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BY ELECTRONIC DELIVERY

David Seltz
Executive Director
Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, Massachusetts 02109

RE: Response by Dana-Farber Cancer Institute, Inc. ("Dana-Farber") to the Preliminary Report: Cost and Market Impact Review of Dana-Farber Cancer Institute, Beth Israel Deaconess Medical Center, and Harvard Medical Faculty Physicians (HPC-CMIR-2024-1) (the "Preliminary Report")

Dear Executive Director Seltz:

On behalf of Dana-Farber, I write in response to the above-referenced Preliminary Report. Dana-Farber appreciates the thorough and thoughtful analysis undertaken by the Massachusetts Health Policy Commission (the "HPC"), and looks forward to engaging with the HPC and the Department of Public Health ("DPH") with the aim of ensuring all residents within The Commonwealth of Massachusetts (the "Commonwealth") have continued access to world-class cancer care, both at Dana-Farber's new facility in Boston (the "Future Cancer Hospital") as well as at community health care facilities throughout the Commonwealth. Dana-Farber appreciates the opportunity to highlight its commitments to cost containment, market access, and equity. Dana-Farber would also like to highlight the work it has been doing and will continue doing to ensure safety and continuity as the care for Dana-Farber's patients transitions to new facilities.

I. Dana-Farber is Committed to Providing Cost-Effective Cancer Care and Collaborating with the HPC on Cost Containment Efforts

In evaluating clinical partners, a critical factor for Dana-Farber was a shared commitment to ensuring cancer care does not become effectively inaccessible due to high and rising costs. Beth Israel Deaconess Medical Center, Inc. ("BIDMC") and Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center, Inc. ("HMFP") have demonstrated that commitment, and the parties are excited by the opportunities presented by the proposed clinical affiliation (collectively, the "Collaboration") to expand access to the highest quality cancer care without driving any material increase in health care costs for Massachusetts consumers.

The Preliminary Report's findings reflect that commitment and careful design by the parties. The Preliminary Report finds that, as a result of expected shifts in patient volume from more expensive settings to Dana-Farber and BIDMC, inpatient spending would decrease on an annual basis. In fact, Dana-Farber strongly believes that the savings will be greater than shown in the Preliminary Report's conservative estimate, especially with respect to shifts in inpatient surgery (see the attached Appendix for additional details on the analysis conducted by experts retained by Dana-Farber).

As an initial matter, Dana-Farber would like to reiterate the difficulty of comparing outpatient costs at a dedicated cancer center, where Dana-Farber provides only cancer services to acutely ill patients, to outpatient costs at general acute care hospitals, which have a range of low-complexity encounters in the outpatient setting, and may not identify or track cancer patients in the same way. Cancer hospitals like Dana-Farber have the highest proportion of metastatic site disease patients (19.5%) and the highest hierarchical condition category risk score compared to general hospitals. This means that Dana-Farber's patients are sicker, and can be expected to incur higher than average costs. For this reason, producing an accurate apples-to-apples comparison of outpatient costs between dedicated cancer centers and general acute care hospitals that incorporates patient acuity is a very challenging endeavor. Dana-Farber would welcome the opportunity to work with HPC to develop such a methodology for comparing costs that appropriately adjusts for factors such as acuity and treatment complexity. With the increasing incidence of cancer and the aging of the population in the Commonwealth, such tools could be useful to the HPC in evaluating the cost impacts of other transactions or material changes involving oncology care providers.

Dana-Farber would also like to note on the record its deliberate strategy to move complex and innovative cancer treatments from the inpatient to the outpatient setting, and to incorporate cost effectiveness in treatment planning decisions. Since 2019, Dana-Farber has made efforts to shift stem cell transplants to the ambulatory setting. Dana-Farber has completed 365 ambulatory transplants with volume increasing from two outpatient stem cell transplants in 2019 to 104 in 2024. Our internal analysis estimates that doing so avoided 1800 inpatient bed days, representing savings to payers of $13.6 million per year from this shift. In addition, Dana-Farber's outpatient CAR-T treatments have increased from zero in 2022 to an average of eight per month so far in fiscal year 2025. While the consequences of this shift may have the effect of making Dana-Farber's outpatient services appear more expensive than other hospitals that only provide such complex services on an inpatient basis, the most important consequence is the positive impact on patients and the health care system as a whole, as shifting cancer care to the outpatient setting where clinically appropriate reduces infection risk and improves overall patient experience. In addition, Dana-Farber's innovative "Pathways" program, an electronic road map of the best treatments currently available for each type of cancer and for every stage of disease, which is available to all clinicians, considers cost along with safety and efficacy in determining the most appropriate treatment plan.

The parties, like the HPC, are also focused on the high cost of oncologic drugs. Importantly, Dana-Farber has limited ability to negotiate prices in the increasingly expensive market for the oncology pharmaceuticals required by its patient population. Dana-Farber does not participate in the 340B program, which provides significant discounts on the acquisition costs of pharmaceuticals

(estimated on average to be between 25% and 50%).[1] All fifteen of the chemotherapy drugs identified in Figure III.A.6 of the Preliminary Report, as well as Keytruda (an immunotherapy drug) are covered by the 340B Drug Pricing Program, which means that other hospitals are able to purchase those drugs at a much lower price point than Dana-Farber.

Further, the investment required to provide a safe, compliant, high-quality oncology pharmacy operation are significant. As part of its model of care, and because of the special safety hazards inherent in the procurement, storage, and administration of cancer drugs (*e.g.*, radioactivity, drug potency, potential side effects, and exposure), Dana-Farber has invested in an extensive (and expensive) pharmacy facility and infrastructure, and offers patients access to dedicated support teams that provide high-touch and frequent education. Dana-Farber has developed a specialized pharmacy infrastructure—including robust order verification programs and specialized safety equipment for medical compounding—commensurate with the risk presented by the drugs it administers on a daily basis, and has invested in equipment like biosafety cabinets (Dana-Farber operates 42, compared to ten at The Brigham and Women's Hospital ("BWH") and 12 and Massachusetts General Hospital ("MGH")) and other significant capital expenditures at its nine infusion pharmacies and three specialty pharmacies. Unlike general acute care hospitals that provide pharmacy services to non-cancer patients, the significant investment made by Dana-Farber on its pharmacy program cannot be re-distributed to, and balanced out by, less costly service lines.

There are many reasons why cost containment in oncology care, and even accurately assessing price differentials, is difficult. For many of the same reasons, industry-wide efforts to date at implementing value-based care strategies in cancer care, such as the CMS Oncology Care Model, have not succeeded. That said, Dana-Farber is committed to ensuring that cancer care within the Commonwealth remains accessible to all, and affordability is an important part of that mission. Dana-Farber will commit, as a condition to a determination of need issued by DPH, to managing growth in its net patient service revenue per case mix adjusted discharge within the bounds of the HPC's cost growth benchmark, with commitments to make additional investments in equity and access initiatives to the extent its growth exceeds the HPC's benchmark. Additionally, and as noted above, Dana-Farber would welcome the opportunity to engage with the HPC to develop metrics which compare the cost of cancer care at dedicated cancer centers like Dana-Farber to cancer treatments at other providers, incorporating acuity, outcomes, and service mix. Such metrics would facilitate the study of outpatient cancer drug pricing statewide to develop a plan for tackling pharmaceutical costs in a manner that does not jeopardize patients' access to life saving cancer drugs and therapeutic innovations. Finally, Dana-Farber will commit to continuing its efforts to transition cancer treatments to the outpatient setting when clinically appropriate, and would be happy to submit annual reports to the relevant regulatory agencies regarding its success in doing so and the estimated savings that have resulted.

[1] Dana-Farber is not an "eligible organization" under the U.S. Health Resources & Services Administration's 340B Drug Pricing Program, which provides discounts to eligible organizations on the acquisition of certain outpatient drugs. Eligibility for the 340B Drug Pricing Program is based, in part, on a hospital's Medicaid payor mix. While Dana-Farber's Medicaid payor mix is consistent with the oncology payor mix of other providers in Massachusetts, because the cancer population skews older, Dana-Farber patients tend to be Medicare enrollees. For information regarding estimates of average discounts, see: Massachusetts Health & Hospital Association - The 340B Program

II. Dana-Farber is Committed to Enhancing Access to Community-Based Cancer Care and Linkages with Primary Care, Health Centers, and Other Community-Based Health Resources

Part of Dana-Farber's mission is to expand community access to cutting edge cancer care and research. While Dana-Farber excels at offering the most sophisticated and innovative cancer services to its patients, it also believes that many cancer patients are best served receiving care in their local communities and, if possible, from their local providers. Dana-Farber is proud of the many collaborative relationships it has established with other providers throughout the Commonwealth with the aim of enabling patients to receive the best care close to home. Examples of this include Dana-Farber's relationships with South Shore Hospital, UMass Memorial Health-Milford Regional Medical Center, St. Elizabeth's Medical Center, and Whittier Street Health Center. The Dana-Farber Cancer Care Collaborative is another way community cancer programs outside of Boston can work with Dana-Farber to improve clinical care for patients in these communities, and current collaborative members include UMass Memorial Medical Center, Phelps Cancer Center at Berkshire Medical Center and Cape Cod Hospital-Davenport-Mugar Cancer Center, as well as hospitals outside of Massachusetts. Through the Cancer Care Collaborative, Dana-Farber provides education for member hospitals' clinicians, offering opportunities to consult with Dana-Farber medical specialists through virtual consults, network case conferences, physician trainings and observerships.

The success and importance of these relationships is evidenced by the glowing letters of support for Dana-Farber's determination of need application, including from UMass Memorial Health Care and Whitter Street Health Center. UMass Memorial Health Care has lauded Dana-Farber's commitment to "keeping care local through collaboration and clinical collaboration" that "allows patients to receive treatment in the most optimal center for their specific diagnosis and individual needs." [2] Dana-Farber will continue this tradition following the implementation of the Collaboration and the opening of the Future Cancer Hospital. Further, Dana-Farber is committed to seeking opportunities to deepen existing relationships and to form new ones.

III. Dana-Farber is Committed to Ensuring Patient Continuity and Safety During the Transition

The transition to the Future Cancer Hospital and the Collaboration is going to be complex and will take place over many years. Working groups across Dana-Farber, BIDMC, and Mass General Brigham's operations are dedicated to ensuring that patients continue to maintain access to continuous care during that period. Those working groups have been meeting for months already and will continue to do so. Dana-Farber believes everyone working within those groups are committed to patient safety and quality above all else. Dana-Farber has also been in active communication with DPH officials regarding transition planning. Dana-Farber is committed to taking all appropriate steps to ensure patient care is not disrupted during the transition, and to keeping DPH informed of transition planning and progress.

[2] UMass Memorial Health Care, Inc. Letter of Support (Apr. 16, 2024), available at https://www.mass.gov/doc/public-comments-2-pdf-dana-farber-cancer-institute-inc-hospitalclinic/download.

IV. Dana-Farber Anticipates the Future Cancer Hospital Will Help Meet Strong Demand for Inpatient Cancer Capacity

Dana-Farber recognizes that the HPC was not able to reach a definitive conclusion in the Preliminary Report about future demand for inpatient cancer capacity in the Commonwealth. This, in Dana-Farber's view, relates to the difficulty of developing an economic model that reflects what Dana-Farber clinicians know to be the truth on the ground today. The Preliminary Report and the independent cost analysis conducted by FTI Consulting for DPH use different methodologies, and arrive at different conclusions, about the number of discharges currently attributable to Dana-Farber and about future organic growth in cancer demand writ large. Dana-Farber understands that third parties rely on data from which it is difficult to identify cancer inpatients in need of oversight and management by a medical oncologist.

That said, it is not necessary to look to expected growth or econometric models to assess the demand for the Future Cancer Hospital's proposed 300 inpatient cancer beds. Right now, Dana-Farber medical oncologists care for, function as the attending of record for, an average of 211 cancer inpatients each day. These are patients where Dana-Farber and BWH (as the license holder) have determined that oversight by a medical oncologist is medically necessary. Nearly all these inpatient patients had a pre-existing relationship with a Dana-Farber medical oncologist that was caring for them. In other words, applying the Preliminary Report's methodology to current state would undercount the amount of inpatients attended to by Dana-Farber medical oncologists by over 20% (see the Appendix for additional details). Similarly, BIDMC cares for an average of 86 medical oncology inpatients each day that will receive care at the Future Cancer Hospital once open. If the Future Cancer Hospital were placed in service today, it would be nearly filled to capacity (and filled well-beyond any target occupancy rate) without drawing a single patient from any community hospital. There is no credible evidence that suggests demand for inpatient cancer beds will decrease any time soon. Further, in light of the ongoing inpatient bed crisis and emergency department boarding crisis (which show no signs of abating), Dana-Farber has no doubt that there will be need for every inpatient bed in the relevant facilities for the foreseeable future without drawing patients away from community hospitals. Unlike Dana-Farber, other hospitals also will be able to use their available capacity for needed services like behavioral health and other critical services, the lack of which are contributing to the boarding crisis.

Dana-Farber certainly appreciates the difficulty of projecting inpatient cancer care market dynamics years into the future with precision. That said, Dana-Farber would urge all to consider the practical reality of cancer care in the Commonwealth, as shared during the determination of need public hearing by clinicians working on the front line. In addition to the demand described above and in the Appendix, those clinicians emphatically believe there is need for the Future Cancer Hospital now.

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Dana-Farber would like to reiterate its appreciation for the work done by the HPC to complete the Preliminary Report and for the thoughtful considerations raised therein. Dana-Farber looks forward to working with the HPC and DPH to ensure the Future Cancer Hospital and the Collaboration expand access to world-class cancer care in the Commonwealth, while furthering all parties' strongly held commitment to cost containment.

Please do not hesitate to reach out if it would be helpful to discuss.

Very truly yours,

/s/ Dr. Benjamin L. Ebert, MD, PhD

Dr. Benjamin L. Ebert, MD, PhD
President and Chief Executive Officer

Enclosures

Appendix

Underestimated Volumes and Savings from BIDMC Inpatient Surgical Oncology

In preparing its determination of need submission, Dana-Farber retained a third-party economist, NERA, to forecast the impact of the Future Cancer Hospital and the Collaboration on the Commonwealth. NERA's model predicted significantly more savings than anticipated by the Preliminary Report for the following reasons:

1) **Volume and Migration:** Unlike other areas of the cancer continuum, the Preliminary Report assumes that the majority of BWH's current surgical oncology inpatients will remain at the BWH post-Collaboration, while assuming a significant percentage of patients will transfer to BIDMC on the outpatient side. Like outpatient surgeries, inpatient cancer surgery is typically non-emergent and typically a planned component of a patient's multi-disciplinary cancer treatment, with the medical oncologists primarily leading the patient's treatment plan. Accordingly, Dana-Farber believes that its modeling, which assumes 75% of surgical oncology transitions out of BWH to BIDMC (for outpatient and inpatient), is the more accurate assumption, reflective of the manner in which cancer care is provided. Moreover, in its modeling, the Preliminary Report only accounts for surgical oncology volumes that BIDMC would be backfilling as a result of transferring medical oncology patients to Dana-Farber post-Collaboration. To the extent BIDMC has capacity available to treat surgical oncology patients (beyond just backfilling capacity made available by shifting medical oncology patients to Dana-Farber) and uses this capacity to treat additional surgical oncology patients from BWH post-Collaboration (in line with the parties' projections), that ought to generate additional savings.

2) **Relative Pricing:** The Preliminary Report estimates that even if all of BWH's surgical oncology inpatient volume were to transition to BIDMC, the savings would equal approximately $7 million (pg. 45 of the Preliminary Report). Dana-Farber believes this underestimates the true extent of savings for a few reasons: (a) first, as noted above, Dana-Farber believes the Preliminary Report underestimates the surgical oncology patient volumes likely to transition from BWH to BIDMC; and (b) second, the relative pricing differences between BWH and BIDMC in surgical oncology inpatient services as reporting the Preliminary Report is inconsistent with the patterns seen in the CHIA Relative Pricing data for all services (see table below). Also, as seen in the overall CHIA Relative Pricing data, the price differences between BWH and BIDMC are significantly greater for payors that are excluded from the HPC's analysis, like United and Cigna.

Relative Pricing Data: BIDMC and BWH

Hospital	BCBS	HPHC	THP	HNE	MGBHP	Anthem
BIDMC	1.19	1.24	1.19	1.25	1.39	1.07
BWH	1.30	1.24	1.47	1.70	1.53	2.37

The fact that BWH is significantly more expensive than BIDMC when taking all services into account, but only slightly more expensive when looking at surgical oncology, is surprising and inconsistent with BIDMC's experience. Dana-Farber recognizes that HPC has more granular access to relative price data. However, other factors may contribute to an underestimation of BIDMC's relative price savings compared to BWH, including the Preliminary Report's methodology for identifying and comparing surgical oncology patients and claims. While the HPC has been provided Dana-Farber's data and methodology regarding the identification, assignment and quantification of patients, Dana-Farber is not aware of the specific methodology used by the HPC to identify, quantify and compare surgical oncology patients and the relative pricing.

Overestimation of Impact to Hospitals other than BIDMC, BWH, and MGH

The Preliminary Report overestimates the revenue impact to hospitals other than BIDMC, BWH, and MGH due to three underlying assumptions:

1) **Underestimated demand for medical oncologist-led inpatient care:** As noted previously, applying the Preliminary Report's methodology would undercount the amount of patients that are currently attended to by Dana-Farber presently. Currently, Dana-Farber medical oncologists care for, and function as the attending of record for, an average of 211 (with a recent high of 240) cancer inpatients each day. These are patients where Dana-Farber and BWH (as the license holder) have determined that oversight by a medical oncologist is medically necessary, and where nearly all these inpatient patients had a pre-existing relationship in the medical record with a Dana-Farber medical oncologist that was caring for them. Dana-Farber models suggest that discharge volume was approximately 20% higher than that identified in the Preliminary Report Figure III.A.9. That may be due to the Preliminary Report only assigning a small volume of cases with non-medical Diagnosis Related Groups ("DRGs") (*i.e.*, DRGs for surgery, pulmonology, and nephrology) to oversight by a medical oncologist, which is not an accurate reflection of how the cancer beds are managed today.

2) **Underestimated Demand for BIDMC Inpatient Surgical Oncology:** See above for a discussion of BIDMC inpatient surgical oncology demand.

3) **Other Factors for Consideration for Backfill at BWH:**

    a. **Boarders:** For any remaining beds that may be 'backfilled', there is this ready source of demand for those beds. Based on Dana-Farber's clinical experience, Dana-Farber estimates that there is a daily average of over 50 boarders (patients housed in the hospital emergency departments due to a lack of available inpatient beds) in the Longwood area alone. Dana-Farber assumes open beds at other hospital will be filled by boarders before patients would come from community hospitals.

    b. **Out of State Patients:** Currently, 14% of BWH's inpatient discharge volume is made up of out-of-state patients, which should be assumed for any excess backfilling at BWH.