



**Corporate Office**

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January 27, 2022

Ms. Lara Szent-Gyorgyi, Director  
Determination of Need Program  
Department of Public Health  
Commonwealth of Massachusetts  
67 Forest Street  
Marlborough, MA 01752

**RE: Determination of Need (DoN) Application 21012113-AS –Independent Cost Analysis Party of Record Comments**

Dear Director Szent-Gyorgyi:

On behalf of the Shields Health Care Group (Shields) Ten Taxpayer Group (TTG), please accept these comments relative to Charles River Associates’ (CRA) Independent Cost Analysis (ICA) of DoN Application 21012113-AS. As a Party of Record, Shields has consistently raised concerns about the independence of an analysis paid for and selected with the approval of the Applicant. After reading CRA’s ICA, those concerns have now been validated. The CRA ICA is woefully deficient in the scope of its analysis and its failure to thoroughly address the questions posed by the Department. The economists rely almost exclusively on the assumptions included in Mass General Brigham’s (MGB) Application and fail to investigate or test the validity of those assumptions.

Shields respectfully urges the Department to reject the ICA’s analysis and findings for the reasons outlined below and respectfully encourages the Department of Public Health (Department) to give greater weight to the independent review and concerns raised by Attorney General Maura Healey (AG) in her testimony to the Health Policy Commission (HPC) on November 17 (enclosed) and the analysis completed by the Health Policy Commission. As two of the Commonwealth’s regulatory bodies charged by law with monitoring health care trends in the market, the findings generated by the AG and HPC must carry more weight than an analysis paid for by the Applicant.

The standards set forth in “105 CMR: 100.00 Determination of Need” are clear that the Application and ICA taken together must “clearly and convincingly” demonstrate that the Proposed Project *meaningfully* contributes to the state’s cost containment goals. As outlined below, the ICA fails to meet this threshold not only in what is omitted from its analysis, but also for shirking its responsibility to investigate and fully vet MGB’s assumptions. To predominantly rely on those assumptions weakens, if not discredits, every conclusion posed by CRA as an independent party to the analysis.

**Failure to Analyze Secondary & Tertiary Referrals**

One of the most glaring omissions in CRA’s report is its failure to analyze the proposed project’s impact on secondary and tertiary referrals. According to MGB’s internal planning documents, “the ambulatory expansion will ultimately increase MGB’s share of the market for inpatient hospital services and covered lives. MGB



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projected it would gain an additional 1-2% of all secondary inpatient admissions in Eastern Massachusetts and an additional 3- 4% of all tertiary inpatient admissions in Eastern Massachusetts. MGB projected it would gain an additional 1-2% of all covered lives in Eastern Massachusetts.”

Additionally, starting as far back as 2014 through present day, MGB has made numerous presentations to JP Morgan regarding its plans to increase network lives in Eastern Massachusetts through the expansion of strategic ambulatory care settings (enclosed). In fact, in a 2020 PowerPoint presentation MGB states that one of the goals of its ambulatory expansion is to “*increase network lives and secondary and tertiary commercial volume.*” The fact that MGB has explicitly stated this as its goal surely warrants an analysis to determine the impact of the highest-cost, market-dominant provider in the Commonwealth further increasing its market share.

### **Failure to Analyze and Validate Projected Volume Assumptions**

As cited in the AG’s report, MGB’s internal planning documents project significantly higher volumes than what MGB filed in its DoN Application. At a minimum, the Applicant must explain why its internal volume assumptions project 85% OR capacity utilization and yet the DoN Application assumes only 70% OR utilization. Without an analysis of this discrepancy, one could assume that MGB lowered its volume assumptions to intentionally obscure the true cost implications of the proposed project on the Commonwealth and the consumer. Furthermore, one could assume that the 15% gap between the two projections more accurately reflects the volume MGB predicts it will divert from existing lower-cost community providers. In filing the DoN application, the Applicant attests to the validity of the information submitted. The question must be asked which number is accurate: the number submitted to the Department, or the number submitted to the AG.

CRA presumes, post ramp up, that the new facilities will perform the *exact* number of surgeries, and CT and MR scans specified by MGB in its DoN Application. However, the CRA narrative states volume will come from Plymouth, Bristol and all of Essex and Suffolk Counties. This is inconsistent with the Applicant’s statement. In the Application (Attachment 2 Primary Service Area), MGB states volume will come from specific cities and towns. Those cities and towns are in Norfolk, Middlesex, and Worcester Counties, and also include two towns in Essex and two sections of the City of Boston: West Roxbury and Hyde Park. The Applicant does not reference any volume from Plymouth or Bristol County and, in the case of Essex County, only Lynnfield and Andover are cited. In Suffolk County, the Applicant only references a section of Milton (02136), Hyde Park and West Roxbury. Yet, CRA’s analysis assumes that the new facilities will meet MGB’s volume projections to the number.<sup>1</sup>

The analysis also states that CRA’s demand model for “...the predicted number of CT and MR scans performed at the facility match the volumes projected by MGB in its DoN Application submissions,”<sup>2</sup> which should be called into question given the discrepancies between the sources of volume in the ICA and Application. Another example of CRA neglecting to analyze the validity of MGB’s volume projections is demonstrated in footnote 90,<sup>3</sup> where CRA acknowledges that “to match MGB’s projected volume, we mathematically ‘expand’ or ‘shrink’ the Proposed Clinic until the volumes predicted by our model match MGB’s projections.” To

<sup>1</sup> Pg. 32 para 78

<sup>2</sup> Pg. 32 para 79

<sup>3</sup> Pg. 34



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accomplish this end, did CRA expand the volume footprint by including cities and towns outside of the scope put forth by the Applicant?

It's quite clear that CRA is adapting its economic forecast to favorably confirm MGB's suppositions. CRA has not produced an objective and accurate forecast. To conclude the predicted changes in MGB's market shares in the service areas are "modest" is myopic, misleading and, to the providers in those communities, will strike at the economic foundation of a very fragile health care eco-system.

Furthermore, in estimating the demand for outpatient diagnostic imaging services, the ICA includes patient claims for PET/CT services. PET/CT is not a service MGB explicitly proposes in the Ambulatory Expansion Application. PET/CT services are separate and distinct from out-patient MRI and CT services; therefore, all PET/CT claims must be excluded or the analysis dismissed for inaccuracy.<sup>4</sup> Additionally, the ICA mistakes the projected Woburn MRI scan volume in the Application as 5,722,<sup>5</sup> when it is in fact 5,944; however, the mathematical model the ICA used to 'shrink' or 'expand' achieved a projected 5,722 scans and did not achieve 5,944 as stated in the Application. It is also worth noting that the map of site services<sup>6</sup> is misleading, as it appears to show PET/CT sites of service, as well as a Shields location in Quincy that does not provide imaging services.

### **Failure to Analyze Backfill**

The Applicant notes throughout its filing that it intends to shift appropriate surgical procedures from inpatient settings to the proposed outpatient centers. The ICA, however, does not analyze how capacity at the hospital sites will be backfilled. Given that the Applicant has filed additional DoN Applications to increase capacity at its Boston hospital locations, the Commonwealth should analyze how the decanting of volume at its inpatient settings will impact the request for additional capacity at those same hospitals, as well as impact capacity at MGB's community hospitals, such as Newton Wellesley, and MGB's out-patient sites, including Waltham, Foxboro and Somerville, among others.

In a similar vein, it is noteworthy that the ICA does not reference out-patient imaging capacity for the recently approved three MRI units at MGB's \$14.9 million capital project in Somerville.<sup>7</sup> The Applicant is also silent on this \$14.9 million project in its responses to DoN question #2A.<sup>8</sup>

Without analyzing the volume intended to backfill MGB's existing academic medical centers, community hospitals and out-patient sites of service, the true cost to the system or savings to MGB cannot be realized. The cost of MGB backfilling inpatient capacity with more-acute, higher cost care will tremendously outweigh any cost savings that may result from shifting volume to outpatient locations.

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<sup>4</sup> Pg. 29-30 para 73

<sup>5</sup> Pg. 35 para 80

<sup>6</sup> See Figure ICC2

<sup>7</sup> See DoN #PHS 19093011-HS (February 2020), filed by Partners HealthCare.

<sup>8</sup> Available at <https://www.mass.gov/doc/mass-general-brigham-incorporated-multisite-responses-to-don-questions-1/download>, pg.



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### **Existing Outpatient Surgical Capacity**

In its question and response document posted on the Department’s website, the Applicant states that there is existing outpatient surgical capacity within its satellite locations in Foxborough, Danvers, Waltham and Wellesley. Specifically, on page 11 the Applicant states that “there is still OR capacity” within the system’s current ASC/HOPD sites. The explanation given for the existing capacity is the Applicant’s inability to efficiently manage block scheduling, a self-imposed limitation of surgical specialties and the failure to utilize dedicated surgeons.

Respectfully, this response demonstrates that the Applicant is not an efficient operator of outpatient surgical services. At a minimum, the Applicant should consider expanding its offering of surgical specialties, more effectively managing block scheduling and utilizing dedicated surgeons thereby permitting more efficient OR scheduling and utilization.

### **HOPD vs Freestanding Surgical Rates**

On page 11, of the Applicant’s response to the Department’s questions, the Applicant states that they do not offer any freestanding ambulatory surgical services. However, based on the Applicant’s earlier response they appear to operate several underutilized HOPD satellite facilities in Foxborough, Danvers, Waltham and Wellesley. The Applicant claims that the need for its DoN Application is to offer lower-cost freestanding (non-hospital based) services to its patients.

If the Applicant is, as it states, committed to lowering the cost of care for its patients, it should consider changing the reimbursement status of their existing HOPD satellite facilities to freestanding rates. As the Applicant knows, the same procedure performed in an HOPD setting can cost Medicare upwards of 48% of the cost of the same procedure performed at a freestanding surgical center. Additionally, patients undergoing surgical procedures in these settings would be spared the cost of an added facility fee.

### **Failure to Analyze Impact of Workforce Shortages**

The COVID-19 pandemic has exacerbated clinical workforce shortages, the impact of which is being felt on both a state and national level. This situation is likely to extend well into the future as burnout among health care workers continues to increase. This presents significant operational challenges for hospitals and health care systems. The introduction of these centers will undoubtedly have an impact on local health systems already struggling to recruit and retain clinical staff. Additionally, MGB has leverage as the largest and most expensive hospital provider to pay salaries that far exceed the salaries paid by lower-cost community hospitals. As suggested by the AG, the migration of clinical staff, like primary care doctors and specialists, from lower-cost providers to MGB is something that must be evaluated.

It is also noteworthy that CRA’s tacit conclusion that COVID-19 has had no impact on workforce shortages directly contradicts MGB President & CEO Anne Koblanski’s own public statements regarding workforce challenges in her testimony at the HPC 2021 Cost Trends Hearing. Furthermore, the datasets outlined within the ICA include “professionals who have retired, but have not deactivated their NPI,” thus continuing to overestimate available personnel in the market. Given the significant increase in early retirements and professionals leaving the workforce, it is likely many of the NPIs CRA designated as “active” are, in reality, inactive.



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### **Failure to Analyze Shifting Volume Away from Community Providers and its Impact on Underserved Communities**

CRA's ICA does not include any meaningful comparative analysis of the cost to the Commonwealth of shifting volume away from lower-cost providers. As the Department well knows, low-cost community and safety-net providers are reliant on limited commercial margins to fund the cost of care for low-income patients and communities with high barriers to care, many of which are communities of color. Even a narrow shift in commercial patients away from lower-cost community hospitals threatens their financial viability, directly jeopardizes the Commonwealth's ability to meet its cost containment goals and further disenfranchises underserved communities.

It is incumbent upon the Department to have a robust understanding of the implications this transaction will have on underserved communities. The ICA lacks insight into the impact of the expansion project on underserved communities due to the notable absence of race and ethnicity information in the APCD.<sup>9</sup> At a time when the COVID-19 pandemic has highlighted and further exacerbated health inequities and disparate health outcomes in communities of color, we urge the Department to consider a quote included in AG Healey's Report, *Building Toward Racial Justice and Equity in Health: A Call to Action*, "the data on racial and ethnic health care disparities in Massachusetts paint a bleak picture. In general, residents of color are less healthy and die younger than white residents." It should therefore not be taken lightly how MGB's siphoning of commercially insured patients from community health providers that offer essential safety net services will be impacted by these projects and how, as a result, health equity and access will be negatively impacted.

Furthermore, the ICA's answer to the Department's question as to what the effects of the proposed project will be on 'competition, utilization and capacity of other health care providers in Massachusetts' again, is woefully inadequate. There is no greater or more gaping hole in the analysis than the omission of the August 30, 2021, Approval of the Emergency DON #20121611 of a \$325.7 million investment to resurrect Norwood Hospital with 4 new out-patient operating rooms (an increase of 1 OR), 5 in-patient operating rooms, a new MRI unit and 2 new CT units. This investment follows a catastrophic event forcing the hospital to transfer all in-patients to other facilities and abandon services. 800 Washington Street, Norwood, is 6.7 miles from the proposed Westwood site and 8.1 miles from the Brigham's Foxborough site with MRI and CT services. Any expansion of the MGB Westwood site must take into account the impact on the approved and newly developed \$325.7 million Norwood site. Should MGB Westwood divert physicians and/or patients who would otherwise provide or seek services at Norwood, it will leave a \$325,700,000 investment in a newly constructed hospital sitting below anticipated capacity, or, at worst, idle, at a great cost to the Commonwealth. Who will ultimately bear this cost? As the ICA indirectly answers: it will be employees, employers, consumers, and the taxpayers of the Commonwealth.

### **Marketing Campaign**

MGB has undertaken an unprecedented multimillion dollar advertising campaign for its pending DoN Application. The Applicant has spent precious dollars that could otherwise be directed toward patient care on primetime television, print and digital advertising that promotes the centers as if it is a foregone conclusion that they will be approved. Meanwhile, regulators are evaluating the impact the Application will have on the Commonwealth's ability to meet its cost containment goals and the Applicant's ability to meet all the DoN factors of approval. Not only is this advertising campaign an attempt to influence, it also is clearly designed to attract new patients to these centers. MGB's blatant attempt to cherry pick patients from existing, lower-cost

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<sup>9</sup> Pg. 25 para 61





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providers conflicts with MGB's claim that each facility is intended to serve only current patients – a faulty premise that functions as a primary cornerstone of the ICA's scope of evaluation and the conclusions it draws.

### **Failure to Weigh Market Dominance in Bargaining Leverage**

The assertion CRA makes that MGB is "...unlikely to meaningfully change the system's bargaining leverage with health insurers" is specious and unsubstantiated. It is well-documented that hospitals' market power in contract negotiations with payers is significant.<sup>10</sup> CRA notes negotiations are formed on the basis of "value" to the health insurer and provider. However, value stems from a myriad of elements and is not confined to frequently mentioned capacity constraints; rather, these elements include range of services, reputation and clinical quality, convenient locations, and other desirable amenities.<sup>11</sup>

The Proposed Project is a massive market expansion plan to build three ambulatory care centers with ambulatory surgery, physician services, and high-tech imaging at new sites in Westborough and Woburn and a significant expansion of MGB's existing physician site in Westwood. MGB also released plans to renovate and expand Massachusetts General Hospital and Brigham and Women's Faulkner Hospital. Given its market dominance, MGB's ability to negotiate reimbursement rates that are beneficial to the system is unprecedented, which will likely result in higher rates than are projected by the ICA and to the detriment of consumers and the Commonwealth.

Additionally, CRA improperly cites a 2009 study from the American Economic Review that asserts [that] "...relaxing providers' capacity constraints through entry or expansion decreases their negotiating leverage with health insurers and may result in lower prices for health care services." The author of this study makes her arguments in the context of capacity-constrained hospitals. The ICA must analyze MGB's Proposed Project based on what the system will be and not what is currently is. If approved, MGB will not be a capacity-constrained hospital; therefore, the entry/expansion phenomenon asserted in this study would not apply in the evaluation of MGB's future renegotiation of its contract portfolio.

### **Failure to Validate Applicant's Assumptions**

As mentioned above, CRA's ICA relies almost exclusively on the price, volume, and market assumptions that MGB makes in its application – neglecting to investigate the validity of those assumptions. Consequently, the Department's only recourse is to reject CRA's "analysis," which was clearly predicated on formulating conclusions drawn from MGB's data.

### **Cost Savings Estimates**

CRA's ICA concludes that MGB's Application will result in cost savings if existing MGB patients move their care from MGB's inpatient facilities to their outpatient facilities, given that MGB's inpatient settings are the most expensive in the state. It is noteworthy, however, that there are no freestanding outpatient settings in the MGB system to validate these cost savings, with the ICA also acknowledging that MGB has not yet negotiated rates. Furthermore, the ICA does not evaluate the long-term implications of patients migrating from lower-cost community settings to MGB and that impact on statewide total medical expense.

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<sup>10</sup> Devers KJ, Casalino LP, Rudell LS, Stoddard JJ, Brewster LR, Lake TK. Hospitals' negotiating leverage with health plans: how and why has it changed?. Health Serv Res. 2003;38(1 Pt 2):419-446. doi:10.1111/1475-6773.00123. Online at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360893/>

<sup>11</sup> Pg. 38, para 86



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The Department should also take note that professional components are excluded entirely from the analyses.<sup>12</sup> That is, the expense to the Commonwealth and consumers for physician fees generated by non-employed MGB physicians and specialists are not calculated in the ICA analysis. This is a grave omission. The ICA fails to address the Department’s request to answer the question (*para-phrased*) ‘who bears the cost of these services and who benefits.’

The economists of the ICA predict a decrease in health care expenditures with the Proposed Ambulatory Care Centers of 0.1% (Westborough), 0.2% (Westwood) and 0.1% (Woburn)<sup>13</sup> and ‘believe ....the project is consistent with the Commonwealth’s health-care cost-containment goals’; however, the AG report released on November 17, 2021,<sup>14</sup> asserts health care costs will likely rise if the project draws patients from lower cost providers. As asked by the Department, who will bear this cost? Paragraph 168 of the ICA begins to answer this question, stating “primarily the employee of employer-sponsored health plans on a one-for-one rate.”<sup>15</sup> Given the limited scope of the ICA, the validity of its estimated cost savings must be called into question.

Furthermore, CRA explicitly states the ICA analysis excludes the top and bottom 5% of claims from the analysis as “potential outliers.”<sup>16</sup> MGB has been referenced by independent subject matter experts as one, if not the most, significant outlier in the top cohort of highest cost providers. To be credible, the ICA must include the rates and charges of the Applicant, even if they are considered “outliers.”

### **Failure to Analyze Full Breadth of Services MGB plans to offer at the ASCs**

CRA neglects to assess the full breadth of services that will be included in the Proposed Project.<sup>17</sup> CRA’s limited assessment of only the Proposed Sites’ effect on the delivery of “advanced” imaging services does not provide a complete scope of potential impacts. Additionally, CRA accepts MGB’s representation that the outpatient services offered at the integrated care clinics does not represent the surgical services that MGB [in fact] *plans* to provide at the Proposed Sites – the services included in the ICA simply represent the surgical services that *could* be performed at the Proposed Sites.<sup>18</sup> In this case, MGB would appear to violate the demonstration standard defined in 105 CMR 100.210 (A) of the DoN regulations – that being the requirement to demonstrate with “clear and convincing” evidence that the Applicant’s submission meets the DoN need factors.

### **Irrelevant Inclusion of Appropriateness of Certificate of Need Programs**

Respectfully, the Department should take note of CRA’s irrelevant inclusion of commentary challenging the appropriateness of Certificate of Need Programs. CRA’s editorial comments are out-of-scope and an attempt to deflect from a flawed report.

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<sup>12</sup> Pg. 19, footnote 59

<sup>13</sup> Pg. 2

<sup>14</sup> Available at <https://www.mass.gov/doc/ago-examination-into-cost-drivers/download>.

<sup>15</sup> Pg. 79-80

<sup>16</sup> Pg. 21, footnote 62

<sup>17</sup> Pg. 6 para. 16

<sup>18</sup> Pg. 20 para 47 & footnote 60



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For all the reasons above, we respectfully request the Department to reject CRA’s ICA. The standards set forth in 105 CMR: 100.00 Determination of Need are clear that the Application and ICA taken together must “clearly and convincingly” demonstrate that the Proposed Project *meaningfully* contributes to the state’s cost containment goals. By failing to examine all cost drivers, especially those highlighted by the AG, and in failing to validate the assumptions included within MGB’s application, CRA’s ICA should be deemed irrelevant. We urge the Department to carefully consider the testimony and analysis of state regulators including the AG and HPC, who by law are charged with monitoring health care trends, and to dismiss this inadequate and biased analysis commissioned by the Applicant and completed by CRA.

Thank you in advance for your time and consideration.

Sincerely,

Carmel Shields, Executive Vice President  
Shields Health Care Group

CC: Chairwoman Cynthia Friedman, Joint Committee on Health Care Finance  
Chairman John Lawn, Joint Committee on Health Care Finance  
Attorney General Maura Healey  
Executive Director David Seltz, Health Policy Commission



**Examination of Health Care Cost Trends and Cost Drivers  
Pursuant to G.L. c. 12C, § 17**

**Report for Annual Public Hearing Under G.L. c. 6D, § 8**

Office of the Attorney General  
Commonwealth of Massachusetts

November 17, 2021

The ambulatory care expansion of high-cost hospital systems is poised to transform the Massachusetts health care market. Whether this transformation harms consumers by driving up statewide costs and health insurance premiums or helps consumers by providing more convenient access to care in the suburbs (or both), these proposed projects are significant market changes and merit complete, transparent, and data-driven analysis. Unlike mergers or acquisitions, proposed system expansions do not trigger notification to antitrust regulators, nor the option of a full Cost and Market Impact Review at the Health Policy Commission (HPC). In its 2021 Cost Trends Report, the HPC recently highlighted the need for enhanced scrutiny and monitoring of provider expansions and ambulatory care. Assumptions and conclusions by the proponents of these projects must be thoroughly tested against the state's health care cost containment goals. Whether a proposed expansion project ultimately raises or lowers costs depends in large part on whether it shifts commercial market share to or away from higher-priced options.<sup>1</sup> Low-cost community hospitals rely on narrow commercial margins to stay in business, and a shift of commercial patients away from them threatens their continued viability as affordable and high-quality options in the market.

The Attorney General's Office (AGO) has a special role in promoting access to affordable health care in Massachusetts. The AGO is charged by law with monitoring trends in the health care market, especially in the size of provider organizations<sup>2</sup>, and is authorized to obtain information through civil investigative demands related to health care cost trends and cost drivers from market participants.<sup>3</sup>

Mass General Brigham (MGB) is one of the most preeminent health care institutions in the world, and Massachusetts residents benefit immensely from the high quality and cutting-edge research, training, and care it provides here in the Commonwealth. It is also the biggest and highest

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<sup>1</sup> The Attorney General's Office has issued previous reports citing commercial market share shifting toward high-priced providers as a key driver of overall health care costs. See OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 3-5, (Oct. 17, 2019); OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS at 23-24, (Sept. 18, 2015).

<sup>2</sup> Mass. Gen. Laws ch. 12, § 11N ("The attorney general *shall monitor* trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market.") (emphasis added).

<sup>3</sup> Mass. Gen. Laws ch. 12C, § 17 ("The attorney general may require that any provider, provider organization, or payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends, factors that contribute to cost growth within the commonwealth's health care system and the relationship between provider costs and payer premium rates.").

priced health care system in Massachusetts. In early 2021,<sup>4</sup> MGB released plans to build three ambulatory care centers with ambulatory surgery, physician services, and high-tech imaging in Massachusetts: new sites in Westborough and Woburn and a significant expansion of MGB's existing physician site in Westwood.<sup>5</sup> At the same time, MGB also released plans to renovate and expand Massachusetts General Hospital and Brigham and Women's Faulkner Hospital. Consistent with its statutory responsibility to monitor and investigate health care cost trends and drivers, the AGO initiated an independent examination of the cost impacts of MGB's ambulatory care expansion proposal, including a review of documents MGB has produced in response to our civil investigative demand. The AGO thanks MGB for its cooperation with this examination.

The HPC and the Department of Public Health (DPH) are undertaking reviews of these proposals. Market participants, community organizations, members of the public and other stakeholders have an opportunity to comment on the proposals, informed by materials MGB has released through its Determination of Need (DoN) application. Based on our understanding of the parameters of the HPC and DPH analyses, and after review of documents MGB produced as part of our examination, the AGO determined that disclosure of certain information from our examination is necessary to ensure that the HPC and DPH analyses proceed with the appropriate analytical scope and frame.

After balancing the public interest in this disclosure with the privacy, trade secret, and anti-competitive interests, and determining that the disclosure will promote the health care cost containment goals of the Commonwealth, the AGO concludes that the following limited disclosure from MGB's documents is warranted.<sup>6</sup>

1. The three ambulatory sites MGB proposes in Westborough, Woburn, and Westwood are part of a larger multi-year ambulatory expansion plan across Eastern Massachusetts. In its 2018 planning process, MGB projected that this expansion plan would ultimately contribute direct margins to the MGB system of approximately \$385 million per year, including new ambulatory volume as well as net revenue from incremental hospital volume resulting from new ambulatory sites. New hospital margin from patient referrals from the ambulatory sites to MGB hospitals was projected to outweigh losses resulting from the shift of visits from MGB hospitals to the ambulatory sites.<sup>7, 8</sup>

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<sup>4</sup> MGB initially announced these proposals in December 2019 but delayed its expansion plan due to the COVID-19 pandemic. See Priyanka Dayal McCluskey, *Partners plans \$400M expansion in Boston suburbs*, BOSTON GLOBE (Dec. 19, 2019).

<sup>5</sup> The AGO has not examined MGB's proposed ambulatory care expansion in Salem, New Hampshire.

<sup>6</sup> Mass. Gen. Laws ch. 12C, § 17 (disclosure permitted "in a public hearing under section 8 of chapter 6D, a rate hearing before the division of insurance or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that the disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations").

<sup>7</sup> MGB internal analysis (June 2018).

<sup>8</sup> MGB produced a 79-page report to the AGO dated November 10, 2021 projecting that the three pending DoN proposals (the three ambulatory sites, the Massachusetts General Hospital project, and the Brigham and Women's Faulkner Hospital project) would decrease annual total medical expenditures for Massachusetts residents. The AGO has not vetted the models, data, or assumptions underlying this report, but notes that the report does not account for any increase in medical expenditures generated by MGB backfilling its hospitals as MGB hospital patients move to the new

2. In its 2018 planning process, MGB projected that the multi-year MGB ambulatory expansion plan would ultimately increase MGB's share of the market for inpatient hospital services and covered lives. MGB projected it would gain an additional 1-2% of all secondary inpatient admissions in Eastern Massachusetts and an additional 3-4% of all tertiary inpatient admissions in Eastern Massachusetts.<sup>9</sup> MGB projected it would gain an additional 1-2% of all covered lives in Eastern Massachusetts.<sup>10, 11</sup>
3. Volume projections are a key element to any assessment of cost impacts. The volume of ambulatory surgery procedures performed at a health care facility depends on the utilization plan for its operating rooms (ORs). MGB's projections from 2018 relied on the assumption that the ORs created in its ambulatory care expansion would have a throughput of 1200-1600 cases per year, depending on acuity, and approximately 2000 cases per OR per year for otolaryngology and ophthalmology procedures. MGB projected that OR capacity utilization would be 85%.<sup>12</sup> In MGB's 2021 DoN application for its Westborough, Woburn, and Westwood sites, it relied on significantly lower OR productivity assumptions: 1000 cases per year and 70% capacity utilization.<sup>13</sup> The cost implications of this differential and analysis of any reasons for the decline in volume projections should be part of the cost containment analysis of these proposals.
4. Staffing plans are critical to a complete analysis of the likely cost and market impacts of a new health care facility. Primary care staffing is especially important given the current environment of workforce shortages and the fact that primary care providers often bring their patient panels with them if they move to a new system. Based on MGB projections dated 2018, MGB planned to staff the three currently proposed sites at Westborough, Westwood, and Woburn by adding 22 new primary care physicians to the MGB system in total across the three sites. MGB planned to staff the specialty physician practices at the three proposed sites as follows:<sup>14</sup>

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ambulatory sites. To the extent patients receiving care in the newly available MGB hospital capacity would have otherwise received care at lower-priced competitors, total health care expenditures would increase.

<sup>9</sup> MGB internal analysis (June 2018).

<sup>10</sup> MGB internal analysis (June 2018).

<sup>11</sup> MGB's documents do not quantify projected changes in market share for outpatient hospital services or freestanding ambulatory services.

<sup>12</sup> MGB internal analysis (June 2018).

<sup>13</sup> MGB Determination of Need Application 21012113-AS (2021), p. 9-10 ("Assuming that each OR at a Project Site has a capacity of 1,000 procedures per year, the Applicant projects that each Project Site will need a minimum of four (4) ORs to accommodate this projected volume of Ambulatory Surgery Services."); n. 20 ("The 1,000 procedures per OR per year amount is based on the assumptions that (i) the ambulatory surgery centers at the Project Sites will operate 9 hours per day, 5 days per week for 48 weeks annually; (ii) each surgical procedure will take an average of 95 minutes to complete (including both surgical case time and OR turnover time); and (iii) the ambulatory surgery centers will operate at 70% efficiency (i.e., an average 70% of the available procedure times will be utilized).")

<sup>14</sup> MGB internal analysis (June 2018). The primary care physician staffing projections are net-new to the MGB system, while the specialist staffing projections reflect the total number of specialists (including specialists new to the MGB system as well as specialists relocated from other MGB practices).

<b>Total Number of Specialists at Westborough, Westwood, and Woburn Sites (Projected)</b>	
General Surgery	5
Orthopedics	10
Cardiovascular	5
GI	2
Neurosciences	7
OB/GYN	8
Hematology/Oncology	2
ENT	17
Ophthalmology	8
Pediatrics	4

This information is relevant to the analysis of MGB’s proposed ambulatory care center expansion, including how its plan could impact the Commonwealth’s cost containment goals. The public discussion has focused on the anticipated flow of patients from MGB’s hospitals to MGB’s proposed ambulatory sites (which MGB has stated will have rates approximately 25% lower than MGB’s community hospitals).<sup>15</sup> Our examination and the projections described above speak to the importance of a broad analysis of the cost impacts of these proposals, including the likely shifts in hospital commercial volume and migration of primary care physicians and specialists from lower-cost systems to MGB.

Based on our review, we recommend that HPC and DPH consider this information as part of robust and transparent analyses of MGB’s proposed expansion, including the extent to which these projects contribute to or threaten the state’s goals for cost containment, and their impact on the state’s goals of health care access for all and health equity.

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<sup>15</sup> See John Fernandez, *Better access to health care lowers costs*, BOSTON GLOBE (Oct. 25, 2021) (“The ambulatory care sites we at Mass General Brigham are proposing to build will offer quality care closer to our patient’s homes for approximately 25 percent lower cost than current Mass General Brigham community hospital rates.”)

# Mass General Brigham

Anne Klibanski, M.D.  
President & Chief Executive Officer

Peter Markell  
EVP Administration & Finance, CFO & Treasurer

J.P. Morgan Healthcare Conference  
January 13, 2020

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The presentation you are about to view is provided as of January 13, 2020. If you are viewing this presentation after that date, there may have been events that occurred subsequent to such date that would have a material adverse effect on the information that was presented.

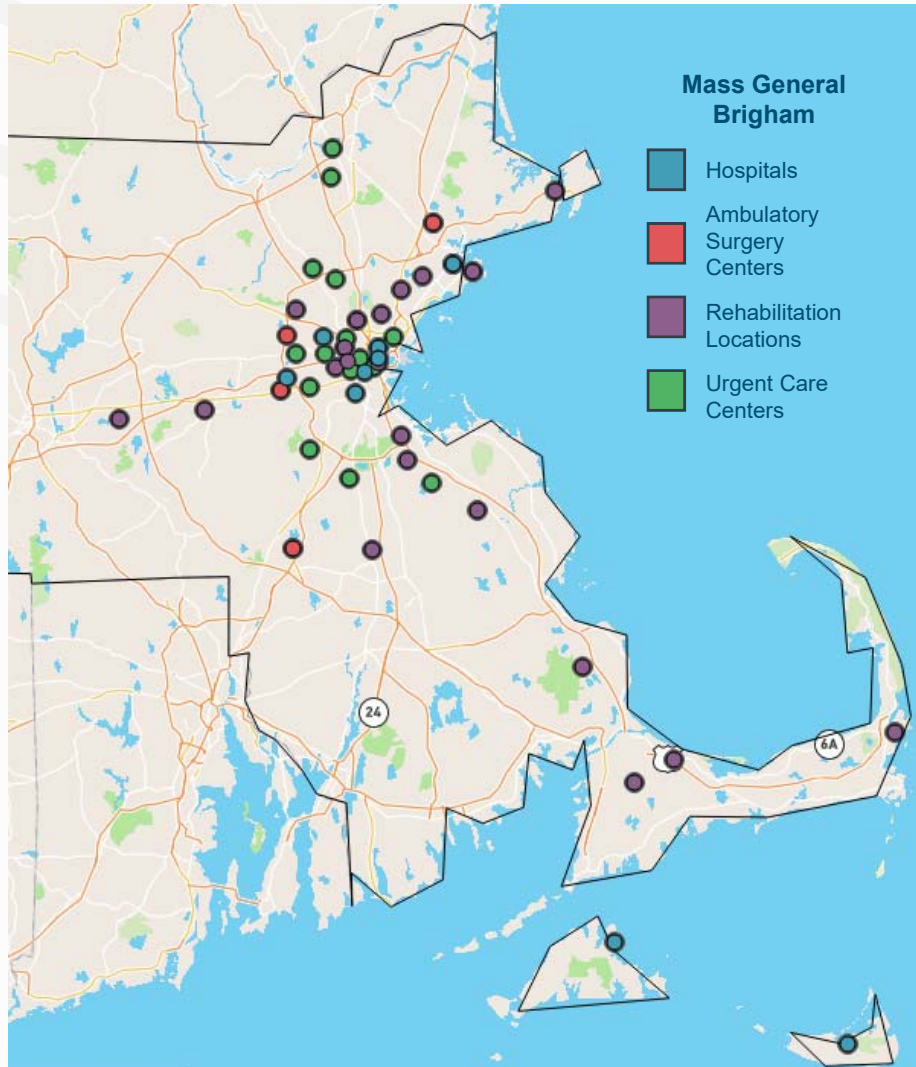
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# Mass General Brigham Locations are Concentrated in Eastern MA



**12**

Mass General Brigham Acute and Specialty Hospitals

**28**

Spaulding Rehabilitation Locations

**4**

Ambulatory Surgery Centers

**21**

Urgent Care Centers



**Mass General Brigham**  
US News AMC and Specialty Hospital Rankings

**#2** in Best Hospital



**#13** in Best Hospital



**#2** in Psychiatry



**#3** in Rehabilitation



**#2** in Ear, Nose & Throat  
**#4** in Ophthalmology



# External Environment *Massachusetts*

- Health care continues to be an area of focus for Massachusetts
- Fall 2019 cost trend hearings led by the Health Policy Commission focused on provider market trends and cost drivers
- Favorable performance relative to MA cost growth benchmark (3.6% in 2016 & 2017)
- Governor Baker's proposed legislation calls for expanding telemedicine, behavioral health and primary care as well as provisions to address surprise billing

# Unified System Goals

Rebranding as Mass General Brigham to better demonstrate what we offer patients and build upon our national and international impact

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- Substantially broaden the number of patients we reach and improve patient outcomes through existing and new delivery methods (e.g., digital health, ambulatory, multi-specialty centers of excellence)
- Expand our impact by getting more breakthrough ideas and innovations out into the world
- Improve patient access and patient experience
- Reduce the total cost of care, while improving outcomes
- Optimize the use of, and innovate across, the full continuum of care we provide
- Grow existing, and develop new, revenue streams

# Five Synergistic Strategic Priorities Focused On Broader Impact, Improved Outcomes, and New Revenue Streams



## Recognition as the “Go To Place”

Enhance regional and national recognition of MGH & BWH as “go to” destinations for key clinical services by developing cross-academic, multi-disciplinary, next-generation centers of excellence



## National & International Business Development

Develop new opportunities for national and international business development by expanding system-wide efforts to attract patients to MGH & BWH and providing remote diagnostics, remote care delivery and advisory services



## Innovation

Substantially increase innovations in diagnostics, therapies, devices, and data analytics brought to market by expanding commercialization investments and infrastructure



## Value-Based Model

Build and implement new value-based operating model for primary, secondary and behavioral health care that delivers “value for price,” improves patient access and outcomes and grows clinical volume and attributed lives



## Community Health Impact

Expand impact on leading community health issues by taking a multi-pronged approach to advance health equity and address social determinants of health in targeted communities

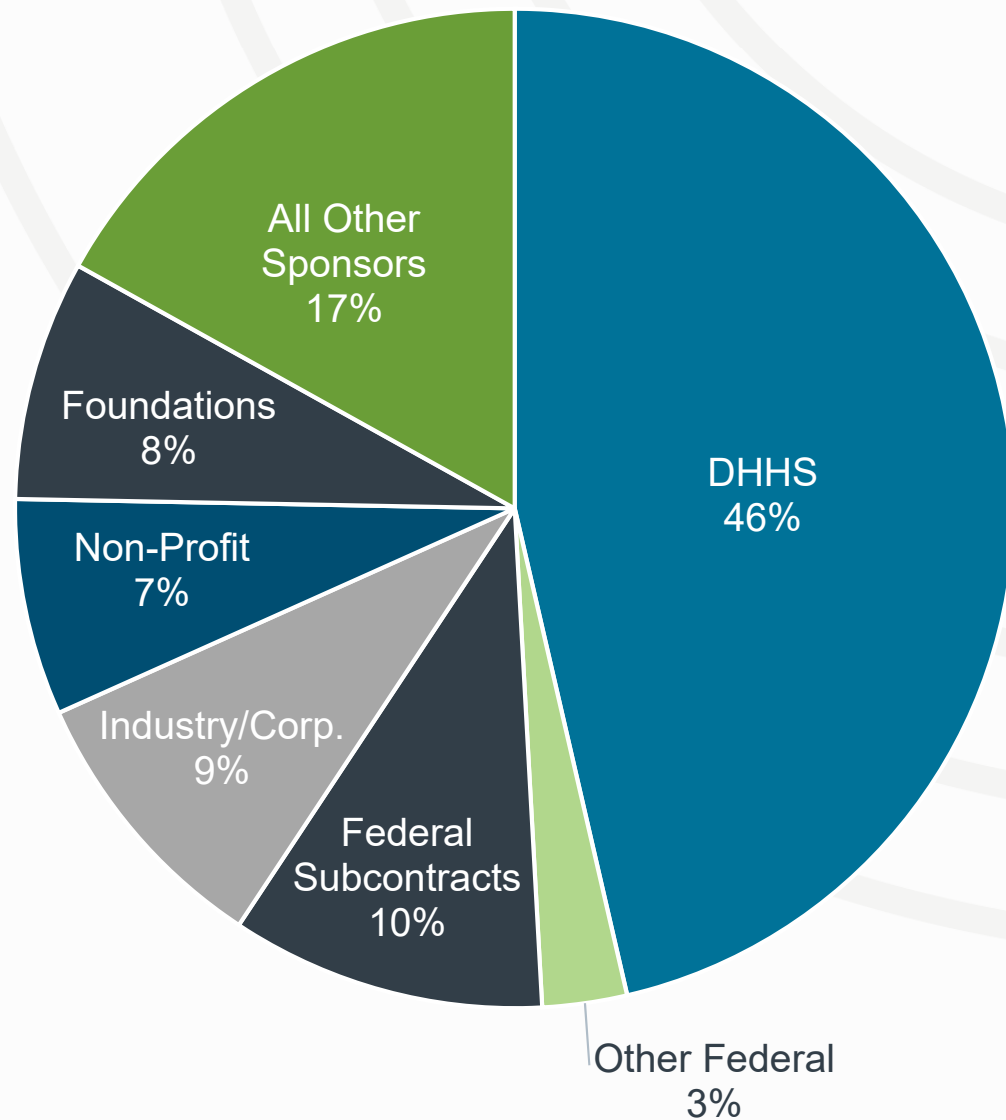
# Mass General Brigham Research Revenue Exceeds \$1.8 Billion

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**#1 recipient of research funding  
globally**

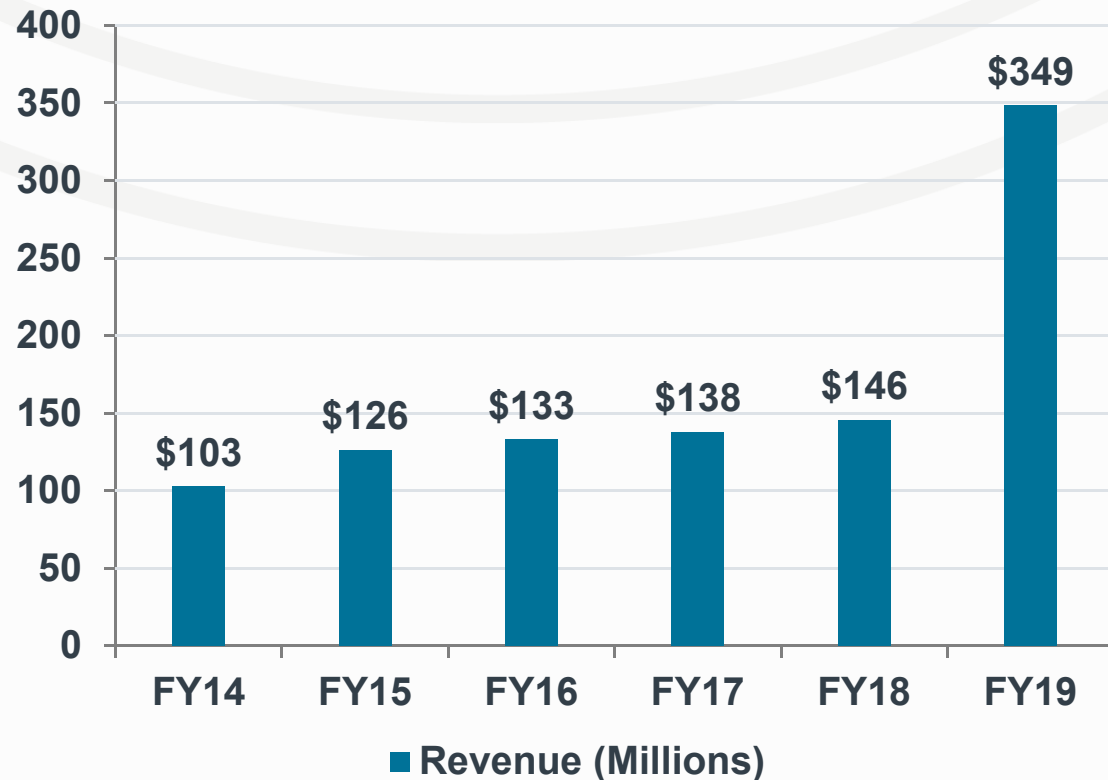
**Committed future research  
funding: \$3.8 billion**

**FY19 Research Revenue by Sponsor**



# Innovation: Commercializing Capabilities and Discoveries of Mass General Brigham Faculty

## Total Innovation Revenue



## INNOVATION FUND KEY STATISTICS

- \$171M Fund
- 38 Portfolio Companies
- 12 Exits
- \$62.5M returned
- Enterprise value >\$8.4B



## NEW INVESTMENT FUNDS LAUNCHED (OCTOBER 2019)

- \$50M Translational Innovation Fund
- \$30M AI and Digital Investment Fund



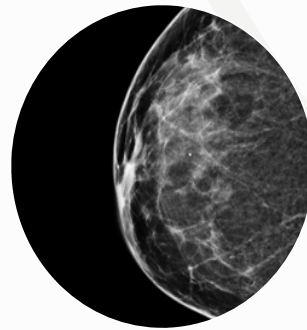
# Mass General Brigham Center for Clinical Data Science

Using Healthcare IT & AI to improve patient experience,  
accelerate digital innovation and transform clinical care

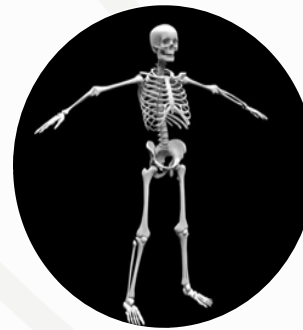
## Initial Clinical Impact



Emergency  
Care



Women's  
Health



Orthopedics



Cardio-  
Vascular  
Medicine

Emerging Areas: Oncology, Critical Care, Anesthesia, Obstetrics

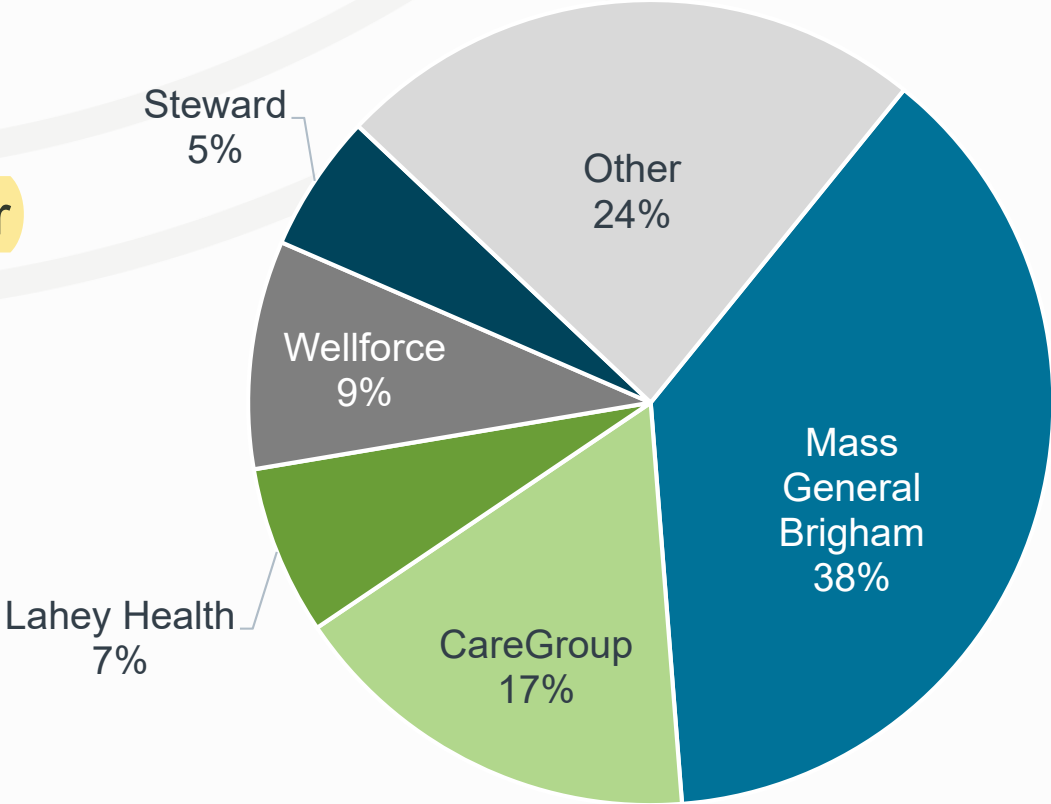
## Massachusetts Market: Competitive Landscape

- Since affiliating in March 2019, BI Lahey has been working to advance its visibility and standing in the marketplace
- Harvard Pilgrim and Tufts have announced their intention to merge, consolidating the #2 and #3 commercial payers in MA
- Care New England acquisition plans were terminated, but clinical collaboration continues with strong relationships at BWH, McLean and Spaulding
- Definitive agreement signed with Exeter (NH community hospital) in spring 2019; public education campaign launched in fall 2019 in response to regulatory headwinds

# Mass General Brigham Market Share

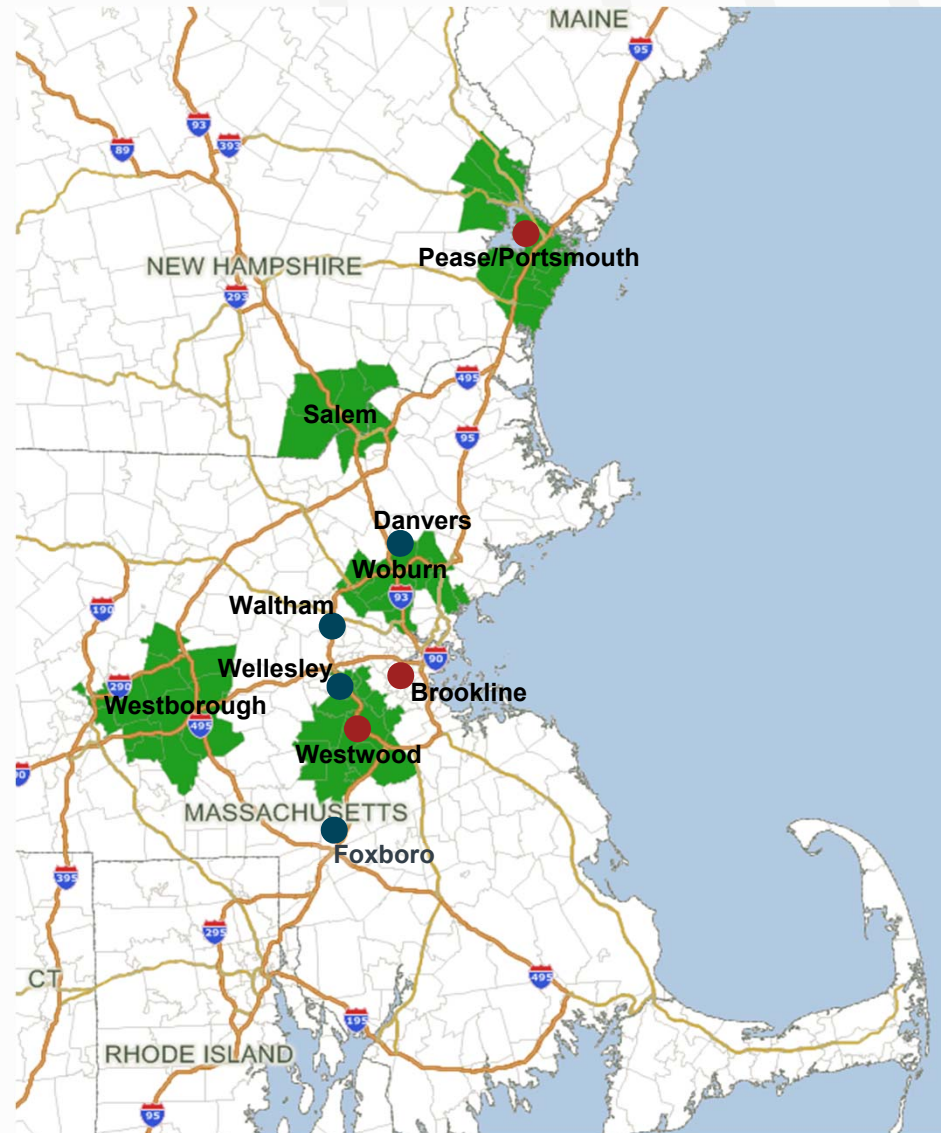
Eastern MA Tertiary Market Share: FY18

Tertiary discharges are forecast to grow at a faster pace than secondary discharges in E. MA



Sources: Sg2 Inpatient Forecast, FY17-27; Mass Center for Health Information and Analysis.

# Expansion of Outpatient Services in Regional Network



- Ambulatory Surgical Center w. imaging
- Medical Office Building w. imaging

■ Ambulatory sites under development or expansion

## GOALS

- Offer wide array of multi-specialty lower cost ambulatory services
- Enable better access for patients closer to where they live
- Enhance ambulatory experience with efficient patient flow and space design
- Increase network lives and secondary & tertiary commercial referral volume

## ACTIVITY

- Plans underway for 3 new sites and expansion of 2 sites

# Mass General Brigham Currently Manages ~650,000 (~12%) of E. MA Lives in Various Accountable Care Relationships

## COMMERCIAL

Alternative Quality Contract

**~350k**

Covered Lives

Younger population, specialists critical to management



## MEDICAID

MassHealth ACO

**~105k**

Covered Lives

Population with significant disability, mental health, and substance use challenges



## SELF INSURED

Employees

**~100k**

Covered Lives

Commercial population, but Mass General Brigham at full-risk for cost and quality



## MEDICARE

Next Generation

**~105k**

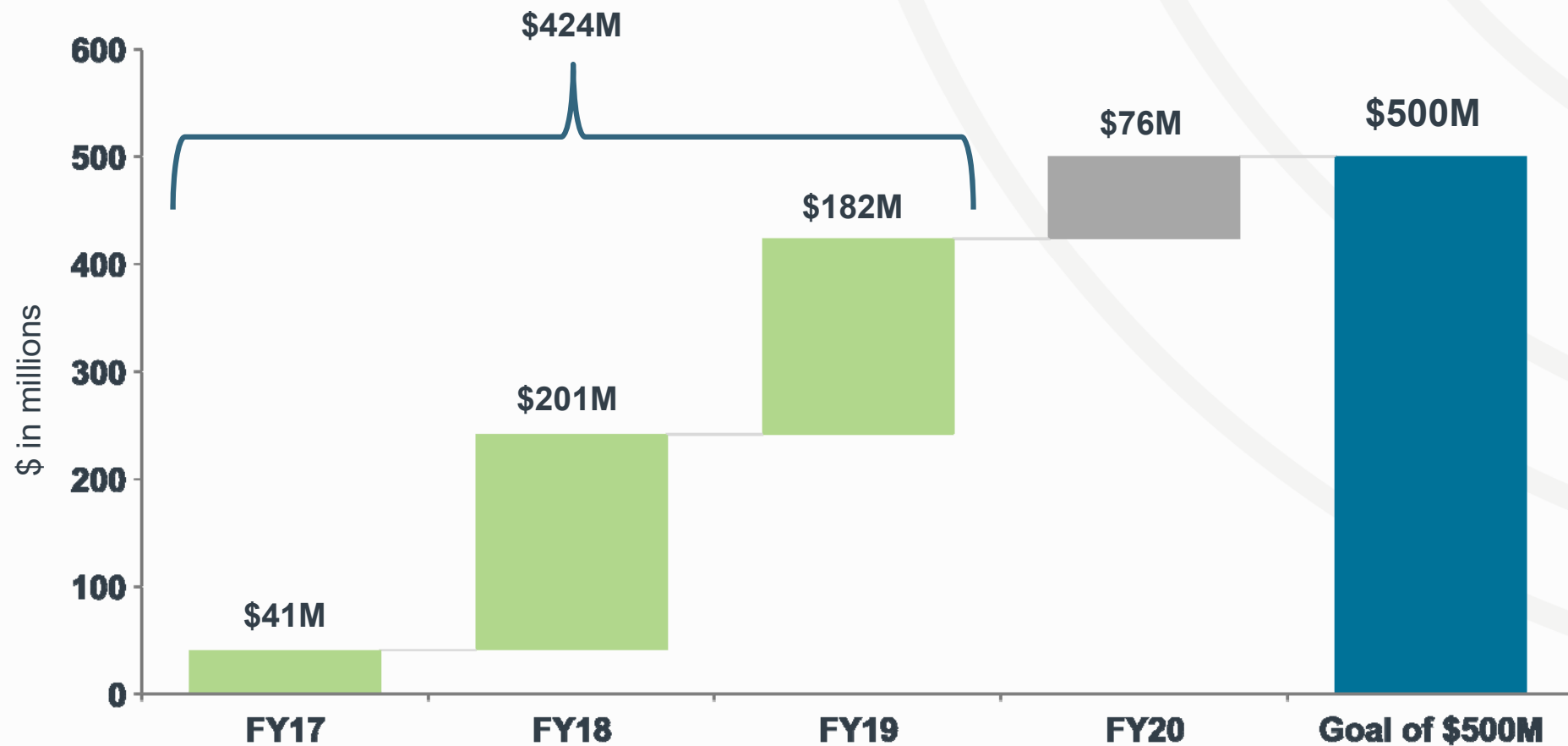
Covered Lives

Elderly population, care management central to trend management



\*ACO = Accountable Care Organization.

# System-wide Expense Management and Revenue Optimization Initiatives Fueling Favorable Financial Performance



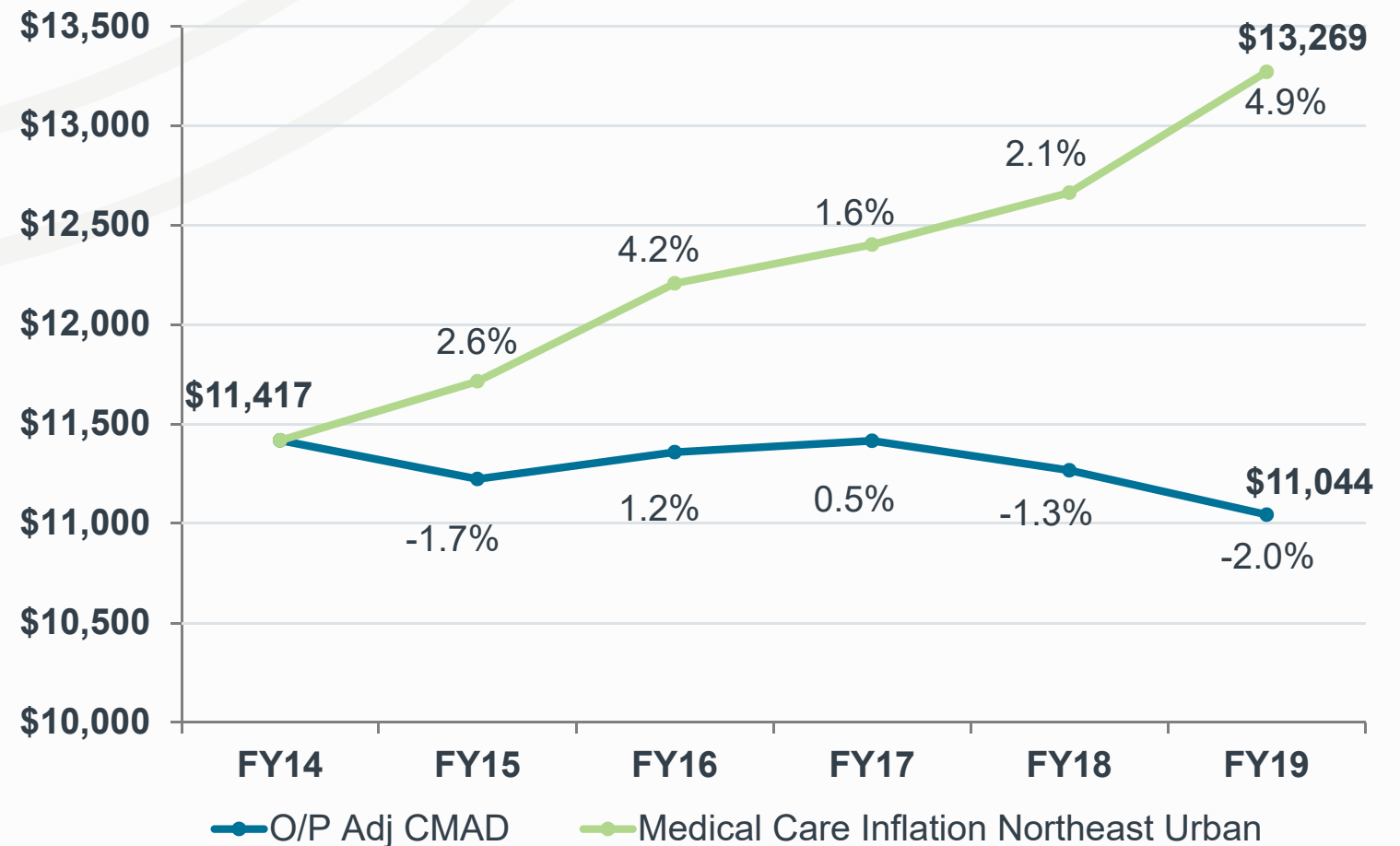
Successful efforts to better align clinical and administrative expenses with payment rates for patient care that have been growing more slowly than medical inflation



# Favorable Cost Curve Trend at Acute Care Hospitals

**AVERAGE ANNUAL TREND**

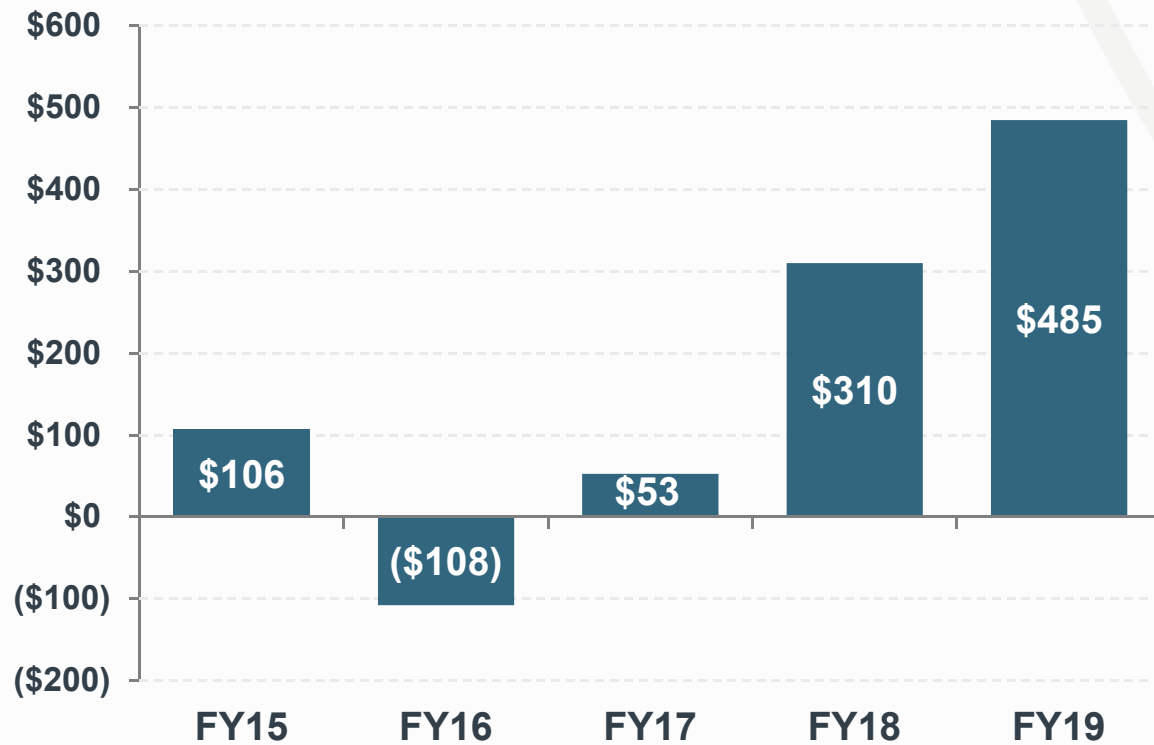
- Mass General Brigham: **-0.7%**
- Regional medical inflation: **3.1%**



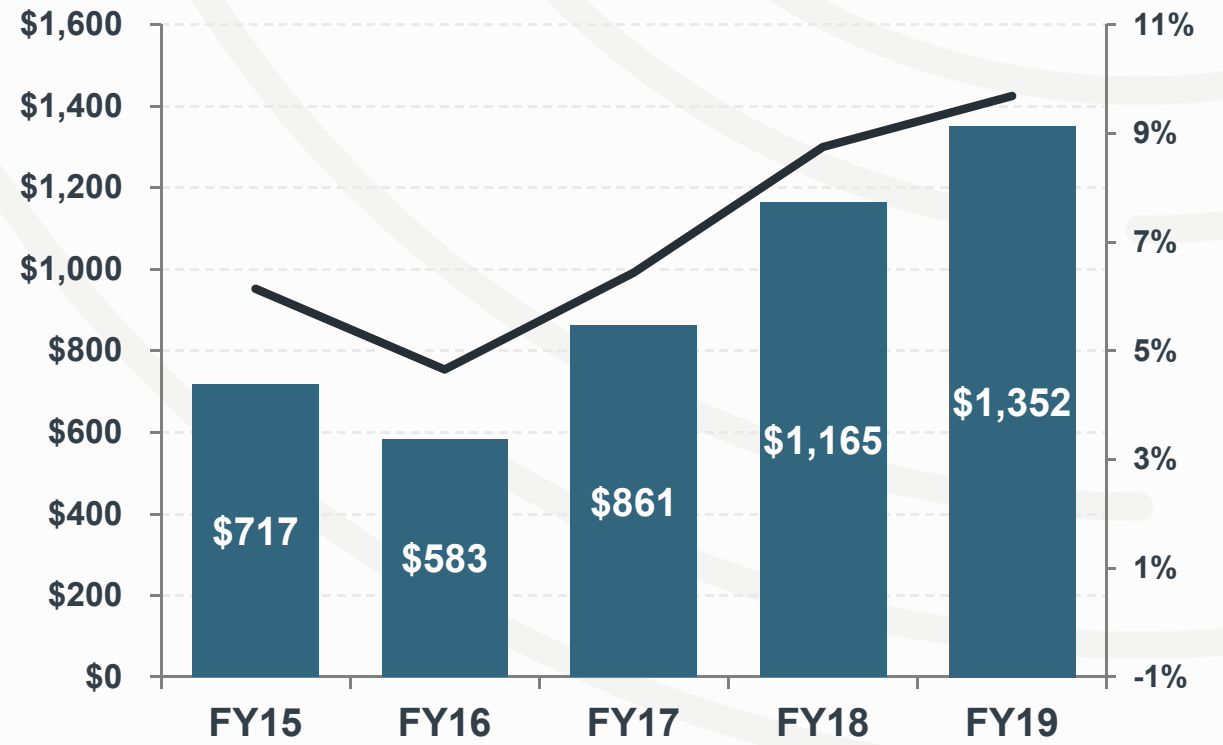
CPI source: Bureau of Labor Statistics, 12 month change as of September in each year.  
 O/P Adj. CMAD = Mass General Brigham acute hospitals.

# Three-Year Trend of Improved Consolidated Operating Performance

## Consolidated Operating Income/(Loss)



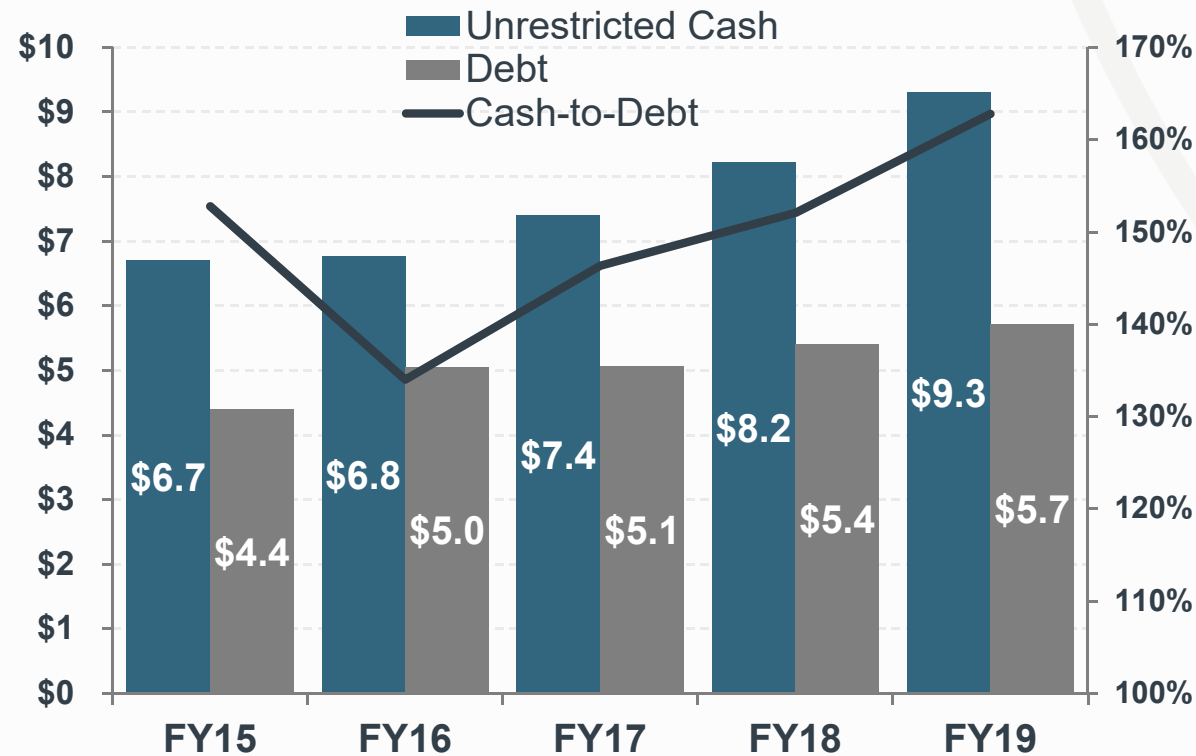
## Consolidated Operating Cash Flow and Margin



\$ in millions.

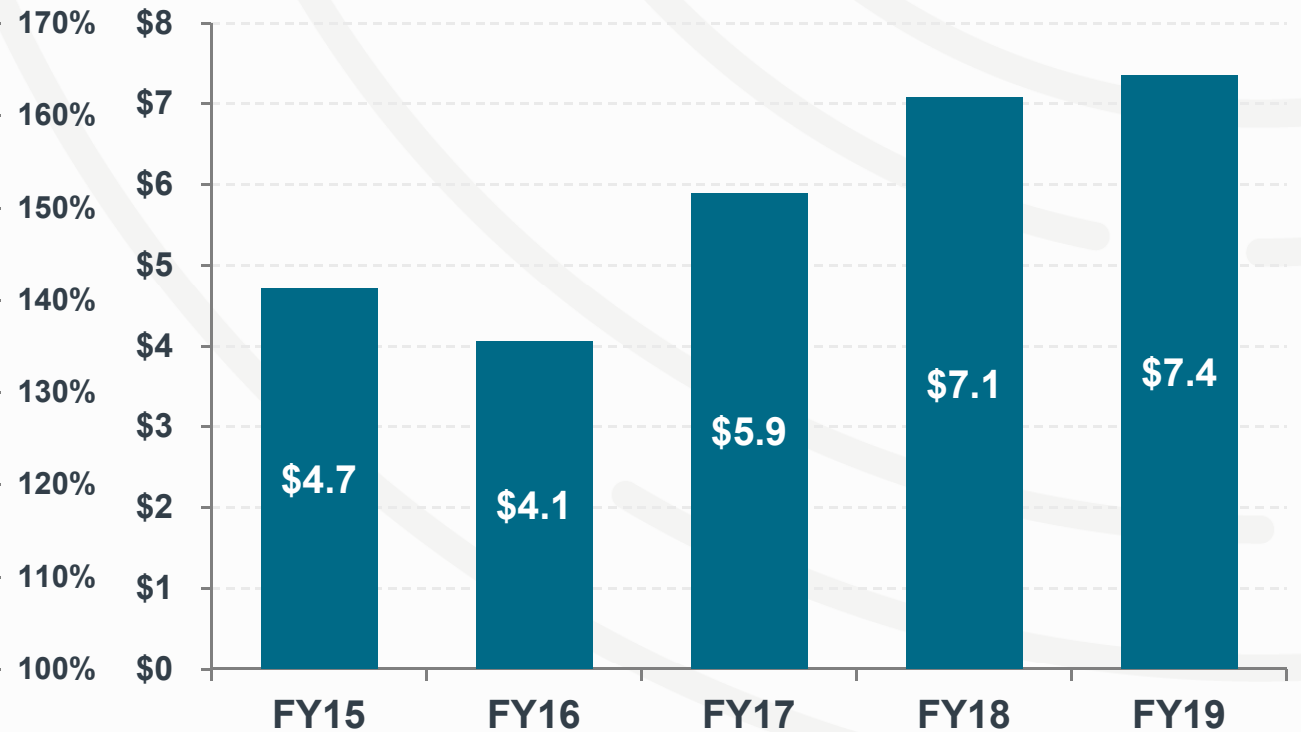
# Key Balance Sheet Metrics also Reflect Improving Trends

## Unrestricted Cash, Debt and Cash-to-Debt



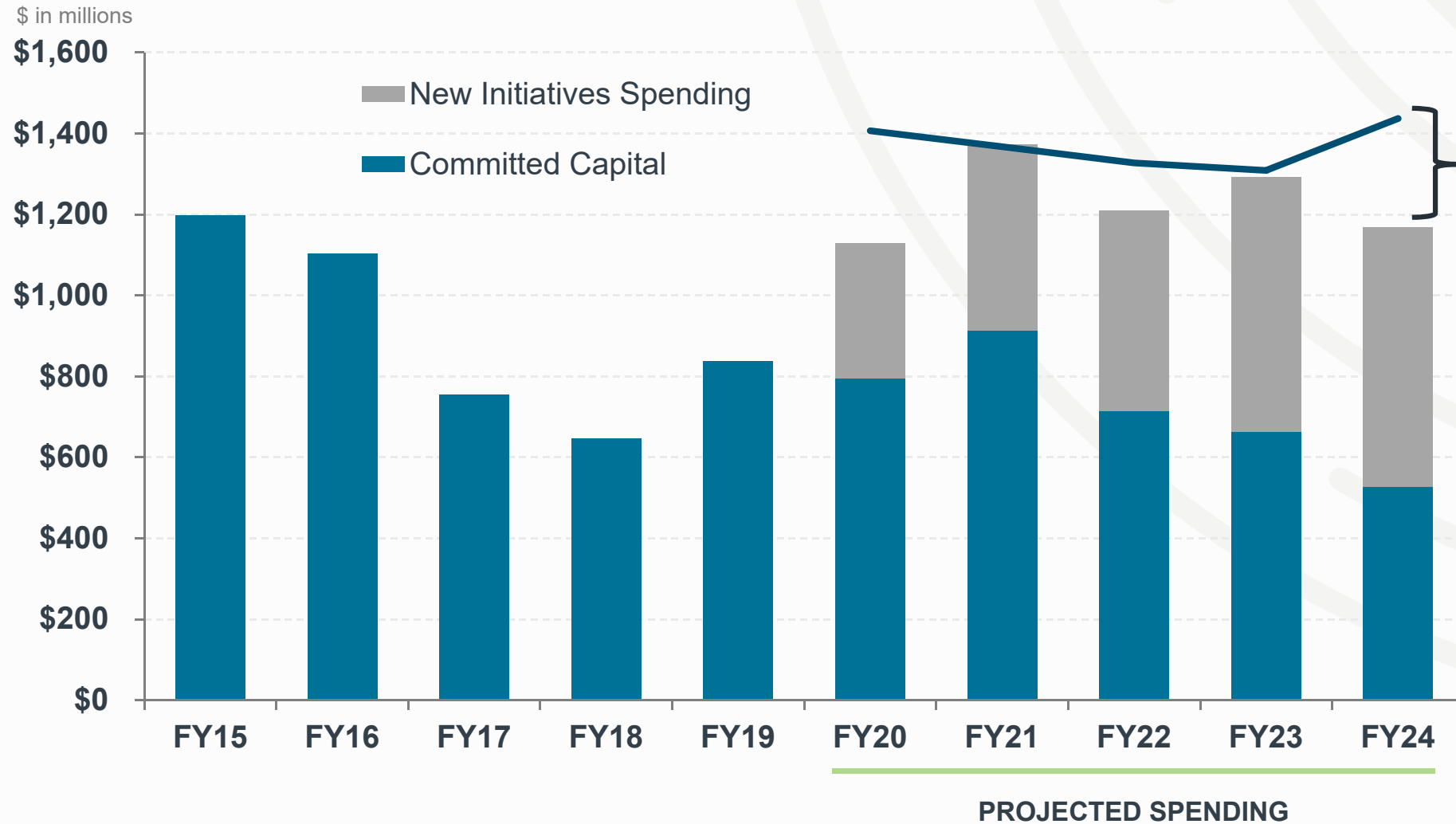
- Unrestricted Cash increased \$2.6B from FY15 to FY19 (8.5% CAGR)
- Debt increased \$1.3B from FY15 to FY19 (6.8% CAGR)

## Unrestricted Net Assets



- Unrestricted Net Assets increased \$2.7B from FY15 to FY19 (11.8% CAGR)

# FY20-FY24 Capital Spending Capacity: \$6.8 Billion



FY20-24 capital capacity exceeds capital requests by ~\$675 million, providing flexibility to accelerate future capex plans

\*Committed Capital has been approved by Mass General Brigham Finance Committee.

# Mass General Brigham Strategic Focus and Key Enablers

- Rebrand system
- Create centers of excellence
- Develop new opportunities for national and international business
- Increase innovation to support commercialization efforts
- Build value-based operating model for primary and secondary care
- Grow commercial insurance business
- Manage total medical expense and risk
- Expand community impact
- Continue to invest in data analytics and digital health
- Physician alignment and retention initiatives addressing compensation and burnout
- Develop and retain high performing talent pool