MASSACHUSETTS
HEALTH POLICY COMMISSION

MASSACHUSETTS HEALTH POLICY COMMISSION REVIEW OF

The Proposed Merger of Lahey Health System; CareGroup and its Component Parts, Beth Israel Deaconess Medical Center, New England Baptist Hospital, and Mount Auburn Hospital; Seacoast Regional Health Systems; and Each of their Corporate Subsidiaries into Beth Israel Lahey Health;
AND
The Acquisition of the Beth Israel Deaconess Care Organization by Beth Israel Lahey Health;
AND
The Contracting Affiliation Between Beth Israel Lahey Health and Mount Auburn Cambridge Independent Practice Association

(HPC-CMIR-2017-2)

EXECUTIVE SUMMARY

Pursuant to M.G.L. ch. 6D, § 13
Final Report
September 27, 2018

EXECUTIVE SUMMARY

In July 2017, Lahey Health System (Lahey); Beth Israel Deaconess Medical Center (BIDMC); New England Baptist Hospital (NE Baptist); Mount Auburn Hospital (Mt. Auburn); CareGroup, the corporate parent of BIDMC, NE Baptist, and Mt. Auburn; and Seacoast Regional Health Systems (Seacoast), the parent of Anna Jaques Hospital (Anna Jaques), signed an agreement to become corporately affiliated. The parties agreed to form a new corporate entity, now called Beth Israel Lahey Health (BILH),[2] which would become the sole corporate parent of Lahey, NE Baptist, Mt. Auburn, Seacoast, and BIDMC and its owned community hospitals, merging the hospital systems and all of their subsidiaries into one organization.

In October 2017, the parties' affiliated contracting networks, Beth Israel Deaconess Care Organization (BIDCO), Lahey Clinical Performance Network (LCPN), Lahey Clinical Performance Accountable Care Organization (LCP ACO), and Mount Auburn Cambridge Independent Practice Association (MACIPA) also signed an affiliation agreement. Under that agreement, BILH would create a clinically integrated network (BILH CIN) that would own BIDCO, LCPN, and LCP ACO. MACIPA would remain corporately independent, but would participate in the design, management, and governance of the BILH CIN.[3] The BILH CIN would jointly negotiate and establish contracts with payers on behalf of the BILH-owned and contracting affiliate hospitals[4] as well as employed and independent physicians who currently contract through BIDCO, LCPN, LCP ACO, and MACIPA. The parties have described the proposed BILH merger and BILH CIN affiliations as interrelated components of a single transaction.[5]

The parties describe the proposed transaction as a market-based solution to address rising health care expenditures, price disparities, payment variation, and health inequities that have been highlighted by the Health Policy Commission (HPC), Office of the Attorney General, and others.[6] The parties describe themselves as a high-quality and lower-cost alternative to other

[2] The transaction agreements, notices of material change, and other filings refer to the new corporate entity as "NewCo." The HPC understands that the parties have since named this entity "Beth Israel Lahey Health (BILH)" and refers to the proposed organization by this name throughout the report. *See, e.g.*, Jessica Bartlett, *Beth Israel, Lahey Announce New Name for Mega-Merger*, BOSTON BUSINESS JOURNAL, May 23, 2018, *available at* https://www.bizjournals.com/boston/news/2018/05/23/beth-israel-lahey-announce-new-name-for-mega.html (last visited Sept. 24, 2018).

[3] MOUNT AUBURN CAMBRIDGE INDEPENDENT PRACTICE ASSOCIATION, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM'N (July 13, 2017), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13, *available at* https://www.mass.gov/files/documents/2017/07/zl/20170713-macipa-caregroup-lahey-bidco-srhs-mcn.pdf (last visited Sept. 24, 2018).

[4] The BILH CIN would establish payer contracts on behalf of the following BILH-owned hospitals: BIDMC, BID-Needham, BID-Milton, BID-Plymouth, Lahey HMC, Northeast, Winchester, Anna Jaques, and NE Baptist. It would also establish contracts on behalf of affiliated hospitals that are part of BIDCO's current contracting network, such as CHA and Lawrence General.

[5] LAHEY HEALTH SYSTEM, NOTICE OF MATERIAL CHANGE TO THE HEALTH POLICY COMM'N (July 13, 2017), AS REQUIRED UNDER MASS. GEN. LAWS CH. 6D, § 13, *available at* https://www.mass.gov/files/documents/2017/07/zo/20170713-lahey-bidco-caregroup-macipa-srhs-mcn.pdf (last visited Sept. 24, 2018).

[6] *See* OFFICE OF ATTY. GEN. MAURA HEALEY, EXAMINATION OF HEALTHCARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 12C, § 17, REPORT FOR ANNUAL PUBLIC HEARING UNDER G.L. C. 12C, § 17 (October 13,

providers in the market and claim that their expanded geographic coverage and scope of services will make them a more attractive option for payers and self-insured employers, and that they will strengthen access to affordable and equitable health care.

After a 30-day initial review, the HPC determined that the proposed transaction was likely to have a significant impact on costs and market functioning in Massachusetts and warranted further review.[7] This transaction also required a Determination of Need (DoN), and the parties filed their DoN application with the Department of Public Health (DPH) on September 8, 2017. In an April 4, 2018 meeting, the DPH Commissioner and the Public Health Council voted to approve the DoN application with conditions.[8] On July 18, 2018, the HPC issued a Preliminary Report presenting the analysis and key findings from its review.[9] The parties provided a written response to these findings on August 17, 2018 (Parties' Response).[10] The HPC now issues this Final Report, including the Parties' Response (attached as Exhibit A) and the HPC's Analysis of the Parties' Response (attached as Exhibit B).

2016), *available at* https://www.mass.gov/files/documents/2016/10/ts/cc-market-101316.pdf (last visited Sept. 24, 2018); MASS. HEALTH POLICY COMM'N, 2015 COST TRENDS REPORT: PROVIDER PRICE VARIATION (Feb. 2016), *available at* https://www.mass.gov/files/documents/2017/01/oj/2015-ctr-ppv.pdf (last visited Sept. 24, 2018); MASS. HEALTH POLICY COMM'N, COMMUNITY HOSPITALS AT A CROSSROADS (Mar. 2016), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf (last visited Sept. 24, 2018); MASS. GEN. COURT, SPECIAL COMMISSION ON PROVIDER PRICE VARIATION REPORT (Mar. 15, 2017), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/ppv-report-final.pdf (last visited Sept. 24, 2018).

[7] *See* MASS. HEALTH POLICY COMM'N, MINUTES OF THE HEALTH POLICY COMM'N (Dec. 12, 2017) (voting to initiate the cost and market impact review of the BILH transaction), *available at* https://www.mass.gov/files/documents/2018/01/31/20180103%20-%20Meeting%20Minutes%20-%20December%2012%2C%202017%20Meeting.pdf) (last visited Sept. 24, 2018).

[8] MASS. DEPT. OF PUBLIC HEALTH, NOTICE OF FINAL ACTION DON APPLICATION NO. NEWCO 17082413-TO CAREGROUP INC., LAHEY HEALTH SYSTEM INC., AND SEACOAST REGIONAL HEALTH SYSTEMS, *available at* https://www.mass.gov/files/documents/2018/04/17/newco-decision-letter.pdf (last visited Sept. 24, 2018). However, the Notice of DoN does not go into effect until 30 days after the CMIR final report and DPH may rescind or amend an approved Notice of DoN on the basis of findings in a CMIR if the Commissioner determines that the parties would fail to meet one or more of the specified DoN Factors. *See* 105 CMR 100, https://www.mass.gov/files/documents/2017/10/11/105cmr100.pdf (last visited Sept. 24, 2018).

[9] MASS. HEALTH POLICY COMM'N, REVIEW OF THE PROPOSED MERGER OF LAHEY HEALTH SYSTEM; CAREGROUP AND ITS COMPONENT PARTS, BETH ISRAEL DEACONESS MEDICAL CENTER, NEW ENGLAND BAPTIST HOSPITAL, AND MOUNT AUBURN HOSPITAL; SEACOAST REGIONAL HEALTH SYSTEMS; AND EACH OF THEIR CORPORATE SUBSIDIARIES INTO BETH ISRAEL LAHEY HEALTH; AND THE ACQUISITION OF THE BETH ISRAEL DEACONESS CARE ORGANIZATION BY BETH ISRAEL LAHEY HEALTH; AND THE CONTRACTING AFFILIATION BETWEEN BETH ISRAEL LAHEY HEALTH AND MOUNT AUBURN CAMBRIDGE INDEPENDENT PRACTICE ASSOCIATION, PURSUANT TO M.G.L. C. 6D, § 13 PRELIMINARY REPORT at 74-75 (July 18, 2018), *available at* https://www.mass.gov/files/documents/2018/07/18/Preliminary%20CMIR%20Report%20-%20Beth%20Israel%20Lahey%20Health_0.pdf (last visited Sept. 24, 2018).

[10] Joint Response for the Proposed Transaction to Create BILH and BILH CIN on behalf of Beth Israel Deaconess Medical Center, Inc., Mount Auburn Hospital, New England Baptist Hospital, Lahey Health System, Inc., Seacoast Regional Health Systems, Inc., Beth Israel Deaconess Physician Organization, LLC d/b/a Beth Israel Deaconess Care Organization, and Mount Auburn Cambridge Independent Practice Association, Inc. (Aug. 17, 2018), *available at* https://www.mass.gov/files/documents/2018/08/20/BILH%20Response%20-%20HPC-CMIR-2018-1_0.pdf (last visited Sept. 24, 2018).

This report is organized into four parts. Part I outlines our analytic approach and the data we utilized. Part II describes the parties to this CMIR and their goals and plans for undertaking the transaction. Part III then presents our findings. We conclude in Part IV. Below is a summary of the findings presented in Part III:

1. **Cost and Market Profile:** Historically, the parties have generally had low to moderate prices and moderate spending levels compared to other Massachusetts providers. As Lahey and BIDCO have grown by affiliating with or acquiring new community hospitals, their prices have not generally risen relative to competitors, and their spending has grown at generally the same rate as the rest of the market based on current available data. While BIDMC and Lahey have had some success at retaining local care at community hospitals they have recently acquired, shifts in care to their hospitals following past acquisitions and affiliations have come from both lower-priced and higher-priced hospitals, and spending trends for local patients have remained largely unchanged.

2. **Cost and Market Impact:** After the transaction, BILH's market share would nearly equal that of Partners HealthCare System, market concentration would increase substantially, and BILH would have significantly enhanced bargaining leverage with commercial payers. BILH's enhanced bargaining leverage would enable it to substantially increase commercial prices that could increase total health care spending by an estimated $128.4 million to $170.8 million annually for inpatient, outpatient, and adult primary care services. Additional spending impacts would be likely for other services; for example, spending for specialty physician services could increase by an additional $29.8 million to $59.7 million annually if the parties obtain similar price increases for these services. These would be *in addition* to the price increases the parties would have otherwise received. These figures are likely to be conservative. The parties could obtain these projected price increases, significantly increasing health care spending, while remaining lower-priced than Partners.

   Plans to shift care to BILH from other providers and to lower-cost settings within the BILH system would generally be cost-reducing and proposed care delivery programs may also result in savings, but there is no reasonable scenario in which such savings would offset spending increases if BILH obtains the projected price increases. Achieving all of the parties' care redirection goals could save approximately $8.7 million to $13.6 million annually at current price levels, or $5.3 million to $9.8 million annually with projected price increases. The scope of care delivery savings is uncertain; however, the parties have estimated that their care delivery plans will save an additional $52 million to $87 million. The parties have stated that BILH would achieve internal savings and new revenue that would allow them to invest in these plans and enable BILH to be financially successful without significant price increases. Nonetheless, to date, the parties have declined to offer any commitments to limit future price increases.

3. **Quality and Care Delivery Profile:** Historically, the parties have generally performed comparably to statewide average performance on hospital and ambulatory measures of clinical quality, with some variation among their hospitals and physician networks on specific measures. They have each developed unique structures to promote and improve

the delivery of high-quality health care and have engaged in a wide variety of targeted care delivery initiatives. They have also participated in various government and commercial payer contracting arrangements that promote quality and efficiency, although their participation in individual payment models varies.

4. **Quality and Care Delivery Impact:** The parties have identified some quality metrics for ongoing measurement post-transaction but have not yet identified baseline data or transaction-specific quality improvement goals, except in relation to a few specific care delivery proposals. They are considering plans for integrating their unique quality oversight and management structures and have stated an intention to expand or integrate current care delivery initiatives. While most of these plans are still in development, the parties have provided more detailed plans for a few of these initiatives, and these proposals suggest a potential for quality improvement.

5. **Access Profile**: The hospitals proposing to join the BILH-owned system generally have a lower mix of Medicaid patients than the overall mix in their service areas and a lower Medicaid mix than most comparator hospitals, although some serve a higher share of Medicare patients. In contrast, current BIDCO contracting affiliate hospitals that are anticipated to be BILH contracting affiliates (Cambridge Health Alliance, Lawrence General Hospital, and MetroWest Medical Center) have a higher mix of Medicaid patients. The parties also provide a smaller proportion of inpatient and emergency department (ED) care to non-white patients and Hispanic patients than other large eastern Massachusetts hospital systems, and their patients come from more affluent communities on average. The parties are important providers of behavioral health services in eastern Massachusetts.

6. **Access Impact:** Based on the current patient mix of the proposed BILH-owned hospitals, the BILH-owned system would have among the lowest mix of Medicaid discharges and proportion of discharges and ED visits for non-white patients and Hispanic patients compared to other large eastern Massachusetts hospital systems. BILH's patients, on average, would also come from more affluent communities. It is not yet clear whether or how BILH's patient mix would change as a result of the proposed transaction, although the parties do not expect significant changes to their current payer mix, and they have so far declined to offer any commitments to expand access for Medicaid patients. While many of the parties' plans for how they might expand clinical services are still under development, the parties have provided some plans for expanding behavioral health services that have the potential to enhance access to these services.

In summary, while the BILH parties have historically been low-priced to mid-priced and have not increased their prices relative to the market as they have grown through smaller transactions to date, the BILH transaction is likely to enable the parties to obtain significantly higher commercial prices across inpatient, outpatient, and physician services. Achieving all of the parties' goals for their proposed care delivery programs and for shifting patients to lower-cost settings would result in savings, but these savings would be less than the impact of projected price increases as a result of the parties' enhanced bargaining leverage. To date, the parties have not committed to constraining future price increases, despite the fact that their own financial

projections indicate that they expect internal efficiencies and new revenue that would allow BILH to invest in its proposed care delivery programs and enable BILH to be profitable without significant price increases.

The parties also claim that the transaction would result in improvements in the quality of patient care and access to services and are developing plans in these areas. Most of the plans provided by the parties are not sufficiently detailed for the HPC to robustly assess the likelihood or degree to which they would result in improvements to health care quality or access; however, the initiatives for which the parties have provided details have the potential to improve care delivery and access to needed services, particularly behavioral health, if implemented as described.

Based on these findings, the HPC concludes that the transaction warrants further review and refers this report to the Attorney General to assess whether there are enforceable steps that the parties may take to mitigate concerns about the potential for significant price increases and maximize the likelihood that BILH will enhance access to high quality care, particularly for underserved populations. The HPC additionally recommends that the Commissioner of the Department of Public Health reconsider the approval with conditions of the Determination of Need Application NEWCO-17082413-TO and assess the need for additional or revised conditions to ensure that the applicable Determination of Need factors are met.

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