

January 25, 2022

VIA EMAIL DPH.DON@State.MA.US

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

RE: Determination of Need Application Project #21012113-AS – Mass General Brigham Incorporated Ambulatory, Independent Cost Analysis Comments

Dear Director Szent-Gyorgyi:

This comment letter is submitted on behalf of the Ten Taxpayer Group (TTG) that consists of physicians and other caregivers who work in the UMass Memorial Health system. Members of our TTG practice in a variety of settings and a variety of specialties, but we all share concerns with the above-referenced Determination of Need (DoN) application by Mass General Brigham (MGB) and its potential impact upon aggregate health care costs and the patients we serve.

At the outset, I would like to state on behalf of each TTG member that we all respect and appreciate Mass General Brigham and the physicians and caregivers it employs. It is a distinguished health system and is fortunate to have thousands of skilled and dedicated physicians and caregivers. These comments are intended in no way to question that.

Nonetheless, we have deep and abiding concerns with MGB's proposed expansion. MGB is not simply the Commonwealth's largest and most costly health system, it is *many* times larger and *dramatically* more costly than all others. Its net assets are over three times larger than those of the next biggest Massachusetts system, Beth Israel Lahey Health, and nearly eleven times larger than UMass Memorial Health's. By its own estimation, MGB already accounts for 38 percent of the tertiary market share in Eastern Massachusetts, a region that it defines as beginning at the Shrewsbury-Worcester line to encompass the wealthiest suburbs in Central Massachusetts where a large proportion of residents are commercially insured.¹

¹ This geographic definition of "Eastern Massachusetts" is reflected in MGB's PowerPoint presentation documents for the JP Morgan Healthcare Conference in 2014, 2015, 2016 and 2020 and, apparently, in internal MGB profit

When a gigantic health system with disproportionately high prices proposes a large expansion, it is imperative that the Commonwealth's analysis be, as the Attorney General insisted, "complete, transparent, and data-driven."² Unfortunately, the independent cost analysis (ICA) upon which we are commenting is radically incomplete, lacks transparency, and within its narrow scope of analysis it relies upon highly suspect assumptions proffered by MGB.

This is especially astounding considering that the purpose of the DoN regulatory scheme is to "ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost."³ The regulations place an unusually high burden of proof upon applicants by requiring them to make a "clear and convincing demonstration"⁴ that their proposal will "meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation."⁵

In addition to being crucial for evaluating the aggregate cost of MGB's ambulatory expansion, a complete, transparent, and data driven analysis is necessary to assess its impact on smaller hospitals and health systems, particularly safety nets, and their ability to remain fiscally viable to uphold their patient care mission.

This ICA misses the mark by a very wide margin, including by failing to conduct any analysis whatsoever of the following critical issues:

- The cost of secondary and tertiary referrals to MGB's high-cost Boston campuses, an absolutely essential element of any assessment of aggregate cost;
- Publicly available investor presentations by MGB executives that describe this proposal as a key element in its strategy to increase MGB's *commercial* market share and lucrative commercial referrals;
- The rationale for MGB's unexplained intent to build a Westborough clinic that is at least three times larger than needed, based upon a comparison of the vastly different patient volume it claims to anticipate for Westborough compared to the identically sized Woburn clinic; and
- Health equity impacts stemming from the project's impact upon safety net hospitals.

forecast documents reviewed by the Attorney General's office in response to a civil investigative demand related to this DoN application.

² *Examination of Health Care Cost Trends and Cost Drivers*, Report for Health Policy Commission's Annual Cost Trends Public Hearing, Office of the Attorney General, November 17, 2021.

³ 105 CMR 100.001.

⁴ The "clear and convincing" burden of proof is significantly higher than the more common "preponderance of the evidence" standard. It is made applicable only in certain exceptional scenarios where public policy priorities are especially high. The standard has been described by the United States Supreme Court as requiring that the fact finder be convinced that the contention is "*highly probable*." *Colorado v. New Mexico*, 467 U.S. 310 (1984).

⁵ 105 CMR 100.210(A)

Aggregate Cost

As physicians and caregivers, we understand well that high acuity services are a predominant driver of medical expense. Primary care practitioners and other providers typically make referrals for high acuity care within the health care system in which they work, assuming that there are physicians within that system who provide the specialty service needed by the patient in question. Due to large variations in commercial payment rates, whether these secondary and tertiary referrals occur within a high-cost health system or a low-cost system has a very substantial impact upon aggregate cost.

For this reason, we find it truly remarkable that the ICA contains no analysis whatsoever of costs associated with secondary or tertiary referrals, nor of other key cost drivers such as backfill at MGB's hospitals. For DPH to rely upon a report that is so strikingly narrow to make an assessment about aggregate cost would be as superficial and unreliable as a primary care physician relying solely upon a cursory glance at a patient to conduct an annual physical, without measuring the patient's vital signs, taking a personal history, or conducting the usual series of exams of the patient's heart, lung, head, neck, etc. that are necessary to make an informed judgment. The chances of accuracy in both cases are about equal, while the consequences of getting it wrong could be devastating.

The Attorney General's Office's (AGO) recent report to the Health Policy Commission (HPC) about MGB's application should raise alarms with state officials charged with this review. Underlying the AGO's call for a complete, transparent, and thorough review was crucial evidence yielded from a civil investigative demand of MGB relating to its application. The AGO report unveiled that MGB's proposal is "part of a larger multi-year ambulatory expansion plan across Eastern Massachusetts" that MGB projected in 2018 will "ultimately contribute direct margins to [its] system of approximately \$385 million per year." It noted that MGB projects that 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." It further revealed that MGB projected it would gain "an additional 1-2% of all secondary inpatient admissions ... 3-4% of all tertiary inpatient admissions ... and 1-2% of all covered lives" in Eastern Massachusetts.

The repercussions upon statewide aggregate costs are unmistakable. As the Attorney General pointed out, MGB is the "biggest and highest cost health care system in Massachusetts." This is clearly established in the public record through a multiplicity of sources including the 2021 *Massachusetts Hospital Profiles Report*, published by the Center for Health Information & Analysis, that shows that MGB hospitals have the highest inpatient rates in the state by far, while Marlborough Hospital has the lowest inpatient payment rate of any hospital in the Commonwealth and UMass Memorial Medical Center has the lowest inpatient payment rate of the six academic medical centers.⁶ Consistent with this low cost of inpatient care at its hospitals, UMass Memorial Health has been ranked the number one health system in the nation for avoiding overuse.⁷

⁶ CHIA measures inpatient rates by "NPSR per CMAD", or (net patient service revenue per-case-mix-adjusted discharge).

⁷ [Which health systems are doing the most to reduce overuse? - Lown Institute](#)

The importance of a thorough analysis of increased costs from patient referrals to MGB's hospitals for high acuity care becomes even more compelling when you consider two things. First, is that expanding referral of commercial patients into the two highest cost hospitals in Massachusetts is *exactly* what MGB's top leaders have publicly and repeatedly stated they intend to do. That the audience for those statements consisted of bond investors and not state regulators does not lessen their reliability; to the contrary, it enhances it. (Just imagine the value an investor would attribute to MGB's expansion of lucrative tertiary referrals from 38 percent of the market to 41 or 42 percent.) Second, is that MGB's construction plan and expansion of physical capacity are fully consistent with its investor presentations, though at odds with its state regulatory filings.

In terms of its statements to investors, beginning in 2014, top MGB executives (known as Partners Healthcare for much of that period) made a series of PowerPoint presentations to the JP Morgan Healthcare Conference, all of which are readily available in the public domain, that feature the profitability of its "Eastern Massachusetts" ambulatory expansion plans. In 2014 Partners executives touted its "network strategy" to "establish ambulatory care centers to support primary care growth in Eastern Massachusetts," stating it would "add new primary care providers in key strategic geographies to grow covered lives in Eastern Massachusetts."⁸ In 2015, executives stated that "referral relationships are an important source of high acuity volume," and described their regional referral growth strategy as a "strong source of high acuity volume and margin." In 2016, executives became even more explicit, describing a "clinical business strategy" to "grow regional, national and international referrals" stating that "referral management" accounts for "~60% of Partners patient revenue." They highlighted that regional referrals "draw high acuity cases to BWH and Mass General" and forecast that expanding Partners' "regional share of business driven by loyal network leads to growth of tertiary care."

After that multiyear history of presentations to the nation's premier healthcare investors and the 2018 internal profit forecast unveiled by the Attorney General, in January 2020 the Chief Executive Officer and Chief Financial Officer of the newly named Mass General Brigham system appeared once again at the JP Morgan Healthcare Conference and, while revealing the specific clinic proposal that is now before you, told this audience of potential bond investors that "tertiary discharges are forecast to grow at a faster pace than secondary discharges" in Eastern Massachusetts and that, while it already had 38% of tertiary discharges in the region, it was pursuing a plan for "expansion of outpatient services in [a] regional network" in order to **"increase network lives and secondary & tertiary commercial referral volume."**

MGB's intent could not be clearer.

This intent is buttressed by its construction plans. MGB intends to build similarly sized clinics in each location and, in the cases of Westborough and Woburn the clinics are precisely identical in size. Moreover, it intends to hire nearly identical numbers of physicians, advanced practitioners and support staff in both locations (45 physicians, 15 advanced practitioners and 163 total staff in Westborough, compared to 45 physicians, 14 advanced practitioners and 174

⁸ The 2014 presentation indicates that Partners was already labeling everything from Shrewsbury east as "Eastern Massachusetts," thereby encompassing wealthy Central Mass suburbs.

total staff in Woburn).⁹ The only specialty with significant difference is radiology, likely due to the Westborough clinic being proposed to have 1 MRI and 1 CT compared to 2 of each in Woburn.¹⁰ This is remarkable considering that MGB's Westborough patient panel is far smaller and the DoN application projects it will yield only 30.5 percent the volume of visits as Woburn.¹¹ This can be viewed in either of two ways: The first, using MGB's application as the only backdrop, is that the executive leaders of a successful health system have dropped the ball and will overbuild by over 300 percent at a time when inflation is the highest in decades, thereby causing the system to incur exorbitant unnecessary costs. The second and more likely scenario is that MGB recognizes that the Westborough service area is where it has the largest potential for commercial expansion, and it is intentionally constructing such a large building to maximize its growth and profit margin. That scenario is wholly consistent with the strategy its leaders described to investors.

Yet, the author of the ICA ignored all this, irrespective of how consistent MGB executives' investor presentations are to the profit forecast revealed in the AGO report, and irrespective of how consistent its construction plans are to both. Instead, he chose to operate solely within MGB's preferred framework by focusing upon potential savings yielded by migration of existing MGB patients from its high-cost hospitals to the ambulatory clinics. Even while doing that, he avoided considering costs associated with backfill at MGB's hospitals for any capacity created by this migration and, apparently, assumed there would be no backfill. We as physicians and caregivers fully understand that hospitals try to fill new capacity with new patients, and we believe it a massive oversight that this was left unaccounted for.

We are also baffled that the ICA only accounted for the costs of CTs, MRIs, and surgeries, with no analysis of costs of the many other service lines MGB plans to offer.¹² Even more astoundingly, it entirely omits any consideration of physician costs. This is simply inexcusable considering that MGB's physician costs are substantially higher than all other systems, by far.

As if to compound the inaccuracies resulting from all these errors, the author accepted assumptions proffered by MGB in its DoN applications without substantially questioning their validity. He accepted MGB's estimate that it would utilize operating rooms at 70 percent capacity, even though the Attorney General revealed that this estimate is significantly lower than the 85 percent utilization rate that undergirds MGB's profit estimate. The AGO report insisted that this discrepancy must be scrutinized, yet it was not.

The author also simply accepted MGB's assertion that 100 percent of its patient panel members who already have an MGB primary care provider will switch their care to the new clinic. As we stated at the outset, we have tremendous respect for our colleagues at MGB. We find it highly

⁹ See Figure ICC 128 in MGB's DoN application.

¹⁰ It is notable that MGB anticipates it potentially adding another MRI and CT in Westborough to match Woburn, stating in its DoN application: "The Westborough Site will be constructed, with necessary shielding, to accommodate an additional 1.5T MRI unit and 128-slice CT unit to accommodate future CT and MRI demand at the Westborough Site."

¹¹ The DoN application and the ICA predict 42,267 physician visits in Westborough and 138,594 in Woburn.

¹² In Westborough alone, MGB plans to offer Primary Care, Behavioral Health, Ambulatory Surgery, General Surgery, Cardiology, Pain Management, Neurosciences, Ophthalmology, Orthopedic Surgery, Rheumatology, GI, Urology, and ENT.

unlikely that every single patient panel member who has one of them as their primary care physician will drop them to go to an unknown provider at the new clinic. For the author to accept this without question results in an artificially high savings estimate from his limited scope of analysis.

Contrast that assumption with MGB's assertion that few patients of other providers will migrate to its clinics. The author accepted this assumption even while MGB is aggressively marketing the clinic to residents of the regions where they will be located. Considered along with MGB's JP Morgan presentations, this can be considered part of a one-two punch. The first punch is an aggressive marketing campaign. The second is recruitment of local primary care providers who can bring a book of commercially insured patients into the system, consistent with MGB's plan for "expansion of outpatient services in [a] regional network" as a means to "increase network lives and secondary & tertiary commercial referral volume."

Taken alone, any one of these omissions or acceptances of unsupportable assumptions would make the ICA highly unreliable. In the aggregate, they result in an ICA that undermines, rather than upholds, the clear purpose and directives of the DoN regulations.

Relation Between Aggregate Cost and Health Equity

Although the purpose of the DoN regulations is to "ensure that resources will be made reasonably *and equitably* available to every person within the Commonwealth at the lowest reasonable aggregate cost," the ICA provides no analysis of the proposal's impact on equitable availability of healthcare.

On this topic, the location of the three clinics appears to be as driven by demography as geography. Each is centered among high-income communities with large numbers of commercially insured residents who are served by other health systems. None are in proximity to large volumes of low-income patients. In other words, they are located where they can best effectuate MGB's stated strategy to increase lucrative *commercial* secondary and tertiary referrals by capturing primary care patients from lower-cost systems.

Consider the Westborough clinic. It would be surrounded by towns that mostly have median incomes in the highest 20% statewide, where a large proportion of residents are commercially insured, where patients are already amply served by multiple providers, and where MGB's own community survey found little to no need for additional services.¹³ And it would be difficult to access for most low-income patients in Central Massachusetts, due to the combination of distance from the clinic and a dearth of public transportation options. This makes it an ideal location to maximize migration of *commercially insured* patients presently served by local providers.

What does this mean for local safety net hospitals as they try to carry out their missions? Marlborough Hospital and UMass Memorial Medical Center are both designated by the state as

¹³ MGB's application included a community survey giving respondents 17 options to choose from as Strengths of their Community. "Accessible Medical Services" was selected by almost 70% of respondents, ranking it as the region's number 2 asset.

High Public Payer hospitals and by the federal government as Disproportionate Share Hospitals because of the high proportion of publicly insured or uninsured patients they serve. Both sustain substantial losses from implementation of their safety net missions, particularly because they are paid rates by MassHealth that are considerably below the actual cost of providing care. To achieve fiscal balance, they must cross-subsidize these losses with revenue from treating commercial patients. This is enormously challenging, considering that their commercial insurance rates are far lower than MGB's.

This delicate balance is put at risk by MGB's proposal. As MGB implements its clear plan to capture a high volume of commercially insured patients from other providers, Marlborough Hospital and UMass Memorial Medical Center will be impacted. While driving up statewide aggregate cost by increasing the volume of commercial secondary and tertiary referrals to the Commonwealth's two most expensive hospitals, this scheme will also financially destabilize two critical safety net providers in the Central Massachusetts region.

As physicians and caregivers, we fear what this could mean for our most vulnerable patients and for the communities we serve. Patients who are covered by MassHealth or who are uninsured, and who don't live near the new clinic nor have transportation to it, will continue to come to our hospitals for their care. And we will do our best to serve them. But with less commercial revenue to subsidize the losses from safety net care, our ability to do so will be hampered. The loss of revenue could put our hospitals in the unenviable position of having to reduce or cut vital services to remain afloat fiscally. Patients are the ones who would pay the biggest cost for that.

MGB's expansion would also exacerbate staffing challenges at a time when our hospitals, and all healthcare providers, already struggle to hire sufficient licensed staff to meet inpatient demand. As MGB's own CEO stated in her testimony at the HPC Cost Trends Hearing in November, due to the COVID-19 pandemic, "our workforce and our hospitals...we're all very fragile now." As she described, the pandemic has "significantly and permanently changed our healthcare system" and "all of us ... are dealing with a serious shortage of healthcare workers and a very markedly diminishing pipeline for them." Given this reality, if these clinics are approved, the only place where MGB will be able to turn to find an ample workforce supply is local healthcare providers. Their gain will be our loss. Or, to put it differently, it will be the loss of the patients left behind, many of whom will be lower income and publicly insured or uninsured.

Anything that destabilizes safety net providers has a direct impact on their patients and thereby inhibits the Commonwealth's goal of ensuring "that resources will be made reasonably *and equitably* available to every person within the Commonwealth."

Conclusion

As described above, the stakes are far too high to risk getting this wrong. MGB bears the burden to demonstrate, consistent with the clear and convincing standard of proof, that its proposal is *highly likely* to meaningfully contribute to the Commonwealth's goals. Contrary to the exhortation of the Attorney General, this ICA is far from a "complete, transparent, and data driven analysis" and therefore does remarkably little, if anything, to inform DPH's review nor its pending recommendation to the Public Health Council.

We respectfully suggest that contrary to the ICA, the overwhelming evidence in the public record demonstrates that MGB's proposal is the cornerstone of its strategy to expand its dominance of the commercial healthcare marketplace, particularly for the most profitable sphere of business, tertiary referrals. This will inevitably drive up aggregate cost and negatively impact the equitable availability of healthcare to all residents. We therefore request that you recommend to the Public Health Council that it deny the application outright.

Sincerely,

A handwritten signature in black ink, appearing to read "Kimberly D. Eisenstock". The signature is fluid and cursive, with a large loop at the end.

Kimberly D. Eisenstock, MD