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VIA EMAIL DPH.DON@State.MA.US

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

RE: Project #21012113-AS (Mass General Brigham Ambulatory) Independent Cost-Analysis Comment by Worcester Ten Taxpayer Group

Dear Director Szent-Gyorgyi:

I am filing this comment letter on behalf of the Ten Taxpayer Group consisting of a variety of Worcester leaders (referred to on the DPH Determination of Need website as the Worcester Regional Chamber of Commerce TTG).

We believe the Independent Cost Analysis (ICA) is exceptionally narrow in scope and thus wholly insufficient to aid the Department of Public Health (DPH) in fulfilling its public responsibility to provide a thorough analysis of the proposed project's impact on statewide aggregate cost. The ICA entirely fails to analyze major components of Mass General Brigham's expansion proposal that will substantially inflate healthcare costs and thereby increase health insurance premiums for businesses and employees alike. The ICA's narrow scope also fails to account for the fiscal impact MGB's expansion will have on local safety net hospitals and, therefore, their ability to fulfill their safety net missions. In so doing, it does literally nothing to account for one of the most important public policy issues of our time: health equity.

Shortcomings of the ICA Related to Aggregate Healthcare Costs

Rising health insurance costs are a major concern for businesses and employees alike. As healthcare costs increase, so too do the costs of health insurance, including premiums paid by employers and employees and copays borne directly by employees. For businesses, each additional dollar paid in insurance premiums is one that can't be invested in other priorities like wages or capital investment. For employees, it is a dollar that can't be used to support their family and household needs.

The magnitude of this dynamic is described by the Massachusetts Health Policy Commission (HPC) in its *2021 Annual Cost Trends Report*, which states that "[t]he average commercial health insurance premium for Massachusetts families now exceeds \$21,000 annually, almost triple what it was in the year 2000 and higher than the average price of a new compact car in the

U.S.” The report further states “[n]ot only is the average privately-insured Massachusetts family, along with their employer, purchasing the equivalent of a new compact car each year in health insurance premiums, but they also pay thousands of dollars in out-of-pocket spending.”

This difficult state-of-affairs has been exacerbated by the many uncertainties and difficulties the pandemic has wreaked upon businesses and employees alike, including rising general inflation. At this moment in time when businesses and employees already face steep and unexpected expenses and struggle to navigate through the pandemic, one would assume that an ICA which is purportedly performed on behalf of the Commonwealth would thoroughly investigate key cost drivers. We are deeply disappointed that it does not.

Consistent with the Code of Massachusetts Regulations, the ICA is supposed to assist the Department of Public Health to assess whether MGB’s proposal will help “ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost.” 105 CMR 100.001. The burden is on MGB as the applicant to make a “clear and convincing demonstration” that its expansion “...will meaningfully contribute to the Commonwealth’s goals for cost containment, improved public health outcomes, and delivery system transformation.” 105 CMR 100.210(A). Contrary to these regulatory requirements and despite the extraordinary challenges presently confronting businesses and employees, the ICA entirely ignores the largest cost drivers associated with MGB’s proposal.

The ICA’s most obvious shortcoming is that it failed to analyze, or even acknowledge, the costs of referrals to the Commonwealth’s highest priced hospitals, despite an unprecedented revelation and recommendation by the Attorney General and despite MGB’s own statements to investors about its strategy to increase such referrals. This is simply astounding.

The Attorney General’s Office (AGO) released a report in November revealing that it conducted a civil investigation of MGB’s expansion proposal that unearthed **an internal MGB study forecasting a \$385 million annual profit from its ambulatory expansion strategy**. Noting that it is already the “biggest and highest cost health care system in Massachusetts”, the report highlighted that “MGB projected it would gain an additional 1-2% of all secondary inpatient admissions ... 3-4% of all tertiary inpatient admissions ... and 1-2% of all covered lives” in Eastern Massachusetts.¹ It attributed a substantial portion of this profit to “hospital margin from patient referrals from the ambulatory sites to MGB hospitals.” In other words, the ambulatory plan would increase referrals to the Commonwealth’s highest cost hospitals, which would, of course, drive up statewide aggregate cost.

The ICA’s failure to account for referral costs is not only contrary to the directive of the Attorney General, but it also ignores MGB’s own statements and actions. These statements and actions were spotlighted in public testimony and therefore were readily available in the public record for review by the ICA’s author. They include a January 2020 presentation by MGB’s chief executive officer and chief financial officer to an audience of investors at the national JP Morgan Healthcare Conference in which they described MGB’s ambulatory expansion as having

¹ It is notable that MGB defines “Eastern Massachusetts” as beginning at the Shrewsbury-Worcester border, to encompass the wealthiest suburbs in Central Massachusetts.

the goal to “increase network lives and secondary and tertiary commercial referral volume.” In plain English, adding network lives means taking patients from lower cost providers; increasing *commercial* secondary referrals means sending more privately insured patients to the state’s most expensive physicians; and increasing *commercial* tertiary referrals means sending more privately insured patients to the state’s most expensive hospitals. The enormous implications this would have on aggregate healthcare costs in the Commonwealth should be clear, making it simply astounding that the ICA report ignores this subject of inquiry entirely.

MGB’s own actions also make clear that its ambulatory plan is overwhelmingly a commercial growth strategy. Consider the size of the clinic it is proposing in Westborough. MGB’s application indicates that annual patient visits in Westborough will be only 30.5% of those in Woburn,² yet it is building clinics that are the exact same size in both communities: 62,000 square feet. It would be ludicrous for any business to bear the expense of constructing a building over three times larger than it needs – unless, of course, its actual intent is to *grow* its business to fill that excess capacity. Growing a business so substantially would necessitate a colossal marketing campaign – such as MGB’s ongoing multimillion-dollar, multimedia advertising campaign that has trumpeted these new clinics to commercially insured local audiences for many months now. It is truly dumbfounding that the ICA did not address this, considering that MGB’s actions are entirely consistent with its own words in the JP Morgan investors presentation and with the \$385 million profit revelation contained in the AGO report.

In addition to the stunning omission of any analysis of referral costs, the ICA fails to account for other important components of cost. For example, it does not analyze backfill at MGB’s own hospitals – i.e., the incremental costs associated with adding new patients to fill up newly freed capacity at the state’s highest cost facilities. The ICA also reviewed only a very small proportion of the services that will be offered at the clinic; it solely focuses on three services lines out of over twenty that the author lists as being offered – CT, MRI, and surgery. And it completely omits the category of physician costs, which is an enormous omission considering that MGB’s physician costs are the highest, by far, in Massachusetts.

Compounding all these problems is that, even within its exceedingly narrow scope, the ICA accepts without question some rather absurd assumptions that MGB included in its DoN application about patient behavior and price. For example, MGB alleges that 100% of its own patient panel members who already have an MGB primary care provider will transfer their care from that provider to the new clinics. At the same time, it assumes that virtually no non-MGB patients will transfer their care, even while it bombards those very people with multimedia advertising designed to get them to do exactly that.

In all these ways this “independent” cost analysis artificially and dramatically reduces its assessment of the total costs of the proposal. This makes it useless as a basis upon which DPH can assess the application’s likely impact upon statewide aggregate cost. The ICA’s conclusion about aggregate cost is analogous to a dietitian concluding that someone is on target to achieve weight loss goals because they drink diet soda – while ignoring that the drink is accompanied each day by a calorie-laden seven course meal.

² 42,267 in Westborough and 138,594 in Woburn.

Shortcomings Related to Health Equity

To repeat, the purpose of the 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 (emphasis added). The ICA contains no analysis whatsoever regarding the impact on equitable availability of health resources or public health outcomes.

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 more commercially focused systems such as MGB. This is because safety nets serve larger proportions of patients who are covered by MassHealth/Medicaid, which pays rates well below the actual cost of providing care, or who are uninsured. To remain fiscally viable, safety nets must counterbalance these losses with revenue from serving commercially insured patients. This balancing act is precarious because their commercial insurance rates are substantially lower than those of MGB’s, due to their comparatively weaker bargaining position with insurers. (MGB’s sheer size and its high volume and proportion of commercially insured patients give it far more leverage than in negotiations with insurers than other health systems and hospitals).

Each MGB outpatient clinic is proposed to be located precisely where it is easily accessible to high-income communities with large numbers of commercially insured residents who are presently served by local health providers, but not easily accessible to large volumes of low-income patients. Westborough is a case in point: the proposed 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 amply served by multiple providers.

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 viable. As they lose commercial patients, they will no longer have sufficient revenue to counterbalance losses from safety net care and, therefore, will likely be forced to reduce services to remain afloat. This is a risk that the Commonwealth must be very wary of, yet it is entirely unaccounted for in the ICA report.

To play this out locally, consider Marlborough Hospital and UMass Memorial Medical Center. Because of their high proportion of safety net patients, 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.³ Both are low-cost providers compared to their peers and, in the case of UMass Memorial Medical Center, it has the lowest inpatient rates among the Commonwealth’s six academic medical centers, while the two MGB

³ *Massachusetts Hospital Profiles Report*, Center for Health Information & Analysis, (March 2021).

academic medical centers have the highest rates.⁴ As MGB's massive marketing campaign attracts commercially insured patients away from Marlborough Hospital to its Westborough clinic, it will destabilize Marlborough by diminishing its ability to counterbalance losses from treating such a large proportion of MassHealth and or uninsured patients. Moreover, it will also do the same to UMass Memorial Medical Center. This is because, instead of Marlborough referring these commercially insured patients to the Commonwealth's *lowest cost* academic medical center for highly specialized care, the Westborough clinic will instead send them to the two *highest cost* academic medical centers – exactly as MGB's chief executive officer and chief financial officer described in their JP Morgan presentation. While this will be tremendous for MGB's bottom line and for the bond investors persuaded by the JP Morgan presentation, it will be quite the opposite for low-income Central Massachusetts patients who rely upon Marlborough Hospital and UMass Memorial Medical Center.

Conclusion

The ICA is so woefully inadequate that it is useless for the purpose of informing DPH's analysis of the likely impacts of MGB's proposal. It ignores obvious and critical areas of inquiry. It disregards the urgent advice of the Commonwealth's top legal official. And it overlooks ample evidence in the public record about MGB's strategy and true intentions. We therefore strongly urge that DPH see the ICA for what it is: a document that, whether wittingly or unwittingly, is written to advance MGB's apparent goal of pulling the wool over the eyes of public officials charged with upholding the interests of the residents of the Commonwealth.

Considering the ICA's colossal insufficiencies and the overwhelming evidence in the public record about the actual impact of MGB's proposal on aggregate healthcare costs and equitable access to health services, we urge DPH to recommend that the Public Health Council reject MGB's application in its entirety.

Sincerely,

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

Alex Guardiola
Vice President of Government Affairs and Public Policy
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⁴ *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 Mass General Hospital it is \$16,967.