MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of October 16, 2013

MASSACHUSETTS HEALTH POLICY COMMISSION

THE HEALTH POLICY COMMISSION
Gardner Auditorium
Massachusetts State House
24 Beacon Street
Boston, MA 02133

Docket: Wednesday, December 18, 2013, 11:00AM

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1. Approval of Minutes from November 20, 2013 Meeting (APPROVED)

2. Executive Director Report

3. Care Delivery and Payment System Reform Update

4. Quality Improvement and Patient Protection Update

5. Community Health Care Investment and Consumer Involvement Update
    a. CHART Investment Program

6. Cost Trends and Market Performance Update
    a. Annual cost trends report
    b. Preliminary report on cost and market impact review (CMIR) (APPROVED)
    c. New cost and market impact reviews (APPROVED)

7. Public Comment

8. Schedule of Next Commission Meeting (January 8, 2014)

Health Policy Commission

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.

Date of Meeting: Wednesday, December 18, 2013
Beginning Time: 11:04 AM
End Time: 2:01 PM

Board Member	Attended	ITEM 1	ITEM 6b	ITEM 6c	ITEM 6c
		Approval of Minutes from November 20	Issuance a Preliminary CMIR report	Approval of Lahey/Winchester CMIR	Approval of Partners/Hallmark CMIR
Carole Allen	Yes	Yes	Yes	Yes	Yes
Stuart Altman*	Yes	Yes	Yes	Yes	Yes
David Cutler	Yes	Yes (M)	Yes	Yes	Yes
Wendy Everett	Yes	Yes (2nd)	Yes (M)	Yes	Yes (M)
Paul Hattis	Yes	Yes	Yes	Yes (M)	Yes
Rick Lord	Yes	Yes	Yes	Yes	Yes (2nd)
John Polanowicz (Ann Hwang)	Yes	A	Yes	Yes	Yes
Glen Shor (Kim Haddad)	Yes	A	Yes	Yes	Yes
Marylou Sudders	Yes	Yes	Yes	Yes (2nd)	Yes
Veronica Turner	Yes	Yes	Yes (2nd)	Yes	(ab)
Jean Yang	Yes	A	Yes	Yes	Yes
Summary	**11 Members Attended**	**Approved with 8 votes**	**Approved with 11 votes**	**Approved with 11 votes**	**Approved with 10 votes**

*Chairman

(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; A: Absent from Meeting

PROCEEDINGS

A regular meeting of the Massachusetts Health Policy Commission was held on Wednesday, December 18, 2013, at Gardner Auditorium, Massachusetts State House, Boston, MA.

Commissioners present included Chair Stuart Altman; Dr. Carole Allen; Dr. David Cutler; Dr. Wendy Everett; Dr. Paul Hattis; Ms. Marylou Sudders; Mr. Rick Lord; and Ms. Veronica Turner.

Mr. John Polanowicz, Secretary, Executive Office of Health and Human Services; Mr. Glen Shor, Secretary, Executive Office of Administration and Finance; and Ms. Jean Yang arrived late to the meeting.

Chair Altman called the meeting to order at 11:04 AM and reviewed the agenda.

ITEM 1: Approval of the Minutes from the November 20, 2013 Meeting

Chair Altman solicited comments, additions, or corrections to the minutes from the November 20, 2013, Health Policy Commission meeting. Seeing none, he called for a motion to approve the minutes. **Dr. Cutler** made a motion to approve the minutes. After consideration, upon motion made and duly seconded by **Dr. Everett**, it was voted unanimously to approve the minutes from the November 20, 2013, board meeting.

Voting in the affirmative were the eight present Commission members. There were no abstentions and no votes in opposition.

ITEM 2: Executive Director Report

Mr. David Seltz, Executive Director for the Health Policy Commission, welcomed everyone to the eleventh meeting of the Health Policy Commission. He presented a report regarding the status of the Commission.

Mr. Seltz reflected on the first year of the Health Policy Commission. He noted that staff and Commissioners have been working to create a more affordable, efficient, and effective health care system, and thanked the health care industry for its continued cooperation.

Ms. Jean Yang arrived at the meeting.

Mr. Seltz outlined the day's meeting. He noted that there would be two major components to the meeting. First, staff would present the preliminary findings from the 2013 cost trends report. Mr. Seltz stated that the report affirmed Massachusetts' challenges and opportunities to meet the cost growth benchmark. Second, staff would present the preliminary report for the first cost and market impact review (CMIR). Mr. Seltz noted that this preliminary report was another step in the CMIR process, and the preliminary report would now be forwarded to the involved parties.

Mr. Seltz asked commissioners for questions. Seeing none, Chair Altman moved to the next agenda item.

ITEM 3: Care Delivery and Payment System Reform Update

Dr. Carole Allen, Chair of the Care Delivery and Payment System Reform (CDPSR) Committee, provided an overview of activities within the Committee. She thanked Dr. Patricia Boyce, Policy Director for Care Delivery and Quality Improvement, and Mr. Iyah Romm, Director of System Performance and Strategic Investment, for their work on CDPSR's major regulatory endeavors.

Dr. Allen reviewed action taken on the patient-centered medical home (PCMH) certification criteria since the last Commission meeting. She stated that staff had met with stakeholders about the certification process and participation. Dr. Altman commended the progress being made on PCMH certification and thanked stakeholders for their engagement.

Dr. Allen announced that CDPSR met on December 16, 2013 to discuss the proposed regulations on the Registration of Provider Organizations (RPO) program. She stated that these proposed regulations would move to the full Commission on January 8, 2014.

Dr. Cutler noted that a portion of CDPSR's work is very technical and that staff have done well in relaying complicated information to the Commissioners and the public.

Seeing no further comments, Dr. Altman moved to the next agenda item.

ITEM 4: Quality Improvement and Patient Protection Update

Ms. Marylou Sudders, Chair of the Quality Improvement and Patient Protection (QIPP) Committee, updated the Commission regarding the status and activities of the Committee.

Ms. Sudders stated that QIPP has been focused on the proposed regulations for the Office of Patient Protection (OPP), which would ensure compliance with the federal Affordable Care Act and provide more consumer protections. She noted that there was a public hearing on the regulations on December 16, 2013, and that written comments on the proposed regulations will be accepted through December 24, 2013 at 12:00 PM. The proposed regulations will be presented to the full Commission at the January 8, 2014 meeting. Dr. Altman commented that OPP constitutes an important segment of the HPC's work.

Ms. Sudders also provided a brief update on the guidelines for mandatory nurse overtime (MNO) that the Committee propagated during summer 2013. During the December 16, 2013 QIPP meeting, Dr. Ann Hwang from the Executive Office of Health and Human Services provided a brief update on the first two months of data reported by hospitals on MNO. This data is being used to create a baseline of the use of MNO and help frame the HPC's questions. Commissioners discussed the potential use for the data.

Dr. Altman asked for any further questions. Seeing none, he moved onto the next agenda item.

ITEM 5: Community Health Care Investment and Consumer Involvement Update

Dr. Paul Hattis, Chair of the Community Health Care and Consumer Involvement (CHICI) Committee, updated the Commission regarding the status and activities of the Committee. Dr. Hattis stated that the Committee had not met since the last Commission meeting but that staff had been busy implementing the CHART Investment Program. He introduced Mr. Iyah Romm to provide an update.

ITEM 5a: CHART Investment Program

Mr. Romm reminded Commissioners of the statutory criteria for eligibility for the CHART Investment Program. He provided a broad overview of the 28 proposals received by the HPC for Phase 1 of the Investment Program. He stated that there is a $10 million cap on Phase 1 Investments and that nearly $13.5 million had been requested across all the proposals. Mr. Romm next provided a list of the 63 partnering organizations included in the Phase 1 grant proposals.

Next, Mr. Romm presented on the themes highlighted in the proposals. He noted the consistent focus on patients and transformation. He also noted the wide variety of regulatory goals and programs discussed in the proposals.

Mr. Romm read the designation of Commissioner Paul Hattis as a member of the CHART Investment Review Board for Phase 1. Dr. Hattis stated that he was glad to be part of the review process.

Finally, Mr. Romm reviewed the timeline for the Phase 1 grant dispersal. He stated that the selection of awardees would occur at the January 8, 2014 Commission meeting and that project contracts would be executed on or around February 1, 2014.

Dr. Cutler stated that he was very excited by the number of proposals received and the generally positive response on the application process.

Dr. Altman thanked the staff for their work. He noted that it was interesting to see the distribution of activities proposed by the applicants.

Ms. Yang asked how the HPC staff envisioned working with organizations once the grants were dispersed. Mr. Romm responded that these types of requirements were laid out in the Request for Proposals (RFP). Many of these requirements are still in development. He noted that more detail would be available in January.

ITEM 6: Cost Trends and Market Performance Update

Dr. Cutler, Chair of the Cost Trends and Market Performance (CTMP) Committee, introduced the agenda items to be discussed by his Committee: the annual cost trends report and cost and market impact reviews (CMIR).

ITEM 6a: Annual cost trends report

Dr. Cutler acknowledged the staff on the cost trends team for their hard work on the HPC's first annual cost trends report. He noted that it was a process that took many months and builds off of work completed by the Attorney General's Office and the Center for Health Information and Analysis (CHIA). He introduced Mr. Nikhil Sahni, Policy Director for Cost Trends and Special Projects, to present on preliminary findings.

Mr. Sahni reviewed the role of the Health Policy Commission with respect to cost trends. He noted that Chapter 224 charges government agencies with bringing health care spending growth in line with the growth of the Massachusetts' economy. The HPC is working towards this goal in a variety of ways, including analyzing and reporting on cost trends through data examination.

Mr. Sahni next reviewed the goals for the 2013 cost trends report. He stated that this report will not address the cost growth benchmark. Instead, it will provide a profile of Massachusetts, a fact-based review of the health care market, and an analysis of specific cost trend drivers in Massachusetts. He noted that the staff was writing the report for a broad audience of industry officials, state agencies, consumers, and businesses.

Mr. Sahni next provided an overview of the topics covered in the 2013 cost trends report. He outlined his presentation of the first four chapters of the report, which pertain to the profile of Massachusetts. At the January 8, 2014 board meeting, he will present on the "deep-dives," or the last three chapters of the report.

Mr. Sahni next provided preliminary findings from the Massachusetts profile section. He stated that, for the purpose of the report, the staff is comparing Massachusetts' spending to spending in the United States. He emphasized that this was not to say that the US spending is the correct average, but rather to provide a comparison that would allow staff to identify areas of improvement and demonstrate where Massachusetts' spending stands relative to the rest of the United States.

Mr. Sahni presented on personal healthcare expenditures relative to the size of the economy for both Massachusetts and the US. He noted that, since 1990, Massachusetts has spent a higher portion of their economy on health care than the US. Since 2001, however, the gap between the two has increased, meaning that Massachusetts' health care cost is growing faster than that of the United States.

Mr. Sahni then reviewed the major preliminary findings from the first four chapters of the report. This information can be found on the Health Policy Commission's website (www.mass.gov/hpc) under the Meeting Agendas and Materials for the December 18, 2013 Commission meeting.

Mr. Sahni reviewed the preliminary findings for Medicare, which stated that the difference between Massachusetts and US spending was driven mostly by price adjustments for teaching and wages. Dr. Altman stated that there were three factors to emphasize: (1) hospitals get more money for teaching; (2) price includes adjustments for cost of living and Massachusetts is an expensive place to live; and (3) the Massachusetts population is more likely to use teaching hospitals and that is reflected in their more expensive price. Mr. Sahni responded that price, as used in the report, symbolized the unit price and use of hospitals.

Mr. Sahni presented on the preliminary findings from Medicaid, which stated that differences in spending are driven by the breadth of benefits, reimbursement levels, and enrollment. Dr. Allen asked what percentage of those on Medicaid in Massachusetts are children. Mr. Anuraag Chigurupati, Deputy Policy Director for Cost Trends and Special Projects, responded that there is a higher proportion of adults in Massachusetts than in the national average. Dr. Marian

Wrobel, Director for Research and Analysis, stated that most spending is on adult Medicaid recipients.

Ms. Sudders stressed three things with respect to Medicaid: (1) Massachusetts was the first state to eliminate the disabled category for Medicaid eligibility; (2) when Massachusetts wanted to insure its population, more citizens were eligible on the Medicaid platform; and (3) when discussing Medicaid, "generous benefits" may be a misnomer because mandatory benefits are quite small.

Ms. Yang asked whether there was a way to address the cost differences by type of policy to see if it explains the increase in spending not attributed to demographics.

Dr. Hattis commended staff on their work identifying spending in Massachusetts that can be contributed to waste in the system. Dr. Cutler stated that eliminating waste would not decrease spending by 20% in Massachusetts. He noted that the national average for health care waste spending is 30% in the United States.

Mr. Sahni presented on commercial prices in Massachusetts. He noted that they were the primary driver of the increased difference from the US average and likely reflected an underlying utilization problem. Dr. Altman echoed this notion. He stated that there was no question that Massachusetts' residents utilize care where they should not. He also stated that there are many implications to the fact that price is more influential than utilization.

Mr. Sahni presented on the importance of shifts in payer mix. He presented a scenario in which payers perform below the statewide benchmark, but the state overall still does not meet the benchmark. He attributed this, in part, to enrollment effects. Dr. Hattis clarified that this was a reclassification issue, not something being done. Dr. Cutler confirmed this, stating that the aging effect is very real.

Mr. Sahni next presented on the Massachusetts delivery system. He noted that Massachusetts uses major teaching hospitals much more than the US. Dr. Altman highlighted the finding that nearly 70% of discharges in Massachusetts come from major teaching hospitals or hospitals within the system of a major teaching hospital. Mr. Lord asked how this compared nationally. Mr. Sahni replied that that was outside of the realm of the available data.

Mr. Sahni reviewed the condition and procedure quality measures in the US and Massachusetts. Dr. Allen noted that the list provided by staff shows where Massachusetts is slightly underperforming, providing opportunities to address the "low hanging fruit" issues. Dr. Cutler affirmed this and suggested analyzing themes and seeing how they can be addressed by other HPC activities such as the PCMH certification program and the CHART Investment Program.

Mr. Sahni presented the conclusions from the first four chapters of the 2013 cost trends report. Dr. Altman thanked the staff for their work and noted that the statistics provided in the report will drive the HPC's efforts and those in the health care system to focus on areas for improvement. Dr. Cutler noted that most of the data in the report predates Chapter 224. He

highlighted the key finding that it has historically been difficult to sustain a decrease in health care spending.

Dr. Cutler asked what comments staff received on the first four chapters from members of the technical advisory group. Mr. Sahni replied that they are more interested in the succeeding chapters because they will provide actionable steps to reduce cost.

Dr. Altman commented on Massachusetts spending. He noted that Massachusetts is a wealthy state, so it is not out of line to spend more on health care. He emphasized the importance of focusing on health care spending as a percent of income. He noted that, across the US, Massachusetts does not spend the highest percentage of their income on health care, but the state does spend a large amount. He stated that the goal is not to just save money, but also to increase quality and access.

Dr. Everett noted that as health care spending increases, the state is able to spend less in other important areas, like education. She emphasized the need to push back on cost growth. Mr. Sahni stated that the report illustrates this crowding out effect.

Ms. Yang expressed her excitement for the report because of the data and framework. She wanted more information on how spending changed as a result of the 2006 health care reform in Massachusetts. She noted that this information would be important for Massachusetts and the US. Mr. Sahni responded that this information will be in the report.

Mr. Lord stated that per capita cost in Massachusetts as opposed to other states is important to employers, especially since Massachusetts is a high wage state.

Dr. Hattis stated that people are willing to spend more money on health care so long as they get more and it does not crowd out other things that will ultimately affect their health.

Dr. Altman asked for any further comments or questions. Seeing none, he moved to the next agenda item.

ITEM 6b: Preliminary report on cost and market impact review (CMIR)

Dr. Cutler introduced the preliminary report on the cost and market impact reviews of Partners HealthCare System, South Shore Hospital, and Harbor Medical Associates (PHS-SSH-Harbor). He noted that the Partners-SSH CMIR began six months ago and that the release of the preliminary report represents another step in the review process. The parties will have the opportunity to respond within 30 days, before issuance of the final report. He thanked the parties for their engagement and data contributions.

Ms. Karen Tseng, Policy Director for Market Performance, presented the preliminary report. She reviewed the purpose and statutory framework for CMIRs, and the HPC's process for conducting these reviews. To evaluate the PHS-SSH-Harbor transactions, the staff gathered data and documents from the parties, payers and other providers, and also relied on publicly accessible data wherever possible to minimize burden on market participants.

Ms. Tseng noted that the two transactions addressed in the preliminary report are Partners' proposed acquisitions of two providers on the South Shore. One, SSH, is the largest hospital on the South Shore. The other, Harbor, is an independent 65-physician practice that is clinically aligned with SSH and has been jointly participating in risk contracts with SSH for many years. Based on the transaction documents, SSH would become a community hospital member of the Partners system, and Harbor would become an owned member of Partners' physician network, in the Brigham and Women's Physicians Organization. In the parties' respective notices of these transactions filed with the HPC, they describe mirroring goals for these transactions to improve population health management and efficiencies on the South Shore. Ms. Tseng then provided more detail on the parties.

In structuring the HPC's review of the impact of these transactions on costs, quality, and access, Ms. Tseng noted that her staff examined multiple years of data leading up to the transactions to establish the parties' baseline performance in these areas. Staff combined that data with the parties' goals, plans, analysis, and the terms of the transaction agreements to model the impact of these transactions in each of these areas. The rest of the presentation is organized into six parts showing our baseline and impact findings on costs, quality, and access.

In terms of the parties' baseline cost performance, Ms. Tseng presented findings on four metrics: financial condition, relative price, total medical expenses (TME), and market share. On financial condition, she noted that Partners and SSH both have significantly greater net assets and operating revenue than other providers in MA, that Partners' total cash and equivalents are more than double those of the next three largest MA systems combined, and that Harbor Medical Associates has also experienced steady revenue growth.

On price, Ms. Tseng noted that Partners and SSH receive higher prices than other area hospitals. Harbor and the rest of SSPHO receive prices that are on the lower end, and PCHI receives prices on the high end, compared to area physician groups. PCHI and SSPHO both have higher TME than other area providers.

Next, Ms. Tseng presented a map of SSH and Partners' hospitals, including the parties' hospital services areas. The map demonstrated that Partners hospitals already provide a lot of care for residents of southeastern Massachusetts, though Partners does not currently have a hospital located in that region. Ms. Tseng noted that SSH and Partners are the top two providers of commercial inpatient services in the SSH service area, accounting for 50% of commercial inpatient volume. Ms. Tseng also noted that PCHI has strong physician market share, receiving 27% of statewide physician revenue from the three largest commercial payers.

Ms. Tseng next reviewed the parties' baseline quality performance. Staff examined more than 100 measures of care delivery across a spectrum of domains: measures of the structure of health care organizations; clinical process and outcome measures; measures of patient experience. Consistent with the analysis of cost metrics, in evaluating quality, staff compared the parties to each other, to other providers, over time, and to national and statewide benchmarks.

Ms. Tseng noted that the parties are all high quality. Across a spectrum of settings, their performance exceeds national and statewide benchmarks. Each party performs better on certain measures, but there are very few measures for which variation is significant.

Ms. Tseng next reviewed baseline findings on access. She noted that many in the Commonwealth monitor the accessibility of patient services. Chapter 224 directs the HPC to examine two measures that are currently not consistently tracked: providers' payer mix and service mix. For the purpose of the current CMIRs, staff focused on measures of hospital payer mix and service mix, where data are the best. Staff looked at payer mix both by revenue and discharges and also examined service mix by discharges.

Ms. Tseng reviewed payer mix by revenue for the five hospitals operating on the South Shore. The highest commercial payer mix is SSH. This pattern holds true for all Partners hospitals except for North Shore Medical Center.

Ms. Tseng presented findings on inpatient service mix, focusing on the service mix of patients in SSH's service area. In 2011, there were 100,000 discharges of patients living in this region. The mix of impatient services they received was 60% medical, 22% surgical, 12% obstetrics, and 6% behavioral health. Out of the 100,000 discharges for patients in this service area, SSH cared for 19,000. Of those 19,000, South Shore delivered medical services 64% of the time, surgery 17%, obstetrics 18%, and behavioral health 1%. Ms. Tseng noted that SSH's four area competitors provided a mix of inpatient services to area patients that was more medical discharges (72% versus SSH's 64%); less surgery (14% versus 17%); less obstetrics (6% versus 18%); but more behavioral health (8% versus 1%). She noted that residents of the South Shore area were traveling outside the region for surgery discharges, notably to downtown Boston AMCs. Monitoring service mix is important because service mix has financial implications – certain service lines, like behavioral health, tend to be lower margin than other service lines, like surgery.

Having completed the baseline review, Ms. Tseng moved to the HPC's analysis of the impact of the transactions on cost, quality and access. The analysis of cost impact focused on three questions: (1) Will these transactions result in changes in price? (2) Will they result in changes in care referral patterns that shift utilization to higher-priced providers? (3) Will market leverage increase, meaning the ability to negotiate more favorable contract terms in future, including more favorable prices?

Ms. Tseng discussed the anticipated impact of the transactions on physicians, before moving to hospitals. She noted that different physician groups are paid different prices in Massachusetts. That means when a lower-priced group is bought by a higher-priced group, prices generally increase. Staff modeled this impact for Harbor Medical Associates, which earlier slides showed is paid lower rates than Partners physicians. Exactly how much prices will go up, and what the impact to total spending will be, depends on the specifics of the payer contract provisions that govern physician network growth. For each of the three major payers, there is room for new physicians to join Partners at Partners' rates. Staff modeled the impact to total medical spending based on this available room in current contracts. Since one of these three contracts is up for renegotiation for January 2015, the HPC cannot know with certainty what the terms of this

contract will be a year from now, which is when Harbor reports they would join PCHI's contracts.

Staff found that under the contracts, there is often a "ramp-up" phase for all physicians to receive full PCHI prices. Ms. Tseng reported that, for the first three years after Harbor joins PCHI, staff expects the three major payers to spend an additional $7.2 million each year (or about $22 million over those three years) for Harbor's services at their new rates. Beginning in Year 4, that annual increase will go up to $8 million.

The staff's review of contracts also indicates there is room for more than just the Harbor physicians to join PCHI. Consistent with past experience in Massachusetts, when a hospital joins a new system, many of its affiliated physicians may follow. Ms. Tseng noted that staff did not model the impact of all 400 SSPHO physicians joining PCHI, but only the additional number of physicians permitted in current contracts, which is a much lower number. The increase in price for those additional physicians amounts to an additional $6 million in spending per year for the three major payers. When the effects are fully felt (after the ramp-up period), that number goes up to $7.7 million per year. Overall, Harbor and some additional physicians joining PCHI would result in a permanent increase to total medical spending in the South Shore region of up to 0.9%.

Ms. Tseng stated that physicians are also important because they help direct where patients get their hospital and other care. She discussed staff analysis that looked not at whether physicians' own prices would change, but whether they were likely to shift care to higher-priced hospitals as a result of the transactions, thereby increasing total spending. When staff examined current South Shore physicians' care referral practices, staff found they look similar to the practices of existing PCHI physicians. There is some room for increased use of the Partners AMCs as opposed to other AMCs, particularly for outpatient care, which would amount to about $1.6 million in increased spending each year by the three major payers. But overall, staff would not expect to see a dramatic change in the care referral patterns and resulting costs of existing SSPHO physicians.

Ms. Tseng stated that changes in care referral patterns would be more dramatic if new physicians, not from SSPHO, join PCHI. Partners and SSH have underscored that two of the three key initiatives of the transactions are primary care physician and specialty care physician initiatives to develop the parties' physician network to successfully implement population health management on the South Shore. The parties have specified recruiting 27 to 42 new primary care physicians to their network. They have stated these physicians do not necessarily have to come from other Massachusetts groups. Consistent with observed industry practices, where physicians are often recruited from other providers operating in Massachusetts, staff believed it was important to provide transparency on how this can affect total medical spending.

Ms. Tseng stated that Partners and SSPHO currently refer to a high-priced mix of hospitals – Partners hospitals and SSH. She noted that all of the other major physician groups operating in the South Shore region use a mix of hospitals for outpatient care that is consistently lower-priced. For inpatient care, four of the five other area physician groups use a mix of hospitals that is consistently lower-priced. If physicians from any of these other groups are recruited to PCHI

and shift their referral practices to be more in line with PCHI practices, the average cost of care for these patients will increase. Staff projects those increases to be on the range of $5.8 to $9 million per year for the three major payers, depending on how many physicians are recruited and from where. Combined with the modest $1.6 million in increased spending from changes in existing SSPHO care referral practices, Ms. Tseng stated that the total impact from shifts in care referral practices would be expected to be on the order of $7.4 to $10.6 million per year for the three major payers.

Ms. Tseng next discussed whether changes in market structure and concentration are expected to increase the parties' ability to leverage higher prices and other favorable contract terms in negotiations with commercial payers. She stated that staff focused on measures of hospital market share and concentration, where data is most readily accessible. Given the importance of hospital services in the health care system, changes in the hospital market can shed light on potential changes in related markets, such as for physician services.

Ms. Tseng presented on the Herfindahl-Hirschman Index (HHI), a well-established metric of market concentration. Ms. Tseng outlined the thresholds used by federal agencies as initial screens for assessing whether changes in concentration (of the HHI) are likely to raise concerns that warrant further review – or may even raise a presumption of enhanced market leverage. She stated that the two numbers to keep in mind are the absolute level of concentration – is it approaching or crossing the threshold of 2500 HHI points – and the change in HHI that results from the transaction – is it increasing concentration by at least 200 points. HPC staff modeled changes in market concentration using both the HPC's definition of SSH's service area and SSH's own definition of its service area.

Ms. Tseng stated that, whether assessing changes in market concentration using the service area the HPC identified or that SSH identified, the results are the same: this hospital merger will raise concentration levels above the 2500 threshold that defines a highly concentrated market and increase concentration by well more than 200 points. This raises concerns about effective market functioning that warrant further review.

Ms. Tseng noted that the preliminary report explores a fourth topic, facility fees, in greater depth. In brief, she stated there is a trend in Massachusetts and nationally where hospital systems have purchased the freestanding outpatient and ancillary facilities owned by independent practice groups. Here, Partners would be purchasing Harbor's clinics and freestanding facilities, like its urgent care center and endoscopy center. If these independent facilities are integrated into the parties' operations as hospital outpatient clinics, the parties have the opportunity to add facility fees, which has been a recent trend. That will also add to medical spending.

Dr. Altman stated that there had been a lot of discussion about added facility fees. He asked whether staff had estimated a specific cost impact of added facility fees from these transactions. Ms. Tseng responded that this would be a very data intensive analysis that was beyond the scope of the current CMIR analysis.

Next, Ms. Tseng discussed the likely impact of the transactions on quality and care delivery. This analysis of care delivery impact focused on three questions: (1) What has the parties'

experience been in improving care delivery and population health management? (2) Based on historic savings, what is the scope for cost savings in these transactions? (3) Are these benefits dependent on a corporate acquisition?

The parties directed staff to three examples of their past work that they highlight as opportunities for these transactions to drive care delivery improvements: Partners' performance in two Medicare programs – a 2006 demonstration for high-risk Medicare patients and the first year of Partners' performance as a Medicare Pioneer ACO. They also directed staff to one program in the commercial space – the parties' performance in Blue Cross Blue Shield's Alternative Quality Contract (AQC). In examining quality performance in each of these programs, staff found positive results that demonstrate the potential for future care delivery improvements. In examining efficiency performance, staff found the potential for two of the three programs to result in efficiency gains. However, the known costs of the transactions far exceed the highest potential range of efficiency gains.

For Partners' 2006 high-risk Medicare demonstration, adopting the highest levels of savings that Partners achieved for its best performing cohort and applying to a comparable population on the South Shore, staff found the highest range of potential savings to be on the order of $6.4 million per year. Conversely, if South Shore's experience were to align more closely with the worst performing Partners cohort, the community hospital that participated, then increases in spending would be projected, not savings. For the Pioneer ACO, staff similarly modeled Partners' Year One savings to the Medicare population on the South Shore and found savings in the range of $150,000 to $240,000 per year.

Staff examined the third program the parties cited, in the commercial space, and found that South Shore performed better than Partners in the AQC. Staff saw no evidence that being acquired by Partners would drive performance efficiencies in the commercial space that South Shore is not already achieving. Ms. Tseng noted it would not be appropriate to apply savings achieved from a high-risk Medicare population to a younger, healthier commercial population, or to presume that interventions effective for one population would yield similar savings in the other.

Finally, Ms. Tseng stated that staff examined whether there were particular features of a corporate acquisition, as opposed to some other form of contractual or clinical relationship, that would be expected to drive desired quality improvement. Ms. Tseng noted that the parties have underscored the necessity of a corporate acquisition to finance what they describe as $200 million in needed investments to improve population health management on the South Shore. Ms. Tseng also noted that SSH and SSPHO are already demonstrating comparable levels of quality performance to Partners, particularly in the outpatient setting, where physicians are central to driving population health management. SSH and its PHO have also been managing the cost and quality of patient care under risk contracts for many years, and Harbor has recently begun bearing risk for Medicare patients. The parties' own experience of strong quality performance and managing risk make it unclear that acquisition by Partners is integral to raising clinical quality performance in the South Shore region.

Ms. Tseng next presented staff's findings the impact of the transactions on payer mix and service mix. She stated that the parties did not identify any plans for specific service line changes or

outreach to populations that would lead staff to project changes in the parties' existing hospital payer mix or service mix trends. She also stated that Harbor Medical Associates indicated it would begin accepting new MassHealth primary care patients following its acquisition by Partners.

Having reviewed the baseline and impact findings on costs, quality, and access, Ms. Tseng presented the staff's conclusions. She stated that the transactions are anticipated to increase total medical spending by $23 million to $26 million each year for the three major payers. She noted that the increases in spending are projected to far exceed the potential cost savings from the expansion of Partners' population health management initiatives into the South Shore region. Ms. Tseng stated that it is unclear how corporate ownership of the parties is instrumental to raising quality performance in the South Shore region. Finally, she noted that Partners and SSH have not proposed specific changes in services that would cause the HPC to anticipate changes to their existing hospital service mix and payer mix trends.

Dr. Hattis asked whether the projected increases in spending are based on doctors moving to different contracts if the deal closes. Ms. Tseng responded that they are based on known numbers.

Dr. Hattis asked Ms. Tseng to confirm that the projected increases in annual spending will increase from $6.0 million in Years 1 to 3 to $7.7 million in Years 4 and onward for the additional SSPHO physicians. Ms. Tseng confirmed this statement.

Dr. Hattis asked whether the number of new physicians projected to be recruited after the transactions close was reported by the parties. Ms. Tseng responded in the affirmative.

Dr. Hattis noted that the analysis was based on the three major insurers. He asked whether there was any way to capture the effect on other commercial insurers. Ms. Tseng responded that the numbers used are all conservative, based on 80% of the market and current contracts. Dr. Hattis asked whether the addition of the missing 20% of the market would cause a spending impact. Ms. Tseng responded that it would.

Mr. Seltz reviewed next steps if the preliminary report is approved by the board.

Dr. Altman emphasized that this is a preliminary report that would be issued to the parties so that they may provide written comments. The final report will be issued after the parties' 30 day period for comments.

Mr. Seltz commented that the staff is recommending referring the transaction to the Office of the Attorney General based on evidence of the need for further review. Ms. Sudders asked what version of the report would be referred. Mr. Seltz commented that the Office of the Attorney General would receive the final report if approved by the Board.

Dr. Hattis addressed the Commissioners and encouraged them to join him in voting to approve the preliminary report. He noted that Chapter 224 relies on the shared responsibility of private actors and encouraged the parties to make decisions based on the report. He noted that the

executives for all of the parties are people trying to do good. He urged them to make decisions based on their organization's mission and consider abandoning the proposed transaction.

Chair Altman solicited any additional comments or questions. Seeing none, he called for a motion to issue the preliminary report on the cost and market impact reviews. **Dr. Everett** made a motion to issue. After consideration, upon motion made and duly seconded by **Ms. Turner**, it was voted unanimously to approve issuance of the preliminary CMIR report to the parties.

Voting in the affirmative were the eleven present Commission members. There were no abstentions and no votes in opposition.

ITEM 6c: New cost and market impact reviews

Ms. Tseng next reviewed the two pending cost and market impact reviews.

First she provided a summary of Lahey's proposed acquisition of Winchester Hospital. She described the transaction and the basis for review.

Next, she provided a summary of Partners' proposed acquisition of Hallmark Health System. She described the transaction and the basis for review. Mr. Seltz noted that Ms. Turner recused herself from all votes and discussions concerning this transaction because she is the chief negotiator for SEIU 1199, which is in negotiations with a Hallmark hospital.

Ms. Tseng summarized the factors the HPC will be examining in conducting both CMIRs.

Chair Altman solicited any additional comments or questions. Seeing none, he called for a motion to authorize the continuation of the cost and market impact review of Lahey's proposed acquisition of Winchester Hospital. **Dr. Hattis** made a motion to issue. After consideration, upon motion made and duly seconded by **Ms. Sudders**, it was voted unanimously to authorize the CMIR.

Voting in the affirmative were the eleven present Commission members. There were no abstentions and no votes in opposition.

Chair Altman called for a motion to authorize the continuation of the cost and market impact review of Partners HealthCare System's proposed acquisition of Hallmark Health System. **Dr. Everett** made a motion to issue. After consideration, upon motion made and duly seconded by **Mr. Lord**, it was voted unanimously to authorize the CMIR.

Voting in the affirmative were the ten present Commission members. **Ms. Turner** abstained.

ITEM 8: Schedule of Next Commission Meeting

Following the conclusion of discussion of the final agenda item, Chair Altman announced the date of the next board meeting, January 8, 2014, and adjourned the meeting of the Health Policy Commission at 2:01 PM

LIST OF DOCUMENTS PRESENTED AND POSTED AFTER THE MEETING

1. Meeting Agenda, 12/18/2013
2. Minutes of the 11/20/2013 Health Policy Commission Meeting
3. Board Presentation, 12/18/2013