

January 27, 2022

VIA EMAIL DPH.DON@State.MA.US

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RE: Mass General Brigham, Incorporated Determination of Need (“DoN”) #21012113-AS (the “Application”) for a \$223,724,658 multi-site project (with 3 Ambulatory Care Centers (ACC) in Westborough, Westwood & Woburn, each including a new freestanding Ambulatory Surgery Center (ASC) with 4 operating rooms, primary & specialty physician services and imaging services (CT and MRI) (the “Proposed Projects”) – Comments of UMass Memorial TTG regarding the Application’s associated Independent Cost Analysis dated December 10, 2021 (released as complete by the Department of Public Health on December 28, 2021, the “ICA”)

Dear Ms. Szent-Gyorgyi:

On behalf of the UMass Memorial TTG, this letter reflects our comments as parties of record in response to the above-referenced ICA.

As a threshold matter, having only recently received the Health Policy Commission’s comprehensive report that was adopted unanimously by the HPC Board on January 25, 2022¹ (the “HPC Comments²”), we have attempted to incorporate the findings into our comments concerning the Application, and the Westborough site in particular, where appropriate. Given the short timing, however, there may be areas we have not been able to address, and we encourage the Department of Public Health (the “Department” or DPH) to consider our comments in the context of that report.

In addition, the following is to provide some context to our comments: UMass Memorial Health Care, Inc.’s (“UMMH”) was created by statute with the public mission to be a safety net system, to provide access to the highest acuity care³ for the region and to support the

¹ See also [PowerPoint Presentation \(mass.gov\)](#)

² Cited herein as (HPC, p. _)

³ [Chapter 163 of the 1997 Session Laws](#) in establishing the merger between the University of Massachusetts Medical Center and Memorial Health Care direct “that the public mission of the teaching hospital and other clinical components of the University of Massachusetts include providing highly specialized clinical services to patients,

THE RELENTLESS PURSUIT OF HEALING

Commonwealths only public medical school. The Commonwealth designates Marlborough Hospital as a “High Public Payer” community hospital and UMass Memorial Medical Center as a “High Public Payer” academic medical center.⁴ Both are the lowest cost providers compared to their peers -- UMass Memorial Medical Center has the lowest inpatient rates among the Commonwealth’s six academic medical centers, and Marlborough Hospital is the lowest cost hospital in the State⁵. UMMH provides over fifty percent of MassHealth inpatient care in the Central Massachusetts region. And it does so with high quality scores, consistent with its public mission and consistent with the AGO’s and HPC’s findings, over many years, that a health system’s cost is not related to the quality of care it delivers.⁶ And UMMH is a high value system, as recently confirmed by its being ranked first in the nation by the Lown Institute for avoiding overuse of low value procedures.^{7,8}

particularly to the extent not available through other area services, and providing free care to indigent patients, remains an important objective which must be preserved or enhanced.”; as well as supporting the Commonwealth’s only public medical school”. (Sections 1(c) and 1(j).

⁴ *Massachusetts Hospital Profiles Report*, Center for Health Information & Analysis, (March 2021).

⁵ *Ibid.* The Net Patient Service Revenue per Case Mix Adjusted Discharge (“NPSR per CMAD”) for UMass Memorial Medical Center is \$13,432; for Brigham & Women’s Hospital it is \$18,028; and for MGB it is \$16,967.

⁶ See <https://www.mass.gov/doc/2021-health-care-cost-trends-report/download> (pg. 24)

“2.CONSTRAIN EXCESSIVE PROVIDER PRICES. Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices for Massachusetts providers (without commensurate differences in quality) continues to divert resources away from smaller, less competitive community providers toward generally larger and more well-resourced systems.”

See also <https://www.mass.gov/doc/examination-of-health-care-cost-trends-and-cost-drivers-2019/download>

“...the AGO documented significant price variation among Health Care Providers that is unrelated to the quality of care provided.”

⁷ January 17, 2022 list of best health systems for avoiding overuse:

<https://lownhospitalsindex.org/rankings/?systems=true&sortBy=OU>. This measure is also tracked by the Health Policy Commission due to its cost implications. See also <https://lowninstitute.org/projects/lown-institute-hospitals-index/>.

⁸ UMMH is constantly evolving to meet the needs of Central Massachusetts (as evidenced by the recent CHNA confirming that the community is indeed well served. In recent years UMMH has undertaken multiple strategies to address health services needs associated with population growth and aging, including at both Marlborough Hospital and UMass Memorial Medical Center. Marlborough Hospital, for example, has invested \$18 million in its Community Cancer Center, \$3 million in the Women’s Imaging Center, has recruited two new behavioral medicine providers including a new chief, has two new orthopedic physician recruits, added two physicians at its Southborough site for colorectal services, and has added three UMass Memorial Medical Center physicians for gastrointestinal surgery. UMass Memorial Medical Center has initiated two innovative strategies over the past year to expand inpatient bed capacity. First, on July 1, 2021, it launched the UMass Memorial Hospital at Home program, a new, cost-effective program that frees up bed capacity by providing acute hospital level care in the homes of qualifying patients. Secondly, also in July 2020, UMass Memorial Medical Center purchased a nursing home facility immediately adjacent to its University campus, with the intent to convert the facility into approximately 75 licensed, acute care hospital beds. Faced with fiscal restraints that have made construction of a new bed tower prohibitive at this time, the purchase and renovation of the nursing home will provide a lower cost alternative to substantially expand bed capacity at the Central Massachusetts region’s primary hospital campus for

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Executive Summary of Response

Mass General Brigham (or “MGB”) has been telling the bond investor community since 2014 that the goal of its proposed outpatient expansion, a significant component of which is the subject of this Application, is to “increase network lives” and “secondary and tertiary commercial referral volume into its Boston hospitals.”⁹ Indeed, that is the only way that MGB can deliver its projected new incremental margin of \$385 million per year, as discovered by the Office of the Attorney General (“AGO”) in its unprecedented report to the Department and the Health Policy Commission (“HPC”). Yet, MGB now comes to the Department to try to convince the agency and the public that the only purpose of the expansion is to move ambulatory care outside of Boston to reduce the cost of care for existing patients. MGB makes no mention these days of its publicly stated strategy to “increase network lives [and] secondary and tertiary commercial referral volume into its Boston hospitals.” Inexplicably, the “independent cost analysis” relied on MGB’s application narrative while wholly ignoring MGB’s publicly available

⁹ See e.g. MGB’s presentation at the J.P. Morgan Health Care Conference, January 13, 2020, as well as prior and subsequent conferences, at the links below. See **Exhibit 1** for MGB’s 2014 presentation.

(2015):
chrome-extension://efaidnbmnnnibpcaJ.P.cglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Femma.msrb.org%2FEA682692-EA532077-EA928291.pdf&clen=785556

(2016):
chrome-extension://efaidnbmnnnibpcaJ.P.cglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Femma.msrb.org%2FEP903128-EP699848-EP1101782.pdf&clen=748083

(2020):
chrome-extension://efaidnbmnnnibpcaJ.P.cglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Femma.msrb.org%2FER1298616-ER1012536-ER1417697.pdf&clen=743914

(2021):
chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Femma.msrb.org%2FP31408531-P31095080-P31504395.pdf&clen=450585

strategic plans and what it has been telling bond investors consistently for years. Although there are many other significant flaws in the ICA, as fully detailed below, this singular failing is so impactful upon the accuracy of an analysis of aggregate cost that it discredits the report in its entirety and makes it unworthy of serious consideration by the Department. Indeed, to rely on such a report under these circumstances would be highly inappropriate.

But fortunately for the public, the HPC did not ignore this information. In an exhaustive analysis of the three pending MGB DoN applications which employed the HPC's full arsenal of its analytic tools, its command of the available data sources and its vast experience in this area,¹⁰ the HPC found based on conservative projections¹¹, the Proposed Projects would result in up to a \$90.1 million annual increase in TME and up to \$260 million in decreased commercial annual revenues for local High Public Payer providers. The HPC concluded that the ICA was utterly lacking and demonstrated by clear and convincing evidence that the applications did not meet the DoN criteria. It is completely unprecedented in the history of the Commonwealth of Massachusetts to have the HPC weigh-in so strongly against a DON application, and for the Attorney General to issue a Report disclosing confidential internal Applicant information of such materiality that it needed to be brought to the attention of the Department. There is no reasonable way the Applicant can demonstrate by clear and convincing evidence that it meets the regulatory standards when this credible and independent state agency¹² which is vested with the very responsibility of monitoring health costs has just found overwhelmingly through detailed analysis that it does the opposite. The ICA must be rejected and the DoN must be dismissed.

And yet there is another compelling reason that this Application should be denied. At the very same January 25, 2022 meeting at which the HPC Commissioners voted to approve the submission of the HPC Comments, the HPC also unanimously voted to **require that MGB enter into a performance improvement plan (PIP) to hold the health system accountable for its massive**

¹⁰ The HPC reviewed the MGB applications both individually and together. This makes sense for the following reasons: First, as emphasized by MGB, the ACCs will be operated just like MGB's hospital outpatient department satellites, fully vertically integrated with MGB hospital operations. Notably these locations could convert to hospital licensed space at any time. The applications also were submitted simultaneously and a single statement of work (SOW) was used to commission the ICA.

¹¹ In addition to information about additional costs which HPC notes was not included in its conservative review, HPC also did not have access to MGB's delayed response to DPH's second set of questions which only posted on the DPH website on January 26, 2022 (regarding surgical services and extended ramp up projections due to supply chain costs and updated volume projections).

¹² The HPC Board includes health economists and other industry experts with decades of expertise in health care delivery and finance in both academic and government settings. The board is chaired by a former Deputy Assistant Secretary for Planning and Evaluation/Health at the predecessor to HHS and HPC commissioners also have served on numerous federal and state advisory commissions including the Prospective Payment Assessment Commission (ProPac), National Bipartisan Commission on the Future of Medicare, Council of Economic Advisers, National Economic Council, and the Legislative Health Care Task Force for the Commonwealth of Massachusetts.

and continuous spending growth. This is the first time in its history that the HPC has imposed a PIP. This unprecedented development renders MGB's pending applications deficient on their face and warrants a prompt and appropriate response by DPH. Based on this fact alone DPH must reject the Application as incomplete.

If the AGO Report and the HPC's two dramatic actions weren't enough, the ICA itself does not fulfill its regulatory purposes, as also noted by the HPC. Instead of the broad scope of inquiry which CRA (the "Consultant") was tasked by the Department to undertake (a scope of inquiry that is bolstered by the DoN regulations), the Consultant undertook an exceedingly narrow scope of review that ignores crucial and obvious external realities that are readily available in the public domain. It omits significant areas of inquiry and relies on questionable assumptions within the exceedingly narrow confines of its actual review. For example, in addition to the Consultant's decision to ignore the report by AGO Report, it did not consider physician data and rates; it did not consider the cost implications of backfill at the Commonwealth's most expensive hospitals; it inappropriately relied on dubious assumptions about the patient panel; it relied on outdated data on workforce supply and inflation, which are directly contrary to recent testimony by MGB's own CEO; it reviewed only a small subset of the services that will be offered at these new sites; it relied on the baseless and unsupported conclusion that MGB should be analyzed as a new entrant in the expansion regions (notwithstanding MGB's purported desire to serve only existing patients); it ignored the impact of MGB's commercial expansion strategy on safety net providers in the region; and it completely failed to address the most pressing health care issue of our time - health equity - despite the fact that the DoN regulations highlight equitable access to health care across the Commonwealth as a public policy priority that the regulations are intended to advance.

The sum total of these procedural and substantive errors and omissions is an incomplete, misleading and fatally flawed ICA which does not address the Department's Scope of Work's ("SOW", **Exhibit 2**) primary elements -- the effects of the Proposed Project on (1) prices of and competition for health care services in Massachusetts; and (2) the utilization of health care services in Massachusetts and the capacity of health care providers in Massachusetts to render those services. Put simply, the ICA neither reflects the realities of the Massachusetts statewide health care landscape nor the market reality in the affected service areas. The ICA is wholly insufficient to support a finding that the Proposed Project satisfies the required factors for DoN approval. It should be rejected.

The Department's authority to reject an Application is clear, as is the Public Health Council's authority to vote to reject. Here, the Application and supporting evidence fall far short of meeting the Applicant's burden of proof, as is evident by the serious inconsistencies highlighted in the AGO Report and confirmed by the HPC, and the ICA's failure to analyze those

inconsistencies and other areas of inquiry recommended by the AGO, and the many material concerns raised by members of the public who testified during the public review process.

I. The PIP, the DoN Standard of Review & DPH's Broad Authority

From both a procedural and substantive perspective, the Department should exercise its broad authority to disregard the ICA and deny the Application.

The PIP

As a threshold matter, the HPC's imposition of a PIP requirement on MGB directly impacts the compliance of the Application with regulatory requirements in two respects. First, MGB as the Applicant is required to provide "sufficient evidence that it is in compliance and good standing with federal, state, and local laws and regulations including, but not limited to, compliance with all previously issued Notices of Determination of Need" (emphasis added). 105 CMR 100.210(A)(3). Thus, in connection with its many previously approved DoN applications since 2017, MGB is now required to report to the Department that it subject to a PIP and is engaged in ongoing efforts to implement the PIP consistent with 958 CMR 10.00. Without that, MGB is unable to make that attestation in the Application. Until MGB has demonstrated to the HPC that it has complied with the PIP process, DPH cannot evaluate whether MGB is in compliance under its existing DoNs calling into question the pending Application's attestation. Second, MGB's pending Application does not include its own required element -- whether the applicant is subject to and in compliance with a PIP. 105 CMR 100.310(A)(2). Thus, compliance would necessitate an amendment to MGB's pending Application.

The DoN regulations do not automatically allow pending DoN applications to be amended, however. Pursuant to 105 CMR 100.425 no amendment to a pending DoN application "shall be accepted that, in the opinion of the Commissioner, substantially alters the Proposed Project in nature, scope, costs, or financing, or in any way substantially alters or affects the Department's evaluation of the Proposed Project...Any proposed amendments which are deemed impermissible by the Commissioner, and which result in the Applicant's inability to proceed with its filing, shall automatically result in a dismissal and the need for the Applicant to file a new Application". 105 CMR 100.425 (emphasis added).

An amendment to the Application would be highly problematic here considering the HPC simultaneously issued the PIP decision together with its highly critical review of the Application. Addressing the PIP will undoubtedly require that MGB also address the HPC's grave concerns regarding MGB's expansion plans which are the basis of the Application. Thus, the PIP would appear to be a necessary component of the Application that is not subject to a simple amendment, but which calls into question the very substance of the Application itself. It is unclear how MGB

can satisfy the HPC PIP requirements while proceeding with the proposed projects that are the subject of the DoN applications at issue here, given the HPC's findings. DPH should require that MGB withdraw the Application and not file again until it has demonstrated to the HPC that it has successfully implemented the PIP in connection with its other DoN approved projects and that new projects such as those contemplated by this DoN application will be consistent with such HPC approved PIP. While the Chair of the HPC Board Stuart Altman was careful to recognize that the ultimate decision with respect to the DoN applications rests with the DPH, the Department similarly is charged with recognizing the statutory and regulatory role of the HPC.

DoN Standard of Review & DPH's Broad Authority

The purpose of DoN regulatory review is to “ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost advancing the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.” 105 CMR 100.001. Before proceeding any further, it must be acknowledged how extraordinary the current record is before the Department. The very agency vested with the authority to manage health care costs in the Commonwealth has opined -- with compelling supporting evidence -- not that resources will be made available at the “lowest reasonable aggregate cost,” but at the highest! The HPC found by every possible measure that MGB has the highest costs by far of any provider in the Commonwealth and, given its market dominance and high prices, this expansion project will add significantly to costs by as much as \$90.1 million per year, while crippling other High Public Payer providers by taking away commercial revenue of up to \$261.1 million and thereby negatively impacting health equity. (It is notable that HPC repeatedly described these as “conservative projections” due to data limitations that limited its review).

But even if the Applicant could somehow prove that the HPC is wrong, which would be no small task, it must do much more. It must prove that it is completely and thoroughly wrong, such that no aspect of its analysis would have any legitimacy. This is because the burden is on the Applicant to make a “clear and convincing demonstration”¹³, an unusually high burden, that

¹³ The “clear and convincing” standard of proof sets a very high bar, requiring significantly more evidence than the preponderance of the evidence standard applicable in most civil cases. It is made applicable only in certain exceptional scenarios where public policy priorities are especially high. To demonstrate that evidence is clear and convincing, MGB as the proponent of the Application must show that the evidence is highly and substantially more likely to be true than untrue, and the fact finder (here, the Public Health Council) can only grant relief if the evidence is “*highly* probable.” See Colorado v. New Mexico, 467 U.S. 310, 316 (1984). Massachusetts law reiterates that “[i]n order to be clear and convincing, the evidence must be sufficient to convey a high degree of probability that the proposition is true The requisite proof must be strong and positive; it must be full, clear and decisive.” In re Adoption of Zoltan, 71 Mass. App. Ct. 185, 188 (2008) (quotations omitted); see also Hon. William G. Young, John R. Pollets, Christopher Poreda, 19 Massachusetts Practice, Evidence, § 102.14 (3d ed. April 2020

the proposal meets all of the DoN factors set forth in the regulations (105 CMR 100.210(A), including the following provisions of both Factors 1 and 2 which are of particular relevance to the Application (emphasis added):

- (i) “Applicant has demonstrated sufficient need...by...its Patient Panel¹⁴;
- (ii) Applicant has demonstrated ...the...Project willprovid[e] reasonable assurances of health equity;
- (iii) Applicant has demonstrated the ...Project will compete on the basis of price, total medical expenses [“TME”], provider costs and other recognized measures of health care spending.
- (iv) Applicant has sufficiently demonstrated that the ... Project “will meaningfully contribute” to all three of “the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.” And
- (v) The [ICA] has demonstrated that the ...project is consistent with the Commonwealth’s efforts to meet the health care cost-containment goals”

Of the above, only subfactor (i) is limited in application to an appropriately identified Patient Panel. The other measures are general statewide goals that are applicable well beyond the patient panel.

Of course, meeting the regulatory burden is impossible in this case, as demonstrated by the HPC. The intent of the DoN regulatory language is clear:

- (i) Applicants must demonstrate need for an appropriately identified patient panel;
- (ii) equity must be reasonably assured;
- (iii) the project as compared to and measured against competitors in the system must demonstrate that it is in line with multiple measures related to health care costs
- (iv) the proposed project must contribute the Commonwealth’s cost containment goals meaningfully, and be part of transforming the health care landscape in a way that does no harm to well-functioning elements of the system and that ensures equitable allocation of resources; and
- (v) if there is an ICA, it must further demonstrate the project’s consistency with the Commonwealth’s efforts to control costs - such as by meeting the state’s health care

update) (clear and convincing proof “must leave no substantial doubt in your mind. It is proof that establishes in your mind, not only that the proposition in issue is probable, but that it is highly probable”).

¹⁴ “If the Proposed Project is for a new facility and there is no existing patient panel, Patient Panel means the anticipated patients”. 105 CMR 100.101. But MGB included its entire patient panel from every provider entity in the system even if a patient only received care on one occasion, still yielding the small Westborough panel as compared to its facility size.

cost benchmark, preserving community hospitals and supporting low-cost high value care.

This is a highly unusual and unprecedented DON Application due to its scope and due to the market dominance of the Applicant¹⁵ and the irreversible and State-wide impact of the Proposed Projects. By and large, most DoN applications are for discrete capital projects which do not have significant ramifications beyond an applicant's own operations, and thus not requiring an extensive analysis of each of these factors. The Application, however, is like no other application ever to come before the Department and, as such, cannot possibly be reviewed in the manner that the Department analyzes discrete capital projects. The optional ICA provision exists precisely for this reason, recognizing that different DoN applications call for different levels and types of scrutiny. In a case such as this involving Proposed Projects that will restructure the Commonwealth's health care landscape entirely, the Department must ensure that the Applicant has satisfied its burden to demonstrate with clear and convincing evidence that it has satisfied each factor in the regulations. To reach such a conclusion, the Department would have to disregard the disclosures contained within the AGO Report, the HPC's Comments and decision to impose a PIP on MGB and other material and relevant information in the public record.

The Department need only find that the Applicant fails with respect to any one factor to warrant dismissing the application. And yet, on the evidence before it, the Department is compelled to find that the Application fails with respect to all or most of the above factors. Uppermost in the Department's consideration must be HPC's findings as the state's foremost independent expert "charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery..." The HPC concluded through its own analysis that the Proposed Project would raise significant costs to the Commonwealth while generating significant losses to safety net providers – wholly inconsistent with both the Commonwealth's health care cost-containment and equity goals. The HPC Comments demonstrate that the ICA utterly failed to fulfill the Department's charge and accordingly should be disregarded. Only by adopting faulty and/or incomplete assumptions that artificially lowered cost projections and minimized related implications for the health care system and patients alike was the Consultant able to reach a conclusion that the Proposed Projects would result in minimal savings with minimal ramifications to affected

¹⁵As shown by recently released financial metrics, the market dominance of MGB is truly staggering. It now has \$16 billion in total assets which is an increase of \$6.3 billion in two years! This amount of increase alone, in these two years, is more than the total net assets of any other system in the state. [Municipal Securities Rulemaking Board::EMMA \(msrb.org\)](https://www.msrb.org/)

providers or other adverse impacts. Even if the Department were to put aside the questionable underpinnings of the ICA's analysis, and the HPC's contrary findings, the Consultant most certainly did not isolate savings that meaningfully contribute to the Commonwealth's cost containment goals.

An ICA can be a helpful component of the DoN review process if conducted in a meaningful way. In this case, despite clear guidance by DPH, the AGO's imperative that a "complete, transparent, and data-driven analysis" be undertaken, and the high evidentiary bar, the ICA does the opposite.¹⁶

In addition to the regulatory failings, the Consultant also failed to heed DPH's specific instructions contained in the SOW which were intended to address key DoN goals and questions arising from MGB's responses to DPH questions and the public comment process. The Consultant was nonresponsive to various individual DPH requests and instructions, and to DPH's general charge that the Consultant thoroughly test information provided and undertake any appropriate independent analysis that the examination called for.¹⁷

In sum, the ICA does not provide a basis on which DPH can determine that the Application meets the regulatory burden for demonstrating compliance with the DoN factors. DPH has an obligation to seriously consider the HPC Comments, and use its full authority to reject or disregard the ICA due to its procedural and substantive flaws as it moves forward with its staff recommendation to the Public Health Council (PHC). The ICA is merely one tool that DPH may employ to help assess whether Applicant's Proposed Projects will meet the regulatory standard. Where it does not serve the purpose for which it was commissioned, as determined by the HPC, DPH can reject the ICA.

In place of the ICA, DPH has much information upon which it can rely in reviewing the Application, including the extensive HPC Comments, the AGO Report, and other reliable and sophisticated data including much information in the public domain, together with DPH's own internal information gathering and analysis.¹⁸ DPH has an obligation to take into account all of the publicly available information, and particularly the materials submitted by the two key regulatory stakeholders in the process, the AGO and HPC, leading to the unavoidable conclusion that MGB has failed to satisfy the factors for approval and that the Application must be rejected.

¹⁶ The also HPC found many methodological questions and concerns (Appendix I.B.) in their review of the ICA results. This further suggests that the ICA results should be disregard, or at a minimum significantly discounted as only one of many inputs in this DoN review process.

¹⁷ **Exhibit 3** highlights the Consultant's procedural and substantive deficiencies with respect to its response to the SOW.

¹⁸ The HPC is well aligned with AGO in its concerns, recommending that Massachusetts "examine provider plans for outpatient service expansions and critically consider how new projects are likely to impact cost, quality, access, and competition in the provider market." [2019 Annual Health Care Cost Trends Report](#).

The Application must be denied since approval of the Proposed Projects would irreversibly set in motion serious harms to the stated goals of the DoN program and the Commonwealth's health safety net system.¹⁹ Such harms are not capable of being mitigated through the imposition of conditions. Even under less challenging circumstances, meaningful and workable DoN conditions are difficult to design to address multi-faceted harms while being careful not to interfere with patient choice and physician behavior. DoN conditions are also difficult to impose because they are static and do not anticipate future changes impacting the health care landscape (e.g. a pandemic). And finally because conditions are typically negotiated to be of limited duration; once they expire, the risks that they were intended to mitigate are likely to quickly be realized. One need look no further that Steward's decision to close Quincy Medical Center after the expiration of the Department's DoN condition requiring that it remain open.

The standard under the DoN regulations is not whether an application that fails to meet the DoN factors can be remedied by the Department through the imposition of conditions. Rather, where as in this case, the Applicant fails to make "a clear and convincing demonstration" that its Application satisfies the regulatory factors, the Application must be rejected. Such a decision to deny the Application would be fully aligned with the HPC's recent imposition of a PIP on MGB and the Department's regulatory obligation to ensure the Commonwealth's public policy goals related to cost containment and equitable access to health care are advanced. Anything short of rejection would be inconsistent with the applicable regulatory standards. In response to such a rejection, the Applicant may develop future alternative project proposals that reflect more cost effective and equitable ways by which it can deliver services to a diverse patient panel with unmet health care needs consistent with DoN regulatory requirements.

II. Detailed Analysis of ICA

Part 1: The ICA Is Exceedingly Narrow, Failing to Account for Secondary & Tertiary Referrals and Backfill:

1. The AGO Report:

As described above, the AGO initiated an independent examination of the cost impacts of MGB's ambulatory care expansion proposal, including a review of internal documents produced by MGB. In what appears to be an unprecedented action, the AGO "determined that disclosure

¹⁹ On the other hand, a final DoN approval of the Proposed Projects would create concerning precedent and open the door to virtually any project. As noted at the HPC Board meeting, consider that MGB's three pending DoN applications are not the tail end of its multi-year expansion strategy – MGB has once again informed investors that its capital capacity well exceeds its capital requests providing flexibility for future projects.

of certain information from our examination [to DPH and the HPC] is necessary to ensure that the HPC and DPH analyses proceed with the appropriate analytical scope and frame” and further stated that limited disclosure from the documents “will promote the health care cost containment goals of the Commonwealth.” The AGO’s limited disclosure specifically described the three proposed ambulatory clinics as “part of a larger multi-year ambulatory expansion plan across Eastern Massachusetts” and it revealed the following from MGB’s 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 any loss of revenues²⁰ resulting from the shift of visits from MGB hospitals to the ambulatory sites.” The AGO Report also revealed the significant market share increases that MGB projected. The AGO stated that it expected DPH and HPC to consider the source of the new referrals and their potential impact on TME.

Notably, the AGO Report described a significant difference in volume estimates²¹ between MGB’s internal projections and the projections contained in its DoN applications, stating, “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.” The AGO also noted that MGB in its recent, confidential report to the AGO did not account for any increase in medical expenditures generated by MGB backfilling its hospitals – a factor also considered by the HPC²².

It further emphasized the importance of a complete and thorough analysis of MGB’s staffing plans, noting “the fact that primary care providers often bring their patient panels with them if they move to a new system” and stating that “[o]ur 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.” (emphasis added).

The ICA entirely ignored the strong recommendations of the Commonwealth’s top legal official and conducted none of the recommended analyses though each fell squarely within the purview of DPH’s SOW. The ICA fails to acknowledge or attempt to explain the vast gulf between its findings of a miniscule 0.1% to 0.3% cost savings and the AGO’s published

²⁰ The Application estimates (based on as of yet unnegotiated rates) that \$7,900,000 will be saved for every 1,000 patients treated at an ACC versus one of its other facilities, and that for CT and MRI services, approximately \$1,750,000 will be saved for every such 1,000 patients.

²¹ Note that MGB’s operating room (OR) throughput and utilization assumptions in the Application (70%) were significantly lower than its 2018 projection of 85%, a common industry efficiency metric.

²² Staff noted at the HPC Board meeting that if patients shift to MGB from other high-cost systems, those systems also would then be able to backfill themselves, further compounding the cost impact.

findings.²³ The magnitude of this omission is made more obvious when one considers MGB's own public statements about its multi-year Eastern Massachusetts commercial expansion strategy.

2. MGB's Own Statements To Investors About Its Planning & Intent Are Consistent with the AGO Report

The ICA's failure to account for referral costs is not only contrary to DoN program goals and the AGO Report, but also ignores MGB's own many public statements over a multi-year period and its accompanying actions. These statements and actions were not only available in the public domain²⁴ but were spotlighted in public testimony and therefore were readily accessible in the public record for review by the Consultant.²⁵

It is clear from its presentations to investors, bond offering documents and related financial disclosures, which present a wholly different narrative from the Application, that MGB has been steadily implementing a multi-year care ambulatory strategy to further increase its share (already the largest in the state²⁶) of lucrative secondary and tertiary referrals in "Eastern

²³ The Consultant only explains when its projections differ from those of MGB.

²⁴ The ICA failed to take account of the vast trove of reliable and useful information in the public records that would be essential to any analysis of the impact of a massive project on health care costs, access and equity including MGB's various approved (See Note 41; **Exhibit 4**) and pending DoN applications, MGB's public statements regarding the pending projects, MGB's own contradictory statements contained in its financial disclosures (bond documents, investor presentations) and press, the public written comments and testimony of MGB and the parties of record; publicly available data (e.g. CHIA, APCD, including data pertaining to community hospitals such as Sturdy that have been impacted by similar MGB projects in their vicinity), and probative governmental reports (e.g. AGO, HPC) regarding health care costs, community hospitals and health equity.

²⁵ See e.g. In the Matter of *Mass General Brigham, Inc. Application for Determination of Need 210121003-AS*, April 6, 2021 Testimony of James Leary, VP Government Relations UMMHC at 1400 West Park Westborough (p 57).

²⁶ *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. <https://www.mass.gov/doc/ago-examination-into-cost-drivers/download>. MGB's hospital pricing is 20% higher and also ranks first in terms of total revenue and total margin. The AGO relies on an extensive public records for this statement. The HPC's October 2021 power point slides on provider price variation (attached as **Exhibit 5**) show that MGB, and particularly MGH, Brigham and Newton Wellesley are some of the highest paid hospital providers in MA from both an inpatient and outpatient perspective. See also <https://search.mass.gov/?q=2021%2Bannual%2Bhealth%2Bcare%2Bcost%2Bchartpack> for the following: MGB's Boston academic hospitals also have the highest FY19 (and FY18) Inpatient Net Patient Service Revenue per Case Mix Adjusted Discharge ("NPSR per CMAD") of the Commonwealth's six academic medical centers (CHIA Acute Hospital Profile Report). According to FY19 CHIA Inpatient Case Mix Data: MGB accounts for 19.6% of inpatient discharges and has \$7.3B in NPSR, almost three times the amount of each of the next few ranked health systems, accounting for over 30% of total operating revenue of all of the state's health systems and hospitals combined; and MGB ranks #1 in both total revenue and total margin compared to all other physician groups with \$2.78B in revenues and a positive 2.7% margin (\$73.9M) based on CHIA FY19 data. See also

Massachusetts”²⁷ by expanding its primary care network. MGB made the firm shift to its ambulatory care strategy commencing in 2015, This strategy may reflect, at least in part, the fact that MGB’s efforts to expand through hospital acquisition was thwarted by attorneys general and other regulators in Massachusetts and other New England states.

MGB’s January 2020 presentation by its chief executive officer and chief financial officer to an audience of investors at the national J.P. Morgan²⁸ Health care Conference describes MGB’s ambulatory expansion as having the goal to “increase network lives and secondary & tertiary commercial referral volume.” According to MGB’s presentation slides, “Tertiary discharges are forecast to grow at a faster pace than secondary discharges in E. MA-” a statement which is accompanied by a pie chart showing that MGB already had 38% of tertiary discharges in the region.²⁹

MGB’s 2020 Presentation³⁰ was apparently the culmination of a long-planned strategy that was laid out to the investor community over a period of years. In MGB’s 2014 presentation to J.P. Morgan, it included a slide describing its “Network strategy” to “Establish ambulatory care centers to support primary care growth in Eastern Massachusetts,” specifically stating that it intended to “Add new primary care providers in key strategic geographies to grow covered lives in Eastern Massachusetts” and “Develop community-based ambulatory care and urgent care centers in strategic geographies.”_ At the time, MGB apparently was still planning to grow its share of inpatient discharges through outside affiliations stating: “Regional ... referrals are a growing source of higher acuity” and “Clinical affiliations throughout New England, ... draw higher acuity cases to Brigham and Women’s Hospital and Massachusetts General Hospital”.

<https://www.mass.gov/doc/final-cmir-report-phs-mee-0/download> for the HPC’s most recent CMIR concerning Applicant.

Finally, from an unadjusted spending perspective, MGB is the system that most exceeds the state health care cost benchmark, twice as high as the next closest health care system, without even taking account of PPO and self-insured plans. See Slide 19 of the HPC Board meeting. [PowerPoint Presentation \(mass.gov\)](#)

²⁷ Eastern Massachusetts, a region that MGB defined in its presentations to investors as early as 2014 as beginning at the Shrewsbury-Worcester line and encompassing the full Westborough PSA, encompasses the wealthiest suburbs in Central Massachusetts where a large proportion of residents are commercially insured. See e.g. MGB’s 2015 J.P. Morgan Presentation (Page 7) and also the aerial map (**Exhibit 6**).

²⁸ J.P. Morgan Securities, L.L.C is one of the underwriters for the two Series 2020 MGB Bonds, as well as the representative of the underwriters of one series and an initial purchaser of both series for retail distribution.

²⁹ Another 38% is split between CareGroup, Lahey, Wellforce & Steward; and 24% is “other”

³⁰ Interestingly, in its January 11, 2021 J.P. Morgan presentation MGB slightly adjusted its narrative. While MGB still makes clear its goal to bring a broader population from the region, leveraging and expanding its reach, it has shifted its narrative to focus on “decreasing demand for high acuity care” and directing all of those anticipated new referrals “to value optimal sites of care”. Perhaps MGB diluting prior statements in light of the expected opposition. ” This narrative shift should be read in the context of the information disclosed in the AGO Report and MGB’s potential anticipation of opposition to its Applications.

As MGB's hospital acquisition efforts were stymied by regulators, MGB refocused its growth strategy. Its subsequent investor presentations illustrate its gradual total shift to seeking greater community referrals through its new ambulatory care strategy. In MGB's 2015 presentation, it included the following heading: "Referral relationships are an important source of high acuity volume," along with the subheading: "Grow regional, national, and international referrals." Thereafter, in a column titled "Regional", it states "Strong source of high acuity volume and margin."

Its 2016 presentation, includes the heading: "Clinical business strategy", underneath which it states "Grow regional, national and international referrals." Later in the same presentation, under the heading of "Strategy to grow regional referrals through key clinical affiliations" it states that regional referrals "draw high acuity cases to BWH and Mass General." This is immediately followed on the next page with a heading stating "Expanding regional share of business driven by loyal network leads to growth of tertiary care" and text that describes "Referral management" as accounting for "~60% of Partners patient revenue."

MGB's commercial expansion strategy appears to be intended to ensure the EBIDA margin increase it forecast to investors. This series of presentations make clear that MGB's strategy is predicated on growing its commercially insured base – already the highest in the Commonwealth – even if doing so is to the detriment of safety net providers who rely on this revenue to care for lower-income communities and particularly to subsidize care for patients covered by MassHealth. As discussed in greater detail below, nowhere does MGB's strategy to grow its patient base to increase secondary and tertiary referrals reflect a commitment to increase the percentage of its patients covered by MassHealth or to address well documented racial disparities in access to care.

3. MGB's Proposed Actions are Consistent with the AGO Report and Statements to Investors, and Simultaneously Inconsistent With Statements In Its DoN Applications - - The ICA's Failure to Address the Inconsistencies is Fatal to its Credibility:

The Consultant fails to recognize that MGB proposes clinics exactly as described in its 2020 and prior J.P. and Morgan presentations, and consistent with the \$385M Eastern Massachusetts market strategy referenced in the AGO Report. Thus, even though it is not stated in the Application, the Proposed Projects itself is consistent with MGB's goal to "Increase network lives and secondary & tertiary commercial referral volume" and to expand its primary care presence in strategic (i.e., wealthy and commercially insured) geographies to thereby increase tertiary referrals. The lucrative nature of tertiary referrals, plus MGB's forecast of growth of such referrals in the region to fill its proposed bed expansions, are consistent with this Application being a key element in the multiyear Eastern Mass ambulatory expansion plan referenced by the AGO.

The ICA fails to analyze how each of the proposed clinics – especially Westborough – is clearly designed and staffed for growth. With respect to size, the Application shows MGB’s Westborough patient visits are 32% of Woburn’s and its patient panel is 41%. Yet it proposes identically sized clinics in both locations (62,000 square-feet). The ICA analysis predicts physician visits at Westborough will be 30.5% the volume of Woburn. (42,267 Westborough, compared to 138,594 Woburn), but fails to question why MGB needs such a large facility in Westborough³¹. Oddly, as shown on the ICA’s Figure ICC28, MGB provides the same staffing estimates by staff type at both the Woburn and Westborough locations³². Either the Westborough physicians and staff will be highly unproductive or the volume assumptions presented and reviewed are grossly understated by MGB. The obvious conclusion is that the Westborough clinic is clearly designed and sized for a future commercial growth strategy consistent with MGB’s J.P. Morgan presentations and the internal MGB studies referenced in the AGO Report, and not to serve an existing regional patient panel. MGB’s ongoing multimedia, multimillion dollar advertising campaign that is bombarding the state is clearly designed to attract new commercial patients necessary to fill the excess capacity in Westborough. The breadth and depth of this mega marketing effort highlights the significance of what this means to MGB from a long-term financial strategy perspective.

It is also important to highlight the Consultant also failed to recognize the disconnect between the physical size of MGB’s proposed clinics and its staffing model versus the present-day realities of health care. The rapid growth of telehealth and hospital at home services since the pandemic has substantially altered the health care landscape³³. The Consultant takes no note of the advent of telehealth³⁴ and its impact at these locations in particular, nor the workforce shortages impacting all Massachusetts providers which further encourage the use of telehealth – even though these topics have been widely discussed by the Applicant including in the connection with the ACCs.

4. Despite AGO Recommendation and Substantial Evidence in the Public Record About the High Likelihood That the Ambulatory DoN Proposal is Intended to Grow

³¹ Note MGB’s convenient response to DPH Question 7a regarding the overall project 14% shift in ASC procedures to the ACCs: “Mass General Brigham did not analyze the above-described shift of ASC eligible procedures on an origin/destination site-specific basis.” It provided the same response to Question 10(b) regarding imaging.

³² The only slight differences in personnel appear to be solely attributable to radiology, which makes sense because Westborough as proposed has 1 MRI and 1CT, while Woburn has 2 of each. But because the buildings are identical it has capacity to add one of each in the future, and specifically said so in the Application.

³³ MGB response to DPH Question 1 makes reference to telehealth now being able to be deployed to serve remotely the growing Medicare population that they had predicted will be significant users of the ACCs: “... will allow for more services that can be provided to the Patient Panel who can, at times, have trouble going into their provider’s office, including older patients and those with complex conditions, which may reduce mobility.”

³⁴ [Ensuring Health Care’s Innovation Boom Benefits All Equally | GIANT Health Event 2022](#); [Hospital Exec Checks In On Care Landscape, Virus Fight - The New England Council | The New England Council](#)

Commercial Referrals to the Commonwealth's Two Highest Cost Hospitals, the ICA Provides No Analysis of the Cost of Such Referrals:

The Consultant failed to consider the AGO Report and the extensive public record confirming that MGB's intended goal is to grow commercial referral volume to MGB's two academic medical centers through the ACCs. The Consultant ignored that the AGO Report urged HPC and DPH (for whom the ICA was allegedly done) to perform a "complete, transparent, and data-driven analysis" and that it insists that thorough scrutiny of the information exposed in its report "is necessary to ensure that the HPC and DPH analyses proceed with the appropriate analytical scope and frame." This is especially egregious considering that the AGO can only disclose this information "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" of MGB.³⁵ It is a disservice to the state entities with primary responsibility to review the Application (DPH and the PHC) as well as to the other state entities who are designated parties of interest (the AGO and HPC) and the Massachusetts residents they serve to disregard the AGO's charge.

Moreover ignoring secondary and tertiary referrals is inconsistent with explicit language of the DoN regulations. The regulations at 105 CMR 100.001 requires a review to "... ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost advancing the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation. How can the ICA possibly assist DPH and the PHC to determine impact on statewide aggregate cost and TME without considering the total aggregate cost of the proposal under consideration? This omission is compounded by MGB's own statements that referral management accounts for approximately 60% of its patient revenue (2016 J.P. Morgan presentation) and that its proposed "expansion of outpatient services in regional network" is intended to "increase network lives and secondary & tertiary commercial referral volume." (2020 J.P. Morgan presentation).

The ICA does not take note of the fact that the Westborough clinic is not located where it would be most convenient for the highest concentration of MGB's existing patient panel, approximately 50% of whom live in the easternmost portion of MGB's self-identified PSA.³⁶ Instead, the Westborough is located where it would attract new (non-MGB) commercially insured patients residing further west in high income towns with a high commercially-insured population where MGB currently serves a lower proportion of patients³⁷. The ICA also ignores

³⁵ Mass. Gen. Laws ch. 12C, § 17.

³⁶ See MGB's response to DPH Factor 1 Question 1 (pg.2).

³⁷ See prior UMass TTG comments dated April 14, 2021: "MGB has strategically located each of the three proposed ambulatory facilities in predominantly upper income areas with high rates of commercial insurance, low

the impacts of past similar MGB expansions that should contextualize and shed light on the pending Application (e.g. MGB's siting of a new ambulatory care center in Foxborough and its impact on Sturdy Memorial Hospital's loss of commercial referrals).³⁸

MGB's own projections of the growth of secondary and tertiary referrals to its hospitals (with proposed new beds) that will arise from the Proposed Projects results in millions of dollars of increased commercial TME for the Commonwealth. The AGO Report states that MGB expected referrals from Eastern Massachusetts to its hospitals to increase its share by as much as 2% for secondary admissions and 4% for tertiary admissions, which HPC estimates half of which would come from the ACCs generating approximately 712 to 2,849 new commercial discharges and increasing commercial spending by \$4.5M to \$17.9M. (HPC p. 22).

The ICA's omission of the financial impact on non-MGB health systems is glaring. The AGO Report stated: "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." The projected annual incremental profit margin of the Eastern Mass ambulatory expansion proposal of which this DoN is a part is \$385 million, which is derived from a combination of (i) new patient volume to be pulled out of existing community providers, (ii) the higher proportional of commercially insured within that group of patients that MGB expects to attract due to its strategic siting, clinic licensure and marketing; and (iii) MGB's dramatic relatively higher pricing margin. But there is a high likelihood that non-MGB health systems could lose substantially more as a result of MGB's three Proposed Projects. For example, community hospitals and safety net providers may be unable to backfill lost patient

social vulnerability index and low rates of family poverty." For example, MGB has done so in its Foxborough satellite where 5 of the towns served have the following demographics: median household income of \$96,062, an average poverty percentage of 5.3%, and an average White alone percentage of 81.8%. Compare this to the towns located in the MGBs proposed Westborough location where they have the following: a median household income of \$112,153, an average poverty percentage of 4.2%, and average White alone percentage of 88.8%. [FY19-Massachusetts-Hospital-Profiles-Compendium.pdf \(chiamass.gov\)](#)

³⁸ UMASS TTG March 12, 2021 comments (F.N.) "As Sturdy Memorial Hospital had forewarned in testimony and public comments submitted to the Department, based on FY16 to FY19 CHIA Inpatient Case Mix data results for the 18 different towns in and around the Foxborough location, the overall Commercial and Medicaid market grew by 149 and 31 discharges respectively. MGB was able to increase its commercial inpatient referrals from these town by 498 discharges while lowering their Medicaid referrals by 242 discharges. In contrast, Sturdy Memorial and Steward Norwood Hospital both experienced increases in Medicaid discharges of 171 and 87 respectively, with Steward Norwood Hospital significantly affected by lower commercial discharges of 218."

In addition, in MGB's own words, ASCs "may attract away significant commercial outpatient services traditional performed at hospitals. Commercial outpatient services, currently among the most profitable for hospitals, may be lost to competitors... Full-service hospitals rely upon the revenues generated from commercial outpatient services to fund other less profitable services, and the decline of such business may result in a decline in operating income... Consequently, hospitals are vulnerable to competition from ambulatory surgery centers." See Official Statement for the \$304,885,000 Massachusetts Development Finance Agency Revenue Bonds, Mass General Brigham Issue, Series A (2020) p. 8 <https://emma.msrb.org/ER1305791-ER1017935-ER1423610.pdf>.

volume or backfill lost commercially insured volume with MassHealth or Medicare volume resulting in lost revenue and an inability to cover fixed costs (staff, equipment, utilities etc.). This dynamic can create a financial downward spiral as community and safety net providers experience diminishing margins resulting in access to less capital to invest in staff and facilities to remain competitive to attract commercial volume. As note in the AGO Report: “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” (emphasis added).³⁹

The HPC’s recently released analysis of MGB’s proposed expansion is consistent with the information disclosed in the AGO Report, and conflicts with the ICA’s prediction of “a small overall **decrease** in health care expenditure”. The HPC “not only used publicly available data, but also “worked closely with economists, actuaries, accountants, and care delivery experts to conduct its analyses.” (HPC p. 12) It highlighted using “conservative projections” (HPC p. 4) in determining that MGB’s proposed expansion is not consistent (HPC presentation slides p. 62) with the Commonwealth’s goals for cost containment. The HPC’s financial review is more consistent with the regulatory framework and scope of review the ICA should have conducted -- exploring all the different factors that impact health care total medical expense (TME).

Through its work HPC has determined a conservative yearly TME increase in the range of 46.0 million to \$90.1 million (HPC p.4), which comes from increased referrals, increased market share capture, and increased rates above those charged by the local competition. The HPC acknowledges in its report that it only presented estimates on those areas of TME that could be confidently assessed, suggesting the potential impact of MGB’s Proposed Projects could be even greater had the HPC had access to other non-publicly available sources of information to which the AGO and DPH do have access.

Additionally, unlike the ICA review, the HPC also evaluated the financial impact that the Proposed Projects would have on local competition and the potential long-term harm it could have on health equity across Massachusetts. The HPC’s review has estimated that a “loss of substantial” revenue (HPC p. 32) would be experienced by local competition, including community hospitals and safety net providers, that would result in decreased commercial annual revenues of \$152.9M to \$261.1M. According to HPC, much of the loss of revenue is attributed to MGB’s targeted approached to high margin service lines such as imaging and surgical services. As illustrated in CHIA’s Massachusetts Hospital Profile results for fiscal year 2019, AMCs rely less on outpatient services to support their financial operations (on average about 57% was for outpatient activity) than do community hospitals for whom outpatient services which can represent 68% -73% of total hospital revenue, highlighting that community hospitals are most likely to be negatively impacted

³⁹ See also Note 72.

by MGB's proposed three ambulatory sites. The HPC findings confirm our assessment that MGB's cherry picking of commercial revenue will result in lost commercial revenue significantly impacting local High Public Payer safety net providers' ability to generate the margins needed to support investments in much needed programs, aging facilities, and staff. This dynamic will only lead to worsening health equity issues that impact the local health of patients throughout Massachusetts⁴⁰.

5. The ICA Does Not Analyze, Nor Even Acknowledge, the Cost of Backfill in MGB Facilities from Which It Purports Its Existing Patients Will Migrate:

One would assume that MGB would have addressed in the Application its plans to make use of freed up capacity resulting from existing MGB patients it expects will be decanted to the new ACCs. One also would assume MGB would address this basic "patient panel need" factor in its other pending DoN applications to explain why the additional capacity being sought in those applications is still needed over and above the proposed additional capacity to be freed up via the Application, and over and above the additional capacity created via the many recently approved DoN projects already within MGB's under its ever expanding universe.⁴¹ An "independent consultant" would be expected to probe this seemingly obvious question.

Consider MGB's projections: For physician services alone, the application projects 42,267 visits in Westborough and 138,594 in Woburn. Nearly all are projected to come from MGB's existing patient panel. (If we add the number of visits for Westwood and add visits for services such as MRIs and CT scans, the magnitude of this omission becomes even larger). Even with this massive migration, the ICA assumes MGB will not backfill newly freed capacity at its acute care facilities with new patients, contrary to the HPC's finding. Yet backfilling is a near certainty as MGB alleges excess demand for its imaging services. And since the Consultant considers MGB as capacity constrained (whether or not that is accurate in light of its vast and continuing suburban spread and burgeoning growth in Boston), backfilling is consistent with that opinion.

Since the facilities where these patients presently receive care are by far the most expensive in the Commonwealth, the cost of backfilling freed up capacity with new patients must be considered in order to understand the full picture of what the Proposed Projects will set in motion. A "complete, transparent, and data-driven analysis" would have to account for these costs.

⁴⁰ See [DoN Question Responses for Multisite - 21012113-AS \(mass.gov\)](#)

⁴¹ See Exhibit 4 for summary chart of MGB service expansions commencing in 2018.

In past MGB applications for suburban expansions, MGB typically has referenced freeing up capacity in prior DON applications for suburban expansions⁴². The omission in this Application is inexplicable. In response to DPH questions regarding which of its locations do and don't have excess capacity, MGB reiterates that it did not conduct a system-wide analysis to determine patient panel need but rather has developed the Proposed Projects to ensure that each location has a full complement of care for the optimal delivery of health care rather than focusing on patient panel need. MGB's approach could be viewed as contrary to the DoN program goal of ensuring equitable access to health care resources.

Analysis, Part 2: ICA's Error of Narrow Scope Is Compounded by Its Acceptance of Highly Dubious Assumptions of the Applicant

1. The ICA Accepts MGB's Highly Dubious Assumptions About Migration of Its Own Patient Panel

An ICA is not intended to be a purely academic study about what happens under idealized and artificial conditions that are not subject to change. An ICA should not accept as givens the self-serving and unsupportable assumptions of the Applicant without proper vetting and analysis⁴³, and should take account all publicly available facts.

⁴² See e.g. page 5 of the [2018 MGPO Waltham CT and MRI](#): "The addition of two 3T MRIs and one 384-slice CT scanner at MGPO Waltham will allow the Applicant to meet the growing demand for MRI and CT services, accommodate more patients in Waltham while alleviating some of the volume at MGH's main hospital campus and freeing up resources for patients that require care in the hospital setting."; and Page 11 of the [2019 MGPO Somerville MRI](#): "The anticipated transfer of utilization to the proposed new MGPO Assembly Row MRI units will relieve some of the capacity constraints and wait times currently experienced at MGH's main campus, thereby freeing up hospital resources for more critical patients that require immediate attention and access to imaging technology. In turn, this will result in shorter wait times to the next available appointments across MGH's and MGPO's imaging locations as demand continues to grow into the future and will ensure that patients receive care at the location best-suited to meet their specific medical needs."

⁴³ See also the ICA's deficiencies with respect to the SOW detailed in **Exhibit 3**: Regarding the Consultant's questionable use of research. For example, the Consultant adopts the assumption that salaried "Physicians who are paid for each service that they provide may be more susceptible to financial motivations than salaried physicians—such as those employed by MGB." The cited article (ICA Footnote 178) makes the claim that employed physicians are less likely to be high follow-up physicians (no support provided). Compare this, however, with the cited 2021 research at paragraph 155 of the ICA where the authors suggest that physicians who are employed by a hospital system may be more likely to refer their patients for services that benefit the hospital financially. The odds of a patient receiving a referral for an MRI increased by 31 percent, relative to a comparison group, following hospital employment of the patient's physician, while the likelihood of receiving an inappropriate referral increased by 22 percent, relative to the comparison group. MGB's in-network referral patterns by MGB employed and community affiliated providers should be examined by the Department. On information and belief, there is extensive pressure and incentive for MGB providers to refer in network.

a. Patient Panel Size:

The Application broadly defines who is in the patient panel as all of those individuals who reside in the respective primary service areas of the Proposed Projects. It does so irrespective of the degree to which an individual patient is actually tied to the system. For example, a patient could have received a single service (such as for a second opinion or an out-of-the-ordinary consult) and be considered part of the Applicant's patient panel. MGB's definition of its own Patient Panel is over inclusive in that it counts individuals accessed a service not only at MGB's Metro Boston hospitals, but also at MGB providers located nowhere near the ACCs or providing specialty services that attract patients from outside the MGB system.⁴⁴ For example, a resident of Marlboro who received emergency services at Nantucket Hospital during a vacation stay would be considered part of the MGB patient panel for Westborough. Moreover, MGB includes patients who already receive care at MGB's other existing suburban sites within its projections undercuts its argument that the Application is purportedly about shifting care from Boston hospitals to the ACCs⁴⁵ In sum, rather than develop a reasonable and factually based patient panel estimate for the three new sites (based in part on MGB's own vast experience in establishing new sites similar to the Proposed Projects), MGB vastly inflates the potential patient panel to serve the purposes of the Application.

Despite contrary publicly available information, the disclosures within the AGO Report and the actual terms of the SOW, the ICA accepts MGB's methodology as valid for the purposes of analyzing the cost ramifications and the impact on other providers. Thus, the Consultant's premise is that patients residing in MGB's identified PSA who may have only received care on one occasion from an MGB provider, and do not have an MGB PCP, are MGB patients -- and will get care at MGB 50% of the time. It is inexplicable how the Consultant could rely on such a critically important assumption without question or analysis, as in reality such patients may (and probably do) have a PCP or primary site of care elsewhere. It has been documented that patients may receive care from multiple provider systems.⁴⁶ At a minimum, prior to accepting the ICA the Department should require further critical analysis of this fundamental issue underlying the ICA's conclusions.

b. Patient Panel Behavior:

⁴⁴e.g. Footnote 3 of the Application includes: North Shore Medical Center, Cooley Dickinson Hospital, Martha's Vineyard Hospital, McLean Hospital, Nantucket Cottage Hospital, Massachusetts Eye and Ear Infirmary, Spaulding Rehabilitation Hospital (excluding data for certain programs), North Shore Physicians Group, Cooley Dickinson PHO.

⁴⁵ e.g. per MGH response to DPH Question 4(a): "Newton Wellesley,...Salem Hospital, Mass Eye and Ear, BWH Foxborough, MG Waltham, and MGH Danvers."

⁴⁶ See <https://www.usnews.com/news/health-news/articles/2021-11-02/almost-1-in-3-us-seniors-now-sees-at-least-5-doctors-per-year> (quoting Alice Bonner)

Again, in total disregard of its obligations, the Consultant accepts the following extreme and unsupported assumptions from MGB's DoN application:

- (1) the utilization rate of the Patient Panel will be 70%;⁴⁷
- (2) 100% Patient Panel members with an MGB primary care provider (which MGB claims is 56% of the panel) will transfer their care to the ASC; and
- (3) 50% of the other Patient Panel members will get care at the ASC also.

MGB's prediction that 100% of patients residing within the PSAs with an MGB PCP will transfer to a new location belies common sense, especially as MGB has not disclosed how they plan to staff their new ACCs. If MGB staffs the ambulatory sites with new PCPs, existing MGB patients may elect to remain with their existing PCPs. If MGB relocates PCPs from other MGB sites to the new locations, patients with current MGB PCPs may still opt to not transfer the location of their primary care. They may remain at their existing locations if they are convenient to work or for a multitude of other reasons. It also assumes that all panel members without an MGB PCP (category 2 above) who reside in towns on the eastern edge of the PSA (Framingham, Ashland) will switch to a new PCP in Westborough despite the likelihood that many if not a majority of working patient panel members commute east and may prefer to see providers near their place of employment." Furthermore, to truly assess the validity of MGB's assumptions and potential impact on costs, the Consultant should determine what percentage of the purported patient panel currently receive PCP care at either MGH West or NWH as opposed to BWH or MGH. Moreover, as noted above, many "patient panel members" without an MGB PCP could have received only a one-time service (scan, emergency services or surgery) at MGB yet incredibly, the ICA uncritically accepts MGB's assumption that such a patient is a part of MGB's patient panel and will access MGB services on a regular basis. The Consultant's failure to question MGB's assumption again undermines the credibility of its analysis and conclusions. Additionally, if HPC's observations around MRI and CT referrals in the Waltham area are accurate, it would suggest about 27% of the commercial volume would be performed at a MGB hospital not the new ACCs. MGB's assumptions ignore how much patients value their relationship with their own PCP and where their PCP wants them to have their surgery. Despite

⁴⁷ "For the purposes of this Application, however, the Applicant has elected to use a conservative projection of the volume of Clinical Services that will be provided to the Patient Panel at the Project Sites. First, the Applicant has assumed that by the end of a 3-year ramp-up period only seventy percent (70%) of the Patient Panel will choose to access Clinical Services at the Project Sites (the "Projected Utilization Rate"). The Projected Utilization Rate was derived by assuming that (i) one hundred percent (100%) of the members of the Patient Panel who have a Mass General Brigham primary care provider and (ii) fifty percent (50%) of the other members of the Patient Panel who have received specialty care or ambulatory surgery services from a Mass General Brigham provider will transfer their care to the Project Sites." DoN Application, Attachment 1, page 8 (page 24 of consolidated online PDF). This estimate was later revised by MGB in its responses to DPH to 78%

how preposterous these assumptions are, the ICA simply accepts them as true without serious consideration of the evidence to the contrary.⁴⁸

2. The ICA Accepts Dubious Assumptions About Migration of Non-MGB patients

The Consultant ran two models of analysis to predict how non-MGB patients in the PSAs will react to the presence of a new ACC: The first scenario assumes, with no justification, that only MGB patients will obtain their care at the proposed sites with no patient migration, and the second assumes migration of non-MGB patients at the levels predicted by MGB in the DoN application. MGB's investment of millions of dollars in an aggressive advertising campaign to attract patients to its new facilities undercuts the credibility of the Consultant's conclusion that the choices of most patients would be unaffected by the entry of the Proposed Integrated Care Clinics (ICA p.89).

On the other hand, acceptance of MGB's migration and volume assumptions ignores material evidence to the contrary that demonstrates that even MGB itself anticipates different outcomes, including the AGO Report; MGB's presentations to J.P. Morgan; the size of the proposed buildings versus volume of estimated patient visits, and the number of staff versus the volume of patient visits.⁴⁹ The Department should not accept the ICA without further analysis by the Consultant to critically test and validate these core assumptions underlying its conclusions.

3. The ICA Accepts MGB's Assertions About Price, With No Serious Analysis About the Validity of the Assumptions

The Consultant conducts no analysis of MGB's assertion that the ACC prices will be 50% of MGB's academic medical centers rates and 75% of its community hospital rates. Instead, the Consultant categorizes MGB as a new entrant to the affected markets, and as a result summarily concludes based on general antitrust economic literature that new entrants lower prices through creating more competition. However, MGB already serves patients in these areas and indeed is arguing that the sole purpose of its Application is to continue serving its own existing patients. As observed by the HPC, given actual Massachusetts market dynamics it is impossible to characterize MGB as a new entrant. Recognizing that MGB is far from a new entrant but rather, by its own terms, an established provider in the relevant market it is necessary

⁴⁸ For example: ICA paragraph 78 states the following regarding its methodology: "We calibrate the demand model so that when these new facilities open, they perform the exact number of CT and MR scans specified by MGB in its DoN application submissions, *i.e.*, we assume that the new facilities meet MGB's volume projections." Paragraph 79 states: "... the predicted number of CT and MR scans performed at the facility match the volumes projected by MGB in its DoN application submissions." And Footnote 94 states: "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."

⁴⁹ Patients who are unwilling to switch may end up switching if MGB recruits their physicians

to evaluate its expansion through a different economic lens. MGB already consistently receives the highest commercial payer rates due to its market leverage. As a result of its dominant market position, excessively high-rate structure, avoidance of Medicaid patients and cherry picking of commercial volume, MGB has been able to accumulate financial resources that dwarf those of all of its competitors. MGB now seeks to leverage those resources to further its market dominance and squeeze out its competitors who serve a disproportionate share of public payer (and particularly Medicaid patients). This is not fair pro-competitive behavior by a new market entrant.

Any shift of commercial volume is relevant, even using the artificially low assumptions of non-MGB patient migration, because of cost increases that would accompany the shift in patient panel from lower cost providers. In fact, the HPC demonstrated through its review that even small increases in market share are desirable for MGB on account of its inflated rates. Slide 77 of the HPC Board presentation demonstrates that even where MGB may have lower market share measured by volume (following the BILH merger), it is still the market share leader based on net patient service revenue⁵⁰.

At a minimum, the ICA should have tested the impact of different pricing assumptions for the Proposed Projects rather than simply adopting MGB's assumptions that rates would be 50% of the AMC rate and 75% of the community hospital rates. MGB is not an average provider or a new market entrant. It has tremendous brand strength,⁵¹ already controls 38% of the Eastern Massachusetts market (MGB 2020 J.P. Morgan Presentation, page 11), and is two times larger than the next four systems in Massachusetts combined.⁵² Due to its dominant position in the Massachusetts market over all, MGB has successfully used its leverage with insurers,⁵³ and is by far, the highest priced system in the Commonwealth.⁵⁴ MGB has significant power to negotiate high rates with health plans because of its control of two premier academic medical centers in Boston and an extensive network of primary care and specialty physicians associated with those hospitals. MGB can demand that health plans accept high rates at the

⁵⁰ [PowerPoint Presentation \(mass.gov\)](#)

⁵¹ MGB touts brand motivation as a significant factor in developing its assumptions about use (50%) of the ACCs by patients without an MGB PCP. See MGB response to DPH Question 3B. See also <https://healthcareappraisers.com/the-value-of-branding-in-health-care/>

⁵² Cited at the HPC Board meeting. Note MGB's FY20 assets were 10X the size of UMMH; 15X the size of Wellforce; 3.5X the size of BILH; In FY21 MGB reported increases of Net Assets of \$5.5B from FY20, bringing MGB's net assets now compared to local health systems at 11X the size of UMMH; 16.5X the size of Wellforce; 4X the size of BILH

⁵³ See e.g. <https://www.beckershospitalreview.com/finance/mass-general-president-size-helps-partners-set-high-prices-for-insurers.html>. As discussed in the UMass TTG April 14 public comments, MGB can leverage its market dominance to cross traditional geographic boundaries in a predatory manner that will destabilize safety net and community providers, e.g. by tying its new facilities to its must-have Boston hospitals. The Proposed Projects may lead to cross market price effects due to MGB's increased leverage in statewide payer contracts.

⁵⁴ See also Note 26

Proposed Projects by threatening to withhold MGH and BWH from any health plan that refuses those high rates. Health plans without MGB's flagship Boston medical centers would face significant challenges in the marketplace. Consequently, MGB's assertions that it is going to offer the Proposed Projects at steeply discounted rates strains credulity.

MGB's unique characteristics as compared to other Massachusetts health care systems, make the studies cited by the Consultant either unreliable or entirely inapplicable, as noted in the HPC Comments. The Consultant's reliance on research regarding new market entrants is inappropriate given the fact that MGB already has 38% of the relevant market and is asserting that its expansion is solely for the purpose of serving its existing client base. The Consultant's unquestioning acceptance of MGB's assertion that it is "capacity restrained" also must be critically reviewed in light of MGB's size and the approved DoN projects coming online (e.g., Somerville MRIs, Newton-Wellesley CT). There is little if any support for the ICA conclusions regarding downward price pressure given MGB's existing physician and facility costs, expected backfill and dominance of the health care delivery marketplace.

4. ICA Neglects to Account for Physician Costs

Under the DoN regulations and the expenditure thresholds that DPH updates annually, all clinic ambulatory costs are to be included in the DoN Factor analysis, inclusive of physician⁵⁵ costs. Although this was required, and the Consultant did in fact consider such costs in connection with MGB's Faulkner application, it did not do so in connection with the ambulatory Application. The ICA completely ignores the professional services that will be offered by MGB physicians at the clinics, and does not consider that MGB's rates for those services will be much higher than the rates of non-MGB physicians. MGB physician rates are the highest in the Commonwealth,⁵⁶ and therefore its failure to include an analysis of physician costs necessarily means that the Consultant's conclusions about the amount of savings are inaccurate as a result of the exclusion of these costs.

If MGB's share of physician visits from the Westborough service area increase as rapidly as its share of ambulatory surgery and imaging services, MGB will capture an additional 15,000 to 25,000 physician visits.⁵⁷ Of course, if the physician visits volume at the Westborough center is comparable to that of the Woburn center (which MGB clearly considers likely given that it is building the two centers precisely in the same size and intends to staff both with equivalent

⁵⁵ Which also should take account of costs associated with community physicians that engage in payer contracting through MGB.

⁵⁶ See also Note 26

⁵⁷ MGB reports 55,385 physician visits from the Westborough area (MGB Response to DPH Question 3.a.), and the ICA indicates its patient volume for ambulatory surgery and imaging would increase by 28% to 46% (ICA Figures ICC13, 14, 17).

numbers of physicians and staff), then MGB's physician visits would increase by 96,000. Shifting such a large number of visits from non-MGB to MGB physicians will have an impact on TME in the Commonwealth that is not addressed in the ICA. More fatal to the Application's ability to satisfy the requirement that it meet the cost containment DoN factor is the recognition that "MGB primary care patients have persistently higher spending than primary care patients of the vast majority of other provider systems in Massachusetts" (HPC, page 16).

5. The ICA Only Analyzes a Small Subset of the Services That MGB Will Offer at the Clinics

The ICA acknowledges that the clinics will provide primary care, psychiatry, radiology, anesthesiology, otolaryngology, general surgery, gastroenterology, ophthalmology, orthopedics, orthopedic surgery, spine, pain management, urology, physiatry, rheumatology, allergy/immunology, cardiology, dermatology, endocrinology, neurology, neurosurgery and pulmonary.⁵⁸ Despite this wide array of services, the entire cost analysis focuses only on surgery, CT imaging and MR imaging, without analysis of costs associated with other service lines or other diagnostic services. The DoN regulations apply to substantial capital expenditures for clinic services regardless of whether categorical DoN services are included. Surgery and high-end imaging are just a small part of the Application and the potential impact on TME. Consider, for example, the large number of physician visits, other imaging, labs and other procedures to be provided at the clinics, as discussed above.

Analysis, Part 3: The ICA is Based on Outdated Information Concerning Labor and Construction Costs

1. Impact of Inflation Upon Construction Costs and Wages is Ignored in the ICA

The Consultant failed to take into account the fact that the information provided by MGB in the Application is now out-of-date given extraordinary recent inflationary, staffing and COVID-related developments. A Proposed Project's maximum capital expenditure should be evaluated based on current publicly available information.

MGB's President & CEO, Dr. Anne Klibanski, testified at the Health Policy Commission Cost Trends Hearing on November 17, 2021⁵⁹: "Inflation is 6 percent ... and that affects everything: supplies ... energy, transportation, but also wages." Price increases in construction materials are in part the result of supply chain delays and resulting reduction in access to

⁵⁸ ICA paragraphs 17 and 175.

⁵⁹ See Cost Trends Hearing testimony at: <https://www.youtube.com/watch?v=7s41S8v7cdY>.

materials.⁶⁰ This information should be incorporated into the financial analysis of the Proposed Project.

2. The ICA Fails to Consider the Impact of COVID-19 Pandemic on the Health Care Workforce Supply

The ICA's conclusion that Massachusetts has a sufficient supply of health care professionals and other workforce is mindboggling and out of touch with the reality of health care in Massachusetts and the nation. Not a day seems to go by without several articles appearing about the health care workforce shortage, now a full-blown crisis due to the effects of the pandemic (e.g. early retirements, career changes and need to rely on temporary staffing) and the aging of the health care workforce.⁶¹ Dr. Klibanski pointed out in her HPC testimony that wage inflation is especially relevant because wages account for over 50% of the cost in health care⁶². Wages have been impacted by the need to pay greater incentives to the workforce to retain and recruit personnel

The ICA superficially acknowledges that "there is widespread concern regarding worsening shortages for many types of health care professionals"⁶³ but then pivots to rely upon outdated studies that mostly predate the pandemic for its workforce analysis, providing no consideration or analysis of newer studies, as well as licensing board data.⁶⁴ MGB's own CEO Dr. Klibanski's asserted in her HPC testimony that data sources that precede the pandemic are no longer reliable, stating: "2021 looks so different from the period of time captured in so much of the data presented this morning," and "we need to have a conversation based on the realities of 2021 where our healthcare landscape is very different." Regarding the health care workforce crisis specifically, she stated: "all of us ... are dealing with a serious shortage of healthcare

⁶⁰ See e.g. <https://www.hfmmagazine.com/articles/4347-covid-19-and-construction-costs>

⁶¹ For example:

- [Biden-Harris Administration Awards \\$103 Million in American Rescue Plan Funds to Reduce Burnout and Promote Mental Health and Wellness Among Health Care Workforce | HHS.gov](#) (HRSA Press Release January 20, 2022)
- https://www.statnews.com/2022/01/19/covid-19-no-longer-biggest-issue-facing-hospitals-staffing-is/?utm_source=STAT+Newsletters&utm_campaign=a5b4d7f9d5-Daily_Recap&utm_medium=email&utm_term=0_8cab1d7961-a5b4d7f9d5-105698109

⁶² See Cost Trends Hearing testimony at: <https://www.youtube.com/watch?v=7s41S8v7cdY>.

⁶³ ICA, paragraph 169

⁶⁴ For example: Trusted Health, *2021 Frontline Nurse Mental Health & Well-being Survey*: "Nearly half of nurses are less committed to the profession than they were before the pandemic, and many are considering leaving the workforce. This finding was particularly pronounced amongst nurses under 40. Nurses between the ages of 20 and 29 and 30 to 39 were 24 percent and 15 percent more likely to report that their commitment to nursing had decreased, respectively;" U.S. News & World Report, *U.S. Faces Crisis of Burned-Out Health Care Workers*, Nov. 15, 2021, citing Dr. Victor Dzau, president of the National Academy of Medicine, as the source for statement that 20% of health care workers have quit during the pandemic.

workers and a very markedly diminishing pipeline for them,” and pointed out that “since 2019, healthcare vacancies have increased by 9 percent and our nursing vacancies are up 41 percent.” In terms of the long-term prospects for health care institutions confronting this ongoing crisis, she conveyed that “the workforce challenges are only going to get worse and we are continuously struggling against that.”

By ignoring the workforce crisis described by Dr. Klibanski and how exceedingly difficult it is to fill positions, the ICA misses a critical point: to staff its new facilities with the number of personnel it has said it will need to hire⁶⁵, MGB will need to recruit most of its workforce away from local providers. There simply is no place else to find so many licensed staff who remain in their profession post-COVID. This means that local hospitals with less financial resources than MGB, all of which already face their own staffing crisis (which in turn contributes to the inpatient capacity crisis), will see that crisis worsen as MGB leverages its overwhelming financial resources to recruit staff away from local community and safety net providers.

Analysis, Part 4: The ICA Fails to Take Into Account the Negative Impact on Safety Net Providers and Health Equity

1. The ICA Fails to Analyze the Impact That Commercial Patient Migration Away from Local Providers Will Have Upon Their Fiscal Viability and Ability to Cross-subsidize Safety Net Care

As discussed above, the ICA dramatically underestimates commercial patient migration away from local providers to MGB, despite multiple red flags, including: DPH’s own regulations which limit the siting of ASCs, the AGO Report; MGB’s J.P. Morgan presentations; the size of the clinics versus the volume of estimated patient visits; staffing volume versus the volume of estimated visits; and an ongoing and relentless multimillion-dollar advertising campaign by the Applicant. The AGO Report is especially relevant: It reveals that MGB’s internal report in which MGB forecasts a \$385 million incremental annual profit from its Eastern Massachusetts ambulatory expansion plan predicted an 85% operating room utilization. By contrast, in its DoN application, MGB used 70% as the utilization rate for these facilities, leading the AGO to state that “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.” At a minimum, the Department should require the Consultant to address this question before accepting the ICA.

Even with its underestimate of patient migration, the ICA fails to analyze the impact of the predicted migration upon local providers’ ability to offset losses from treating MassHealth or

⁶⁵ e.g. MGB confirmed in its response to DPH Question 1: “Mass General Brigham IC will be hiring primary care providers (“PCPs”) at each Project Site.” Also in response to Question 15(c): “Demand for primary care physicians is high”.

uninsured patients, or upon their continued capacity to achieve their safety net missions. For example, utilizing MGB's own assumptions, it concludes that UMass Memorial Health will lose 4.3% of its share of CT scans in the Westborough PSA and 1.9% of its share of surgery but with no analysis of the fiscal impact this shift would have on UMMH. Safety net hospitals such as UMMH incur substantial financial losses from fulfilling their missions⁶⁶, particularly resulting from low Medicaid reimbursement rates and from caring for the uninsured, and they rely upon revenue from commercial patient volume to subsidize these losses. UMass Memorial Health is the primary provider of safety net health care in the Central Massachusetts region and Marlborough Hospital is a safety net hospital in the primary service area of the proposed Westborough clinic⁶⁷. Even loss of this volume predicted by MGB itself, not taking into account the additional loss of commercial volume in the nearly one-dozen service lines that will be offered at the Westborough clinic but were not analyzed by the Consultant, will impact the ability of these two High Public Payer hospitals to cross-subsidize safety net care.

An ICA that fails to estimate the monetary impact of lost commercial patient volume by UMMH, Marlborough Hospital (and other impacted hospitals) is wholly insufficient for assessing whether MGB's proposal furthers the Commonwealth's goal of making health services "reasonably and equitably available to every person within the Commonwealth." 105 CMR 100.001. MGB's years of planning (as evidenced by the J.P. Morgan presentations, and the internal financial forecast revealed by the AGO Report) and present-day actions (building the Westborough clinic three times larger than needed, hiring three times more physicians and staff than needed⁶⁸, and undertaking a massive and ongoing marketing campaign) point to a major growth strategy that by its very design will take commercial patients from local providers. As such, the total financial loss to safety net providers is certain to be enormous significant, directly impacting their ability to fulfill their safety net missions.

2. The ICA Provides No Analysis of the Health Equity Impacts of the MGB Proposal

As described above, and highlighted in the HPC's report, MGB's expansion will have a substantial financial impact upon local safety net providers. Yet, the ICA does not examine what that means for low-income patients and the word "equity" is never used in the report.

⁶⁶ "We are seriously concerned that MGB's unnecessary and duplicative expansion may cause Marlborough Hospital to close certain critical services, or its doors entirely, negatively impacting access to care for our most vulnerable patients across the region. This could include our emergency department or our inpatient behavioral health unit." *In the Matter of: Mass General Brigham, Inc. Application for Determination of Need 210121003-AS*, Testimony of Steve Roach, president at UMass Memorial Marlborough Hospital; UMass Memorial Health Alliance Clinton Hospital. P. 129-120. These are services that will also be used by local MGB patients.

⁶⁷ See also Note 26.

⁶⁸ See Consultant's Exhibit ICC28.

The regulations at 105 CMR 100.001 are clear in their purpose: “to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost advancing the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.” (emphasis added). The ICA, however, contains no analysis whatsoever regarding the impact on equitable availability of health resources or public health outcomes.

For example, as discussed above and in prior public comments, UMMH demonstrated the higher median household incomes and higher proportions of commercially insured residents in the town that comprise the patient service areas that will be served by MGB’s proposed new clinics.⁶⁹ That the clinics are proposed where the proportion of commercially insured residents is high is not a coincidence. In fact, MGB later admitted in its response to DPH question 2c: “Local payer mix was one of the factors that was considered in selecting the communities that would be potential sites for the Mass General Brigham ambulatory care centers.” That MGB intentionally selected sites where the commercial payer mix is high in and of itself indicates that its clinics will not advance the Commonwealth’s goals of equitable access. The Consultant utterly failed to consider the potential differences between MGB’s payer mix at the ACCs compared to the overall payer mix within each clinic’s respective patient service area. This is a curious omission considering the Consultant did so for the Massachusetts General Hospital ICA⁷⁰. For that analysis the Consultant revealed that MGB has a higher commercial pay percentage across the board than the service area from which it draws. This is likely due to the siting of facilities in higher income zip codes which amounts to cherry-picking of the most lucrative commercially insured patients without attracting similar percentages of less lucrative publicly-insured (or uninsured)⁷¹. The Consultant could have used the Foxborough⁷² location as

⁶⁹ See UMass TTG’s February 18, 2021 comments at Note 17: The proposed Westborough facility would expand MGB’s service area to many new communities in the top quintile of income (\$139,428 - \$373,970), and thus with high rates of commercial insurance. All but three of the thirteen towns in Westborough area exceeds the Median household income level at more than 130% of the statewide average. In addition, poverty levels within each town are well below the statewide, Boston, Worcester and two neighboring counties, and have a lower 65+ population than the statewide and Worcester County average. According to US census 2019 information results:

- Median Income: MA (\$81,215) v. Westborough (\$112,153)
- Persons in Poverty: MA & Worcester County (9.4%) v. Westborough (4.6%)

In addition, according to FY19 CHIA IP Case Mix Data, MGB has a disproportionate market share (26%) of commercial patients. (UMass Memorial has 6.7% share of commercial patients.) Significantly, MGB captures a higher proportion of commercial patients at its community locations outside of Greater Boston (39.9% statewide v. 53.7% in Central Massachusetts).

⁷⁰ Consultant contrasts the MGB patient panel for each of the affected inpatient and individual outpatient services lines, (including cardiovascular, oncology, and imaging) with the overall patient demographics in the MGB’s service areas (top 75% zip codes).

⁷¹ See Note 37 and prior UMass TTG Public Comments dated March 12, 2021, Notes 8-9, & 11 regarding the effects of cherry picking.

⁷² See also Note 38 regarding the experience of Sturdy Memorial Hospital.

a model for assessing the expected payer mix of the new ACC volume and associated secondary and tertiary referrals. An additional error that could skew the Consultant's analysis is that the ICA relied upon a county zip code analysis for the ACCs rather than focusing on the primarily high-income zip codes for the towns that MGB itself proposes to be targeting. The Consultant's approach would tend to dilute payer data, and almost certainly would do so in Worcester County considering the significantly higher median incomes in most of the towns in the proposed Westborough site patient service area by way of comparison to the county as a whole.

The Consultant also does not consider whether the location of the proposed sites will address the needs of low-income patients. In the case of Westborough, low-income patients primarily live distant from the proposed site, but the Westborough clinic is completely inaccessible by any mode of public transportation, with the sole exception of a small public ride share service⁷³ that only serves residents of the Town of Westborough and part of Shrewsbury, but not the other twelve communities in the service area.⁷⁴

The health equity repercussions of MGB's proposal are intrinsically tied to its impact upon safety net hospitals and health systems. Safety net providers are critically important to achieving the Commonwealth's health equity goals, yet they face significantly more urgent and acute fiscal uncertainty than systems such as MGB which serve a disproportionately large share of the commercially insured population. This is because safety net providers serve larger proportions of patients who are uninsured or covered by MassHealth/Medicaid, which pays rates well below the actual cost of providing care. To remain fiscally viable, safety net providers must counterbalance these losses with revenue from serving commercially insured patients. This balancing act is precarious for the Commonwealth's safety net providers because their commercial insurance rates are substantially lower than those of MGB's, due to their comparatively weaker bargaining position with insurers.

The proposed Westborough facility is centered among towns where median incomes are in the highest 20% statewide (with the sole exception of Marlborough) and where a large proportion of residents are commercially insured and are already well served by multiple providers⁷⁵. As these clinics draw commercially insured patients away from local providers, it will not only drive up the cost of care (because MGB's commercial rates are so much higher), but it will also disrupt the delicate balancing act that enables safety net hospitals to remain

⁷³ See <https://ridewithvia.com/news/wrta-and-via-launch-new-on-demand-public-transit-system-in-westborough/#:~:text=Called%20E2%80%8BVia%20WRTA%20E2%80%8B,the%20MBTA%20Commuter%20Rail%20stations.>

⁷⁴ In MGB's Westborough community survey included in the DoN application, "Good Public Transportation" ranks last among the 17 options in the survey. Patients expressed this real need which MGB clearly did not prioritize in its siting decision.

⁷⁵ There are approximately 24 facilities within a 10-minute drive and 200 within a 20-minute drive. See March 12th UMass TTG Testimony (Note 38).

viable. As they lose commercial patients, they will no longer have sufficient revenue to counterbalance losses from safety net care and, therefore, may be forced to reduce services. This is a risk that the Commonwealth must be very wary of, yet it is entirely unaccounted for in the ICA report. The ICA fails to recognize or account for this dynamic although it should be central to the Department's review of the Application.

The Health Policy Commission 2016 report "Community Hospitals at a Crossroads" brought data informed attention to these issues. Unfortunately, the environment for community hospital has only gotten worse as MGB has expanded its outpatient facilities in areas like Foxborough and Somerville. Community hospitals depend on their outpatient service lines in order to maintain their Emergency Department, inpatient and community services. Recent CHIA data shine a light on this fact demonstrating that community hospitals are much more directly dependent than academic medical centers on outpatient business.⁷⁶ Indeed, those hospitals most impacted by the proposed Westborough and Woburn sites rely on more than 69% of their outpatient revenue to support their financials (see **Exhibit 7**).⁷⁷

We fear that the resulting fiscal instability from a loss in outpatient services could force Marlborough Hospital to substantially scale back its services simply to remain afloat, jeopardizing the vulnerable patients it serves.

Conclusion:

The ICA falls woefully short and thus cannot be relied upon it as the foundation for a conclusion that it is highly probable – as required under the "clear and convincing" evidentiary standard – that the Applicant has demonstrated that its proposal will satisfy the Commonwealth's cost containment goals.

The ICA:

- 1) Ignores the AGO Report and need to: consider MGB's internal analysis predicting \$385 million increased margin from MGB's Eastern Massachusetts ambulatory expansion plan, and question potential discrepancies between MGB's internal planning documentation and the Application submitted;
- 2) Ignores the cost impact of increased secondary and tertiary referrals to the state's two highest cost hospitals, despite ample evidence in the public record of MGB describing its

⁷⁶ CHIA Hospital Profiles Report

⁷⁷ Moreover, if those outpatient services migrate to a higher cost setting, TME will increase. Additionally, their FY19 inpatient NPSR per CMAD is well below any AMC and pretty far below MGB's Faulkner and Newton Wellesley campuses. In fact, UMass's Medical Center is IP NPSR per CMAD is only \$340 higher than Newton Wellesley Hospital. (MSF funds are not included in the NPSR per CMAD calculation).

- ambulatory expansion as a strategy to increase commercial secondary and tertiary referrals to increase its profit margin;
- 3) Uncritically accepts MGB's unsupported assumptions regarding patient volume and patient migration.
 - 4) Uncritically accepts MGB's unsupported assertions about price, while completely ignoring any consideration of physician costs;
 - 5) Ignores costs associated with backfill at MGB's high-cost hospitals, whereby new patients fill capacity that will be created by the transfer of some existing patients to the ambulatory centers.
 - 6) Limits its analysis to only three service lines that will be offered at the clinics;
 - 7) Ignores the impact of the COVID pandemic upon the size of the Massachusetts health care workforce despite MGB testimony about its fragile state and ignores and the impact of MGB needing to recruit from existing providers;
 - 8) Ignores the likely impact of inflation upon construction and on wages despite MGB testimony to the contrary;
 - 9) Incorrectly characterizes MGB as a new entrant in the relevant marketplace and assumes that general economic studies of the health care market are applicable without modification to a market dominant health system, with the highest price in the Commonwealth, that already controls 38% of the market in the proposed service area;
 - 10) Provides no analysis of the impact commercial patient migration away from local safety net providers may have upon their fiscal viability and how that could impact the Commonwealth's goal of making health services "reasonably and equitably available to every person within the Commonwealth;" and
 - 11) Overlooks all publicly available information that highlights MGBs market position, excessive pricing, and overall financial dominance over local competition.

These material and fatal flaws result in the supportably the ICA assessment of the total costs⁷⁸ of the Proposed Projects rendering the ICA useless as a basis upon which DPH can assess the Application's likely impact upon statewide aggregate cost.

In sum, the ICA ignores obvious and critical areas of inquiry, disregards the urgent advice of the Commonwealth's top legal official, and overlooks ample evidence in the public record about MGB's strategy and true intentions to extend its reach to its outermost limits in every direction, building market share at its inflated rates. In Westborough in particular, it extends MGB's reach to an already well-resourced area with many commercially insured patients at the far/outer edge of MGB's sphere of influence. Furthermore, the findings of the ICA are utterly inconsistent with the recent actions by HPC to place MGB on a PIP as a result of multiple years of excessive cost trends, and HPC Comments. Considering the ICA's fatal errors and

⁷⁸ Only by relying on these unreliable steps could the ICA conclude that the Proposed Projects may eke out miniscule savings of between 0.1% to 0.3%.

insufficiencies and the overwhelming evidence in the public record about the actual impact of MGB's proposal on aggregate health care costs and equitable access to health services, we urge DPH to recommend that the PHC reject MGB's Application in its entirety.

Thank you for the opportunity to provide these comments.

Sincerely,



Douglas S. Brown
President of Community Hospitals and CAO

UMass Memorial TTG Representative

Attachments

cc: Katharine Eshghi
Jennifer Gallop

Exhibits

Exhibit 1: MGB's 2014 Presentation to J.P.Morgan

Exhibit 2: SOW

Exhibit 3: ICA's Deficient Response to SOW

Exhibit 4: Recently Implemented DoNs

Exhibit 5: Health Policy Commission's October 2021 Slides re Provider Price Variation

Exhibit 6: Aerial Map

Exhibit 7: CHIA Analysis – Community Hospital Reliance on Outpatient Revenue