available Beds at a cost that is more competitive (i.e., lower) than the cost associated with the New Beds.

Fifth, the Applicant concludes, without any demonstrated data or analysis, that the Proposed Project will not negatively impact overall health care costs. Most important, this conclusory statement without demonstrated data or analysis does not meet the regulatory standard of establishing clearly and convincingly that the Proposed Project competes on price. The statement is also patently false. The inpatient care in the New Beds would negatively impact

health care costs compared to care that can be provided in the SVH Available Beds and the Affiliate Hospital Available Beds.[21]

Finally, UMMMC is a State-funded institution. Any approval of the Proposed Project for the New Beds would be an unnecessary drain on the Commonwealth's public funds, both in terms of initial capital outlay to renovate the building on Plantation Street and the space on the UMMMC Memorial Campus, and also the additional recurring annual operating expenses of almost $120M. More competitive community services exist without misusing public funds.

For these reasons, the Applicant has failed to demonstrate by clear and convincing evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. Accordingly, the Applicant has failed to satisfy this particular aspect of Factor 1.

(b) The Applicant has demonstrated that the Proposed Project will add measurable public health value in terms of improved health outcomes and quality of life of the Applicant's Patient Panel, while providing reasonable assurances of health equity.

(i) Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

The Applicant seeks to address ED boarding, meet the growing demand for inpatient services, and ensure timely access to tertiary care through the Proposed Project. The Applicant states that "having adequate inpatient capacity for less acute patients is equally important to ensuring capacity for higher acuity patients". The Applicant plans to dedicate the New Beds to low acuity patients, freeing up capacity at UMMMC for the region's sickest patients.

We agree that having adequate inpatient capacity for less acute patients is necessary for ensuring capacity for higher acuity patients. But for the reasons discussed above, the Proposed Project will not add measurable public health *value* in terms of improved health outcomes and quality of life of the Applicant's Patient Panel because the objectives of the Proposed Project can be met by utilizing existing community capacity rather than implementing the Proposed Project.

The Applicant intends to use 72 of the New Beds to treat lower-acuity inpatients and anticipates that the most prevalent diagnoses of patients admitted to these beds will be Septicemia/Severe Sepsis, Chronic Obstructive Pulmonary Disease, respiratory infection, pneumonia, heart failure, and pulmonary edema. SVH and its providers can, and currently do, provide high-quality care to patients with such diagnoses. The SVH Available Beds account for 63 of the 72 New Beds for the proposed renovated Plantation Street building (i.e., 87.5%). The Affiliate Hospital Available Beds and potentially Other Available Beds together could account for the remaining

[21] We note that the negative impact of increased health care costs would significantly impact those households whose income is under 400% FPL, which accounts for 59.3% of the population in the region. 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.

28 beds in the proposed tower on the UMMMC University Campus, as well as the proposed beds on the UMMMC Memorial Campus. Currently, Worcester County has approximately 1.17 medical/surgical beds per 1,000 people, which is 9% higher than the national average and 4% higher than the Massachusetts average.[22] In light of this higher than average ratio, coupled with the SVH Available Beds, plus the existing capacity at the Affiliate Hospital Available Beds[23], the community does not need the New Beds to address the Applicant's ED boarding. Thus, the Application fails to satisfy the regulatory standard.

In addition, we note that the Application implies that the New Beds will reduce hospital acquired pressure injuries ("HAPI") and inpatient falls with injury resulting from ED boarding. However, the Applicant has not provided any evidence to support this proposition and we are not aware of any correlation between HAPI and ED Boarding or inpatient falls and ED boarding. We also call into question the Applicant's assertion that there is a growing demand for inpatient services, as SVH recently has experienced reduced demand compared to pre-pandemic demand.

The SVH Available Beds and the Affiliate Hospital Available Beds (and potentially Other Available beds) are more than adequate to address ED boarding, meet the growing demand for inpatient services, and ensure timely access to tertiary care. They can do so in a manner that promotes cost containment and eliminates the unnecessary spending associated with the Proposed Project. For these reasons, the Proposed Project does not address need in a way that adds measurable public health value. Accordingly, the Applicant has failed to satisfy this particular aspect of Factor 1.

(ii) Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

To assess the impact of the Proposed Project and demonstrate how it will improve health outcomes, quality of life, or health equity, the Applicant plans to evaluate patient experience/satisfaction using a Press Ganey Patient Experience Survey, monitor HAPIs, monitor inpatient falls with injury, and monitor ED boarding. HAPIs and inpatient falls with injury, two of the four metrics, are unrelated to increasing hospital bed capacity, and the Applicant has failed to provide any evidence to the contrary. We also note that HAPI and falls with injury likely would be reduced by a shortened ALOS rather than adding the New Beds. Given that UMMMC has a longer ALOS for its medical/surgical patients than other regional hospitals, this should be an area of operational focus for the Applicant instead of building additional capacity.

The Applicant also proposes using a Press Ganey Patient Experience Survey to address its contention that the Proposed Project is necessary because dissatisfied patients experiencing ED boarding "may result in reluctance to seek emergency or routine medical care in the future."

[22] See Exhibit 11. 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.

[23] See Exhibit 2.

The Applicant makes this assertion without any demonstrative evidence that patients will forgo all future health care based on ED waiting time rather than seek health care at an alternative provider. As a result, three of the four measures that the Applicant intends to use are irrelevant and non-responsive to assessing the impact of the Proposed Project on improvement of "health outcomes, quality of life, or healthy equity". Accordingly, we urge the Department to find that the Applicant has failed to sufficiently satisfy this particular aspect of Factor 1.

(e) The Applicant has provided evidence of sound community engagement and consultation throughout the development of the Proposed Project, including documentation of the Applicant's efforts to ensure engagement of community coalitions statistically representative of the Applicant's Patient Panel. Representation should consider age, gender and sexual identity, race, ethnicity, disability status, as well as socioeconomic and health status; and

The Applicant states that the Proposed Project was presented to the community in a number of forums to engage the community and solicit their feedback in the development of the Proposed Project. The Proposed Project was presented to the Steering Committee of the Coalition for a Healthy Greater Worcester, the UMMMC Patient and Family Advisory Council, the Worcester Together Coalition, and to the public via an in-person and virtual forum that was advertised through the Worcester Telegram & Gazette, Spectrum News, Worcester Business Journal, MassLive, UMMMC's social media channels and through the Worcester Together Now listserv for community-wide distribution.

We question whether the community engagement efforts were truly open and unbiased, as UMMMC Patient and Family Advisory Council is a UMMMC-based organization, UMMMC is a member of the Worcester Together Coalition, and UMMMC is not only a member of the Coalition for a Healthy Greater Worcester, but also has members of its own leadership team on the Steering Committee of the Coalition. Clearly, none of the three organizations are completely independent of the Applicant. With respect to the public forum, we question whether it resulted in true community engagement. First, the Application fails to disclose the number of participants in the public forum. Second, the supplementary materials to the Application state that the Public Forum was "announced through local and social media . . . in the *days* leading up to the event" (emphasis added), which may have been insufficient notice for a public forum of such import. Finally, the Application does not address whether representation considered age, gender and sexual identity, race, ethnicity, disability status, socioeconomic status and health status.

Furthermore, it is our understanding that none of the fourteen members of the Governing Board of SVH were aware of the Proposed Project prior to the filing of the Application by the Applicant. We find this to be extraordinarily surprising, given that all of the members of the Governing Board work in the Worcester region (and several of them work in the health care industry). Similarly, it has come to our attention that other prominent health care leaders in the Worcester area also were unaware of the Proposed Project, further suggesting that the Applicant's community engagement efforts were insufficient.

For these reasons, the Applicant has failed to provide evidence of sound community engagement, and therefore has failed to satisfy this particular aspect of Factor 1.

Factor 2: Health Priorities.

The Applicant has sufficiently demonstrated that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.

(a) Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

The Applicant asserts that the Proposed Project will meaningfully contribute to and further the Commonwealth's goals for cost containment by ensuring timely and equitable access to inpatient services, thereby improving patient outcomes, resulting in lower cost of care. While this may contribute to UMMMC's internal cost containment, the Applicant fails to consider the following as it relates to cost containment for the Commonwealth:

- The Applicant is the largest health care system in Central Massachusetts, has a dominant market share in the region, and is the highest cost provider in the region.
- The Applicant reports an ever-increasing ALOS for its medical/surgical beds and had an O/E LOS of 1.27 in the first half of 2021 that is likely higher now. The Proposed Project would compound the higher costs across more inpatient days, adding more dollars-per-day to more days. In contrast, the SVH Available Beds operate at a significantly reduced O/E LOS of only 0.99.[24]
- The region is already well-served by existing lower-cost, high quality providers in Worcester as well as suburban markets in the region with existing capacity.
- The capacity constraints that the Applicant seeks to rectify can be substantially addressed by utilizing the SVH Available Beds and the Affiliate Hospital Available Beds (and potentially Other Available Beds) and improving management of the Applicant's ALOS and O/E LOS.
- The SVH Available Beds can be utilized without any additional capital expenditure, can be opened when community demand warrants them, and can be utilized to provide both tertiary and lower acuity care.
- Utilization and more robust staffing of the Affiliate Hospitals will reduce or eliminate the need to transfer patients who require specialty care to UMMMC and other high-cost providers.
- The cost of treating a patient in the SVH and Affiliate Hospital Available Beds is less than the cost of treating a patient in a UMMMC New Bed, resulting in lower costs for patients, payors, employers, and the Commonwealth of Massachusetts.
- Expanding UMMMC by 91 beds will significantly weaken the financial viability of local community hospitals, potentially forcing them to cease operations, while strengthening the Applicant's near-monopoly powers. Such monopoly powers will enable the Applicant to negotiate even higher reimbursement rates than the rates currently charged, further increasing health care spending and dis-incentivizing efficient operations.

[24] See Exhibits 6 and 7.

In addition, recently, the Applicant reportedly was trying to fill 2,000 vacancies, one-fourth (or 500) of which are for nurses. As a result, the Applicant hired 700 traveling nurses, costing an additional $10M each month.[25] This suggests that the Applicant will not be able to staff 91 New Beds in a cost-effective manner. Furthermore, the proposed 72-bed tower is not physically attached to the hospital on the UMMMC University Campus, or the hospital on the UMMMC Memorial Campus. As a result, the Applicant must duplicate ancillary and support services. This makes the New Beds less efficient and less cost effective than the Applicant's current beds and significantly less efficient and less cost effective than the existing SVH Available Beds and Affiliate Hospital Available Beds.

For these reasons, the Proposed Project does not meaningfully contribute to the Commonwealth's goals for cost containment. Accordingly, the Applicant has failed to satisfy the requirements of this particular aspect of Factor 2.

(b) Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

The Applicant asserts that the Proposed Project will improve public health outcomes by providing more timely access to inpatient care and ensuring more patients receive the appropriate level of care in the most appropriate setting. The Proposed Project is not the only way—but is a more expensive way—to improve public health outcomes. In fact, the Department can help achieve the same public health improvements at a much lower cost by disapproving the Application, denying the Proposed Project and allowing the SVH Available Beds and the Affiliate Hospital Available Beds (and potentially Other Available Beds) to solve the ostensible problems. The SVH Available Beds account for 87.5% of the beds proposed for the renovated Plantation Street building (i.e., 63 of the 72 beds). Rather than transporting patients from the UMMMC University Campus ED and the UMMMC Memorial Campus ED to the proposed Plantation Street building that will house 72 of the New Beds, patients instead can be transported to SVH. The building on Plantation Street is 0.6 miles from the UMMMC University Campus ED and 1.9 miles from the UMMMC Memorial Campus ED. In comparison, SVH is 2.4 miles from the UMMMC University Campus ED and 1 mile from the UMMMC Memorial Campus ED (see Exhibit 1). Patients transported to SVH rather than internally within UMMMC will receive the same timely access to high-quality inpatient care, thereby improving public health outcomes in the same way. The difference, however, is that patients treated in the SVH Available Beds would receive care: (i) sooner, as no construction time is required; (ii) at a much lower cost than patients treated in the New Beds; and (iii) with a better O/E LOS[26], which reduces the potential for adverse events, HAPIs, falls and other quality concerns.

For these reasons, the Proposed Project does not meaningfully contribute to the Commonwealth's goals for improved public health outcomes. Accordingly, the Applicant has failed to satisfy the requirements of this particular aspect of Factor 2.

Factor 4: Financial Feasibility and Reasonableness of Expenditures and Costs.

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[25] *Nursing shortage at hospitals leads to multimillion-dollar costs*. Boston Globe. July 12, 2022.

[26] As described above, UMMMC's O/E LOS is 1.27 and SVH's O/E LOS is 0.99, indicating substantially better performance at SVH. See Exhibit 7.

The Department, in consultation with CHIA, has determined that the Applicant has provided sufficient documentation of the availability of sufficient funds for capital and ongoing operating costs necessary to support the Proposed Project without negative impacts or consequences to the Applicant's Patient Panel . . . If the Commissioner has determined that an independent cost-analysis is required pursuant to M.G.L. c. 111, § 25C(h), the analysis has demonstrated that the Proposed Project is consistent with the Commonwealth's efforts to meet the health care cost-containment goals.

In connection with this Factor, we re-iterate the importance of requiring the Applicant to undergo an ICA to demonstrate that the Proposed Project is consistent with the health care cost-containment goals of the Commonwealth. In addition, because the Applicant is a publicly funded institution, to ensure that public funds are not misused, we urge the Department to carefully analyze: (1) the source(s) of funding for the Proposed Project to confirm that funding will be used appropriately (for instance, that funds allocated from the 1115 MassHealth Demonstration Waiver will not be directed towards the Proposed Project); and (2) as discussed above, the reasonableness of costs – that is, costs associated with ongoing operational expenses for the New Beds in comparison to SVH, Massachusetts and National average operating costs for the same, as well as costs associated with unnecessary duplicative infrastructure and ancillary services for the Plantation Street building (because it will not be physically attached to any UMMMC Campus).

Factor 5: Relative Merit.

The Applicant has provided sufficient evidence that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the Patient Panel needs identified by the Applicant pursuant to 105 CMR 100.210(A)(1). Evaluation of 105 CMR 100.210(A)(5) shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions.

To address this Factor, the Applicant does nothing more than compare the Proposed Project to no Proposed Project. That is, the Applicant—as with other Factors—wholly fails to consider potential alternatives to or substitutes for the Proposed Project.

For example, the Applicant neglected to consider alternative means for improving ED throughput. The Applicant reports an ALOS for its medical/surgical beds as follows: 4.7 in 2019, 5.1 in 2020, and 5.7 in 2021. The Applicant further projects an ALOS of 5.8 in years 1 through 5 of the Proposed Project. In addition, UMMMC has an O/E LOS of 1.27[27]. As noted above, we estimate that if UMMMC were to reduce its O/E LOS ratio to that of comparable academic medical centers performing in the top quartile average, UMMMC would gain the capacity of 123 incremental beds, thereby eradicating the need for any New Beds[28]. Even if UMMMC could bring its O/E LOS in line with the national academic medical center average (1.22 O/E LOS), UMMMC would increase its capacity by 28 beds[29]. Those 28 beds, coupled with

[27] See Exhibits 7 and 8. Analysis is based on data from the following: 2021 CMS LDS data (Medicare FFS) for academic medical centers in Massachusetts at www.cms.gov; 2021 CMS LDS data (Medicare FFS) for academic medical centers at www.cms.gov.
[28] See Exhibit 8.
[29] See Exhibit 9. Analysis is based on data from the following: 2021 CMS LDS data (Medicare FFS) for academic medical centers in Massachusetts at www.cms.gov; 2021 CMS LDS data (Medicare FFS) for national academic medical centers at www.cms.gov; 2020 AHA data for UMass licensed beds at: https://www.ahadata.com/aha-annual-survey-databasedata (Tabs AHA 2012 – 2020 and Inpatient beds AHA).

SVH Available Beds, equal the total number of New Beds requested by the Applicant. Increased efforts by UMMMC to reduce its ALOS and O/E LOS would improve patient flow and ED throughput and likely would reduce or even eliminate the Applicant's ED boarding problem, without the addition of the New Beds.

Similarly, the Applicant neglected to consider whether the need it identified for the New Beds could be met by its Affiliate Hospitals. The lack of sufficient staff specialists (e.g., vascular, orthopedic, gastroenterology and urology specialists) at Affiliate Hospitals results in the unnecessary transfer of patients from the Affiliate Hospitals. If the Applicant were to invest a fraction of the capital or incremental operating expense identified in its Application for the Proposed Project in increasing specialty care at its Affiliate Hospitals, the Affiliate Hospitals would be able to retain patients, thereby reducing or eliminating UMMMC's stated ED boarding issues and the need for New Beds.

In addition, the Proposed Project, on balance, is **not** superior to the utilization of the SVH Available Beds and the Affiliate Hospital Available Beds for the following reasons:

- The Applicant is the largest health care system in Central Massachusetts, has a dominant market share in the region, and is the highest cost provider in the region.
- The Applicant reports an ever-increasing ALOS for its medical/surgical beds and has an O/E LOS of 1.27 in the first half of 2021 that is likely higher now. The Proposed Project would compound the higher costs across more inpatient days, adding more dollars-per-day to more days. In contrast, the SVH Available Beds operate at a significantly reduced O/E LOS of only 0.99.[30]
- The region is already well-served by existing lower-cost, high quality providers in Worcester as well as suburban markets in the region with existing capacity.
- The capacity constraints that the Applicant seeks to rectify can be substantially addressed by utilizing the SVH Available Beds and the Affiliate Hospital Available Beds (and potentially Other Available Beds) and improving management of the Applicant's ALOS and O/E LOS.
- The SVH Available Beds can be utilized without any additional capital expenditure, can be opened when community demand warrants them, and can be utilized to provide both tertiary and lower acuity care.
- The cost of treating a patient in the SVH and Affiliate Hospital Available Beds is less than the cost of treating a patient in a UMMMC New Bed, resulting in lower costs for patients, payors, employers, and the Commonwealth of Massachusetts.
- Expanding UMMMC by 91 beds will significantly weaken the financial viability of local community hospitals, potentially forcing them to cease operations, and strengthen the Applicant's near-monopoly powers. Such powers will enable the Applicant to negotiate even higher reimbursement rates than the rates currently charged, further increasing health care spending and dis-incentivizing efficient operations.

As a related matter, we note that during the COVID-19 pandemic, hospitals throughout Massachusetts met frequently, and in some cases daily, to collaborate and determine which facility/ies had the capacity to care for patients who needed transfer, including addressing reduction of ED boarding. UMMMC participated in this to a great extent, and this level of collaboration has been praised by leaders throughout the state.

[30] See Exhibits 6 and 7.

However, UMMMC has failed to consider a similar collaboration as a potential alternative to the Proposed Project, where SVH Available Beds could be utilized to assist UMMMC in achieving its goal to increase capacity for low acuity medical/surgical beds.

For these reasons, the Applicant has not provided sufficient evidence that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the Patient Panel needs identified by the Applicant. Accordingly, the Applicant has failed to satisfy Factor 5.

Additional Considerations

Technical Non-Compliance: Incomplete Application

We note that Item 12.5 of the Application – total proposed construction costs, specifically related to the Proposed Project, if any, which will be contracted out to local or minority, women, or veteran-owned businesses expressed in estimated dollars – is blank.

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Due to the concerns and issues described above, we urge you to closely analyze whether the Proposed Project meets the DoN criteria regarding need, and meets the State's health care priorities of health care cost containment and improved public health outcomes.

In addition, we request that an additional public hearing be scheduled after the ICA has been conducted in order to more accurately understand the impact of the Proposed Project.

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