MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

January 25, 2022

Agenda

CALL TO ORDER

APPROVAL OF MINUTES **(VOTE)**

EXECUTIVE SESSION **(VOTE)**

PERFORMANCE IMPROVEMENT PLAN PROCESS

MASS GENERAL BRIGHAM DETERMINATION OF NEED PROCESS: HPC PUBLIC COMMENT **(VOTE)**

EXECUTIVE DIRECTOR'S REPORT

SCHEDULE OF UPCOMING MEETINGS

Agenda

CALL TO ORDER

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SCHEDULE OF UPCOMING MEETINGS

VOTE

Approval of Minutes from the September 15, 2021 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on September 15, 2021, as presented.

VOTE

Approval of Minutes from the November 8, 2021 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on November 8, 2021, as presented.

Agenda

CALL TO ORDER

APPROVAL OF MINUTES **(VOTE)**

EXECUTIVE SESSION (VOTE)

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VOTE

Enter into Executive Session

MOTION

That, having first convened in open session at its January 25, 2022 board meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with M.G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, M.G.L. c. 6D, § 2A, and M.G.L. c. 12C, § 18, in discussions about whether to require performance improvement plans by entities confidentially identified to the Commission by the Center for Health Information and Analysis.

The Board has voted to enter a closed Executive Session.

The livestream of the public portion of the meeting will recommence at approximately 1 PM.

Agenda

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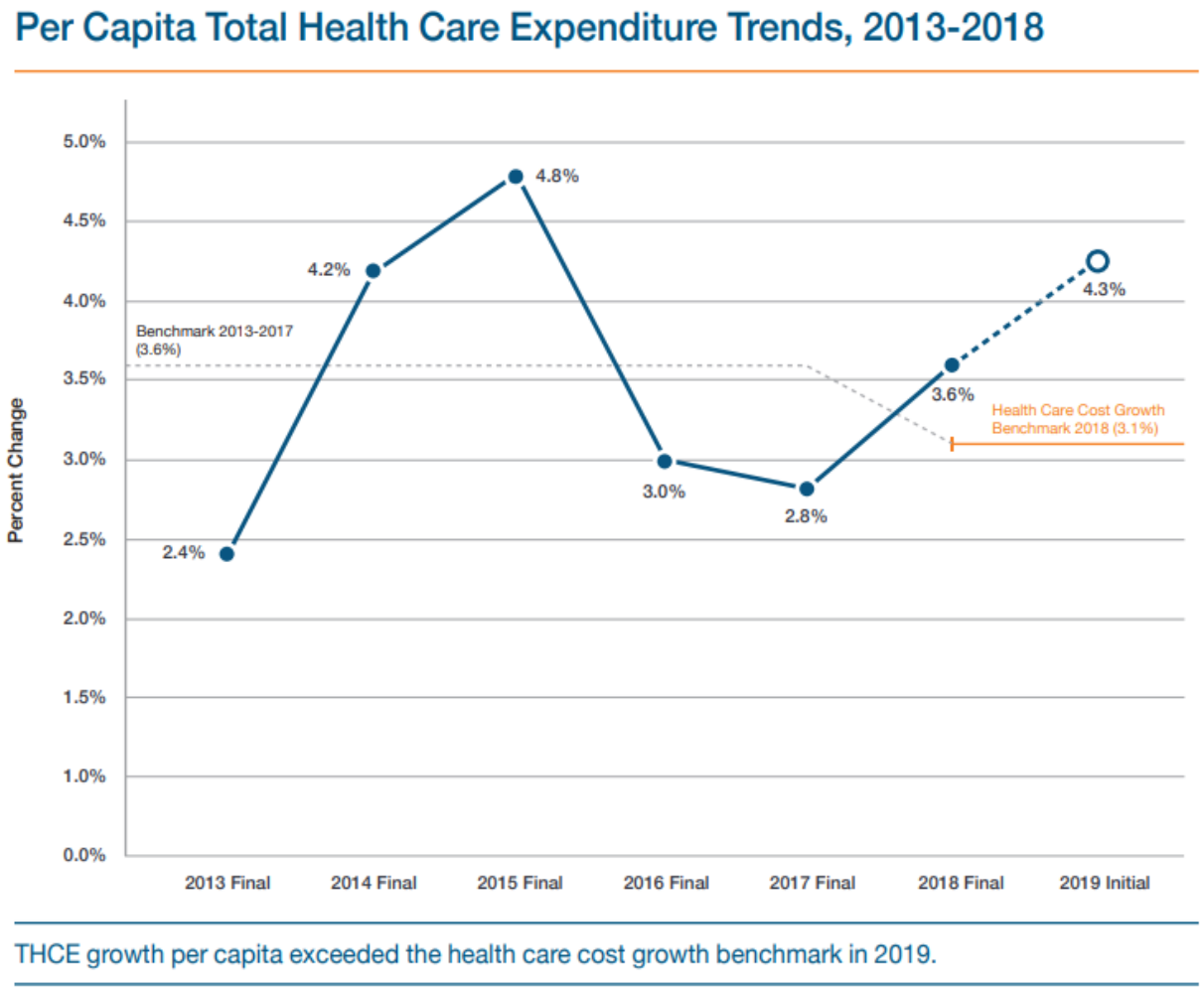
EXECUTIVE DIRECTOR'S REPORT

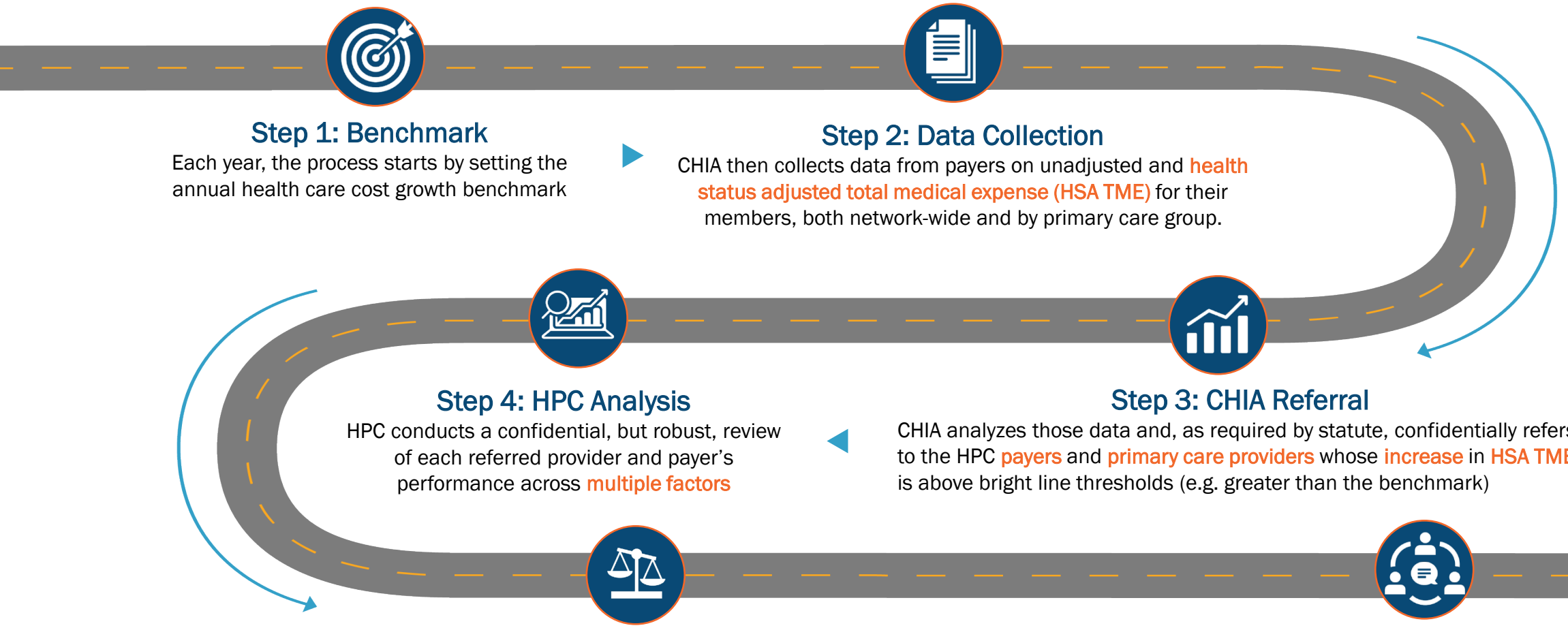
SCHEDULE OF UPCOMING MEETINGS

Overview of Performance Improvement Plans: Purpose



- From 2017-2018 and 2018-2019, statewide Total Health Care Expenditures grew faster than the benchmark, at 3.6% and 4.3%, respectively.
- The HPC can hold individual payers and providers accountable for their spending growth relative to the benchmark by requiring them to develop and implement a Performance Improvement Plan, or PIP.
- A PIP developed by the entity must contain strategies, action steps, and measurable expected outcomes to improve the payer or provider's spending performance.

Accountability for the Health Care Cost Growth Benchmark



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and health status adjusted total medical expense (HSA TME) for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and, as required by statute, confidentially refers to the HPC payers and primary care providers whose increase in HSA TME is above bright line thresholds (e.g. greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across multiple factors

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the HPC Board votes to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

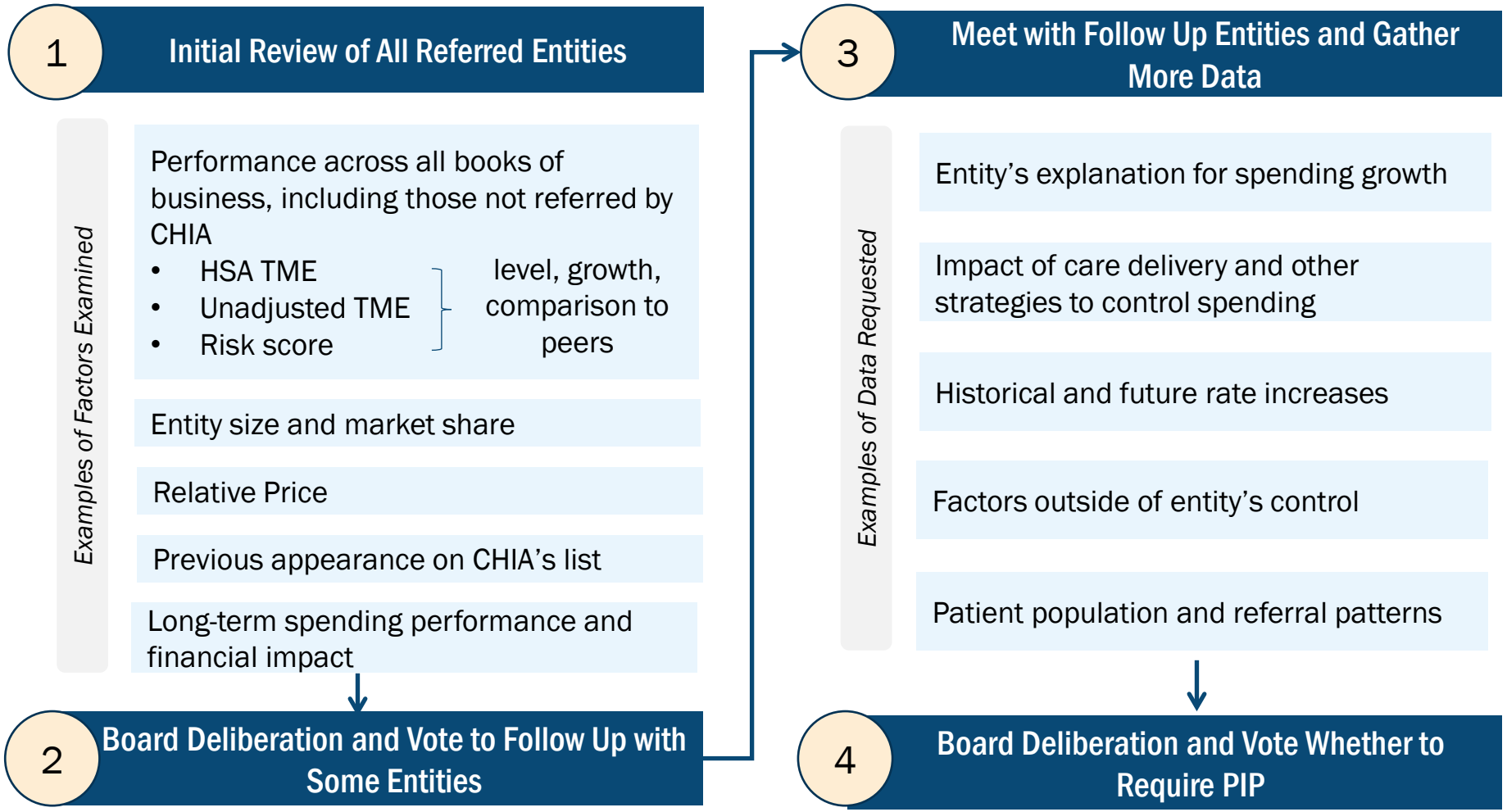
We are here

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to ongoing monitoring by the HPC during the 18-month implementation. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

Overview of Performance Improvement Plans: HPC Review

After referral of payers and providers by CHIA, the HPC conducts a confidential, robust, and multi-factored review of each referred entity, in consultation with its Commissioners.



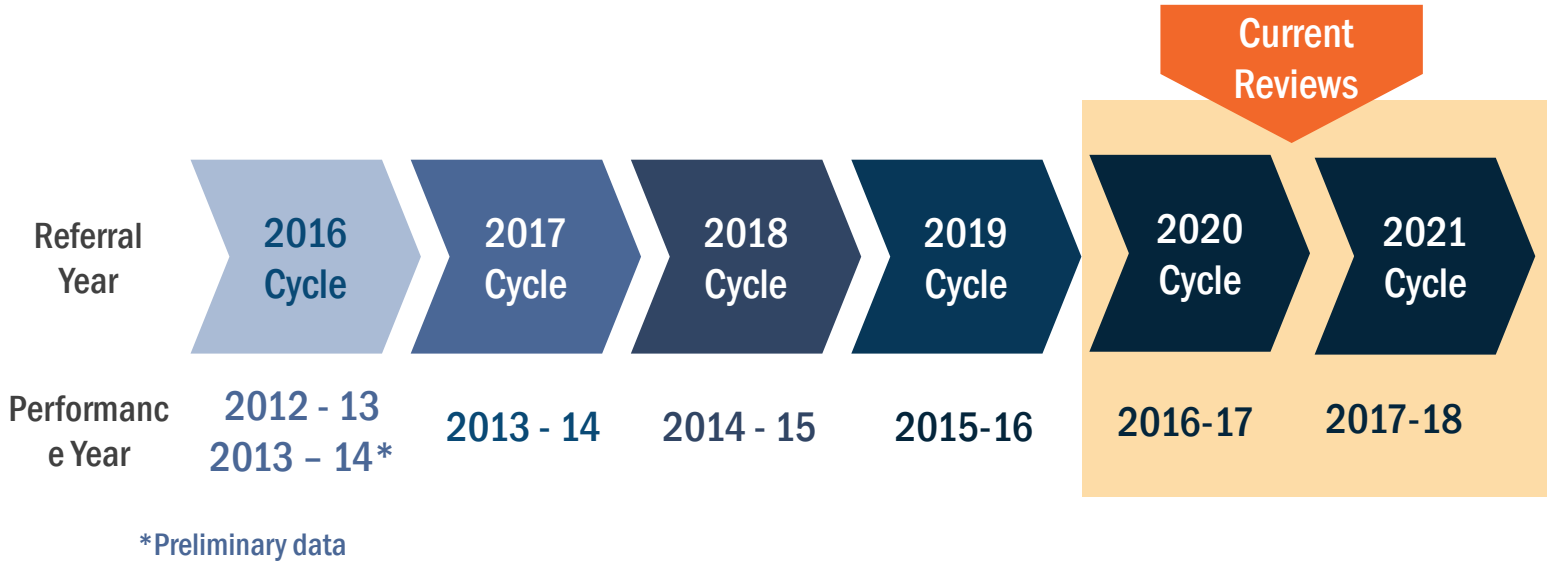
Overview of Performance Improvement Plans: Factors Review by the Commission

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies significant concerns about the Entity's costs and determines that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

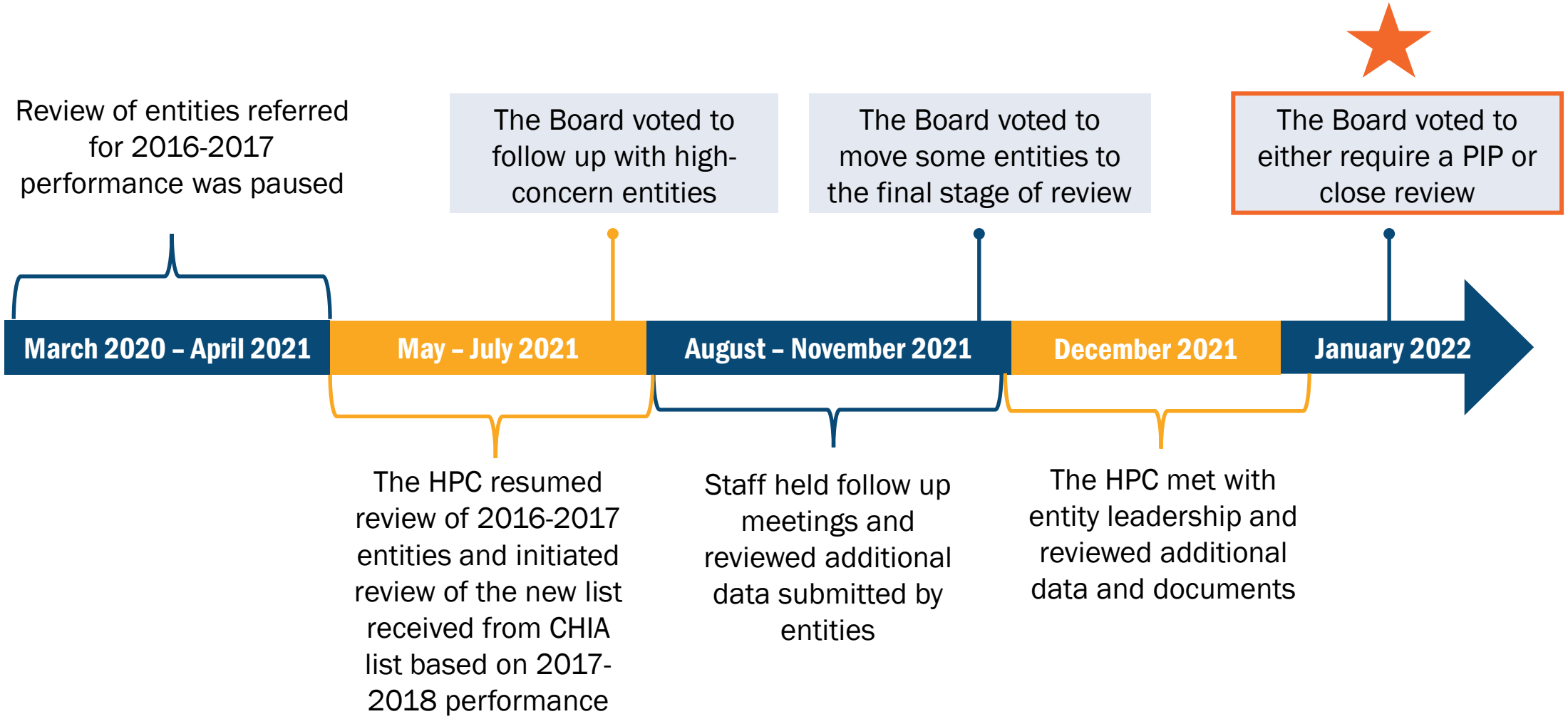
REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

Performance Improvement Plans: Program History

- The HPC has been reviewing spending trends in the PIPs process for six years.
- With each additional year of data, the HPC has been better able to differentiate between spending increases driven by time-limited factors (e.g., high-cost outliers; employers or physician groups leaving or entering networks) and persistent patterns that raise more significant concerns.



Timeline of 2020 and 2021 PIPs Reviews



PIPs Vote in Executive Session

The Board has voted to require a Performance Improvement Plan from Mass General Brigham.

In reviewing MGB's long term spending trends and the regulatory factors[1], the HPC found that:

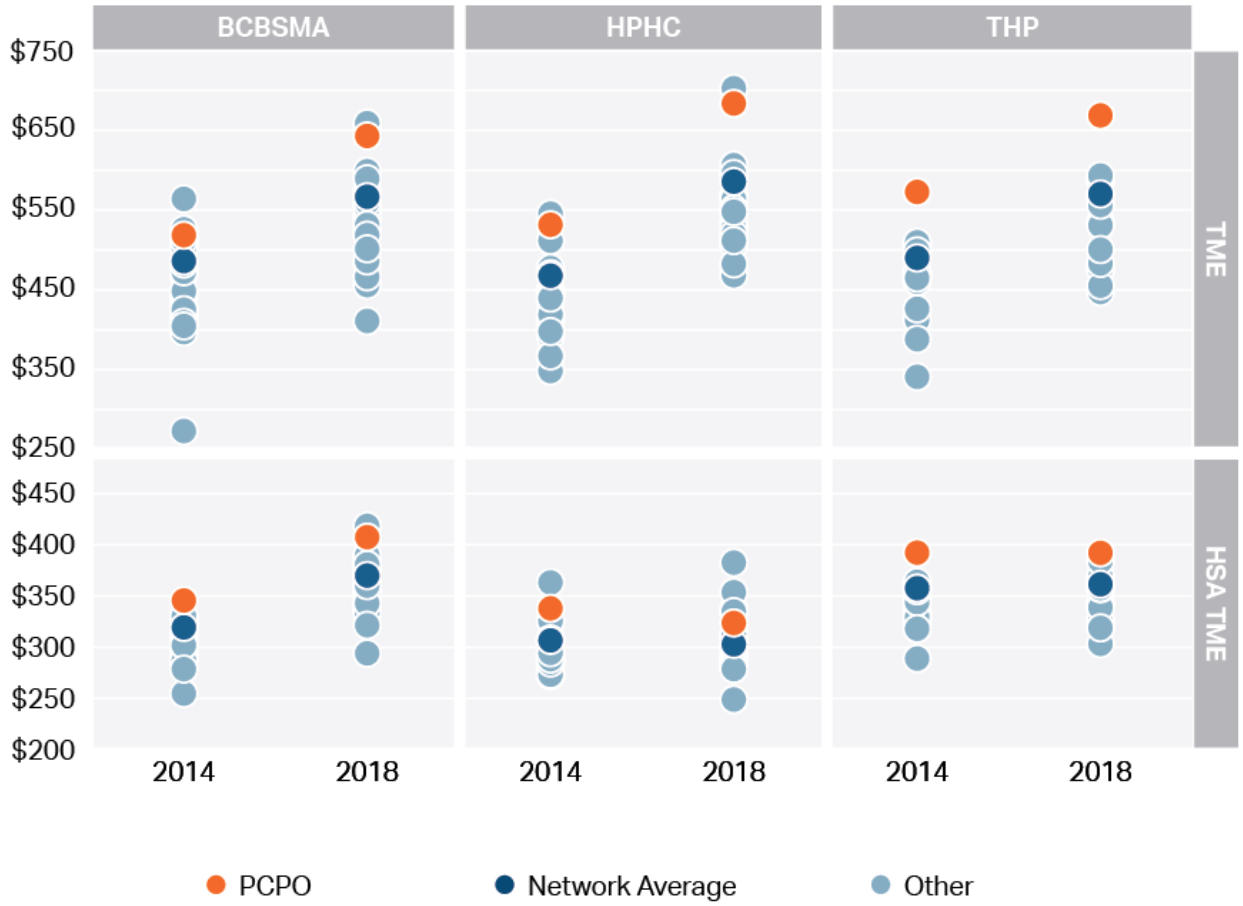
- Spending performance for MGB raises significant concerns and has likely already impacted the state's ability to meet the health care cost growth benchmark.
- Unless addressed, MGB's spending performance is likely to continue to impact the state's ability to meet the benchmark.
- The information provided by MGB in meetings and in response to HPC's requests did not allay the concerns identified by the HPC in its analyses of MGB's performance.

The HPC determined that a Performance Improvement Plan could result in meaningful, cost-saving reforms.

1. The Board examined a wide array of both public and confidential data sources during the PIPs review. In accordance with its statute, the HPC is only releasing confidential information in summary form or when it has determined that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations.

Summary Performance: Mass General Brigham

Unadjusted TME and HSA TME Levels

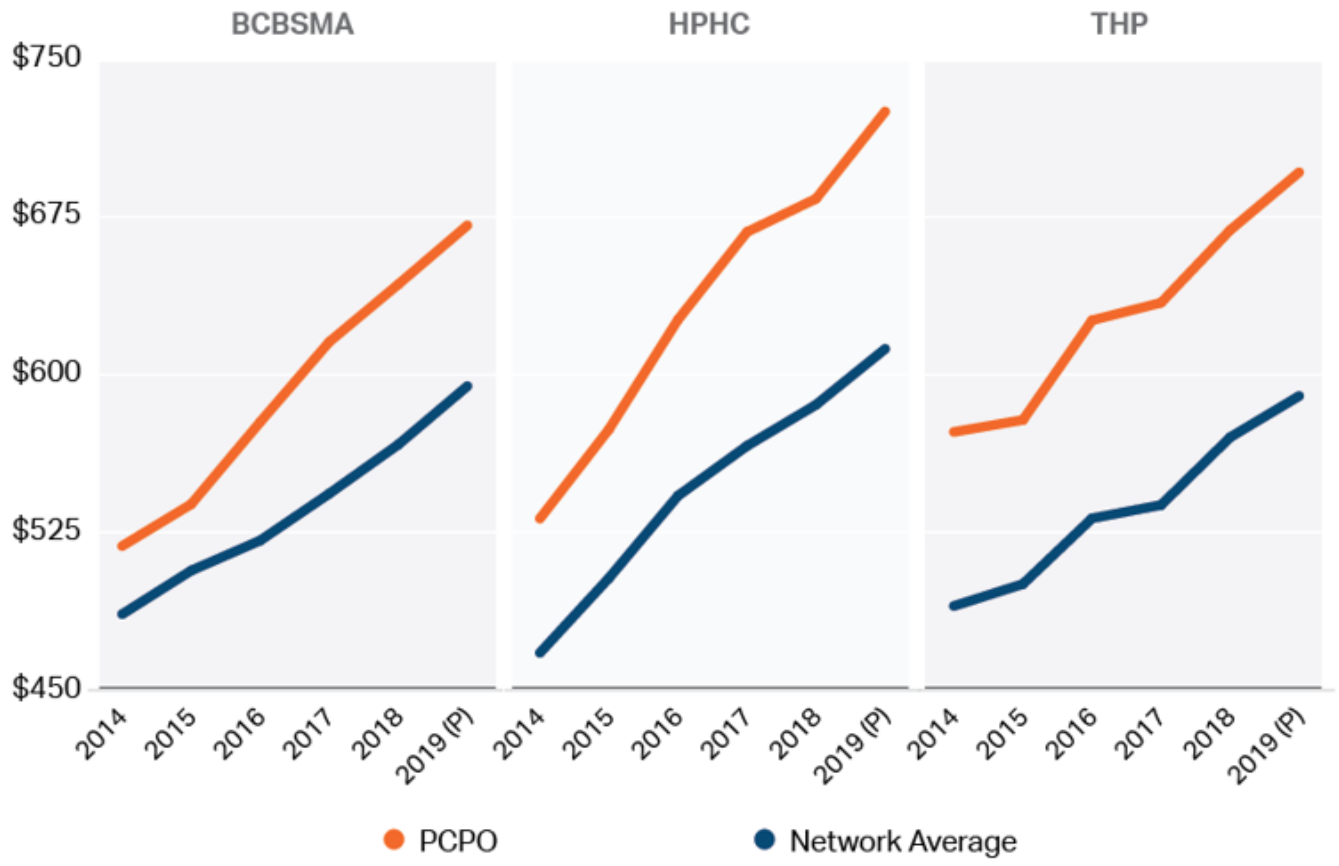


Partners Community Physicians Organization (PCPO), the largest physician group within MGB, has unadjusted and HSA TME levels are substantially higher than network averages and are consistently among the highest in the state for the big three commercial payers.

Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019.

Summary Performance: Mass General Brigham

Unadjusted TME Growth

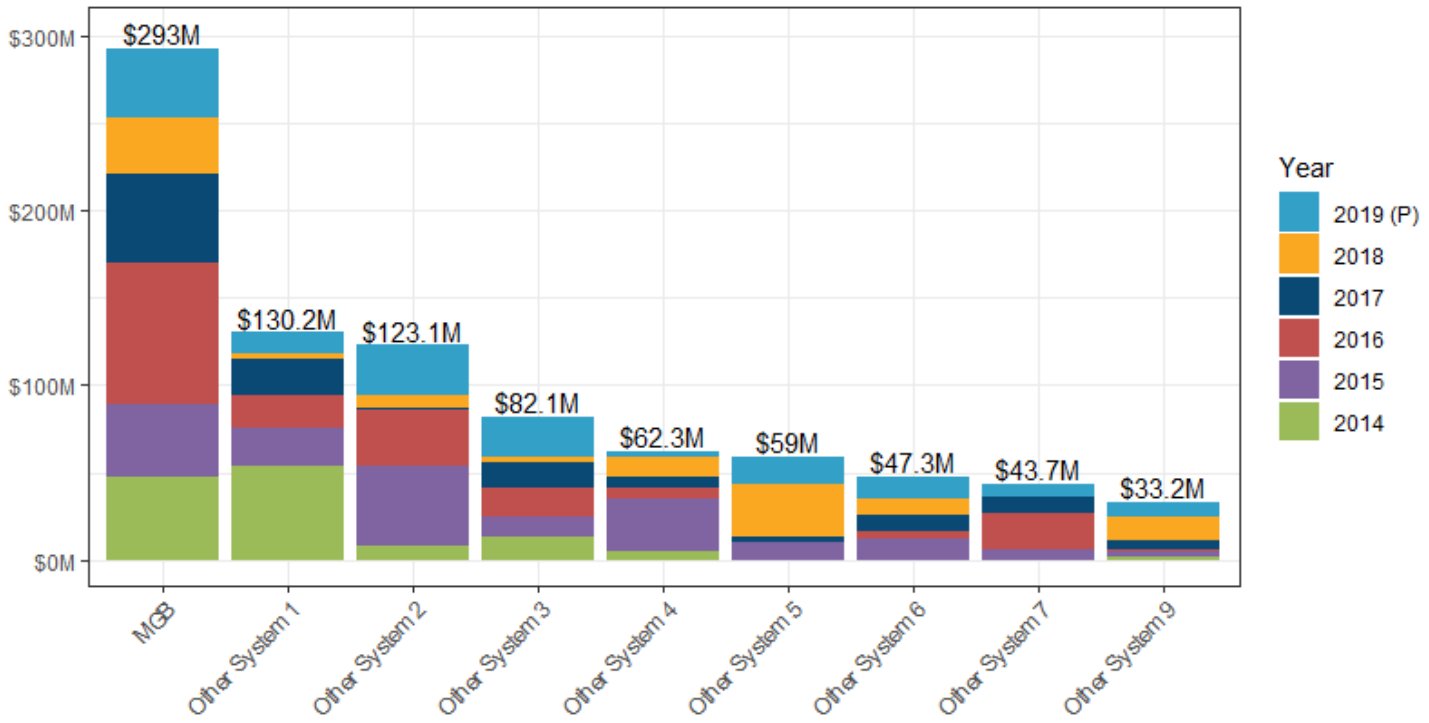


- PCPO's unadjusted TME has generally grown apace or even faster than these payers' network average in most years.
- Even in APM contracts, spending for MGB's primary care patients is growing at rates above the benchmark across multiple years and multiple payers.

Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019. -

Summary Performance: Mass General Brigham

Cumulative Financial Impact of Above-Benchmark Commercial Spending Growth (2014 – 2019)



- MGB has had more cumulative commercial spending growth in excess of the benchmark from 2014-2019 than any other provider, totaling $293 million.
- These figures represent unadjusted spending. Because MGB has stated that its primary care patients' health status was not worsening over time, health status adjusted growth understates the spending growth for MGB's primary care patients.

Based on HPC analysis of CHIA Confidential Total Medical Expense Data: 2014-2019. This number represents unadjusted (actual) spending above the benchmark in those contracts with unadjusted spending growth above the benchmark. The figure is presented at the system level and spending for MGB therefore includes the total for PCPO and other affiliated entities for which TME data are available (e.g., CD Practice Associates). The total excludes non-commercial spending and insurance products that either do not require PCP selection (e.g., PPO) or which have carve-outs (i.e., many self-insured plans). Not all of this spending constitutes revenue to the MGB system.

Summary Performance: Mass General Brigham

REGULATORY FACTORS		ASSESSMENT
a.	Baseline spending and spending trends over time, including by service category;	• MGB's commercial contracts with above-benchmark unadjusted TME growth have had a cumulative impact of $293 million from 2014-2019, significantly more than any other provider or system. • The commercial spending levels (HSA and unadjusted) for MGB's primary care patients are high compared to other providers, and its unadjusted TME has grown apace or even faster than network averages. • Even in APM contracts, spending for MGB's primary care patients is growing at rates above the benchmark across multiple years and multiple payers.
b.	Pricing patterns and trends over time;	• MGB's hospital and physician prices are higher than nearly all other providers in the Commonwealth.
c.	Utilization patterns and trends over time;	• The HPC's analysis of key spending drivers for MGB show that for the categories of spending driving growth, price and mix have been bigger drivers than utilization.
d.	Population(s) served, payer mix, product lines, and services provided;	• MGB's patients are more likely to be higher income and commercially insured as compared to most other providers. • MGB provides a number of high acuity services, including quaternary services, and is a major provider of behavioral health services. However, MGH's and BWH's case mix index is not significantly higher than other institutions in Massachusetts with lower price points.
e.	Size and market share;	• MGB is the largest health care system in the Commonwealth by most metrics (13.3% of commercial lives in 2018 and 20% of discharges, 28% of inpatient NPSR, and 24% of outpatient NPSR in FY19). • MGB has significantly more new or expanded facilities than other Massachusetts providers since 2014 based on RPO and DPH filings.

Summary Performance: Mass General Brigham

	REGULATORY FACTORS	ASSESSMENT
f.	Financial condition, including administrative spending and cost structure;	• MGB has significantly more resources than other systems, and its financial performance has been consistently strong. • MGB's assets, net assets, and operating revenue are greater than the next four largest systems combined.
g.	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;	• MGB stated that its strategies to control costs going forward would be a continuation of its current efforts, including payer-blind clinical and care management programs, shifting patients to lower-cost settings, and taking on more risk in its payer contracts. • MGB did not provide data or evidence that continuing these strategies would be effective to keep its spending growth below the benchmark. • Additional risk exposure may incentivize MGB to lower its spending but, as demonstrated by MGB's high spending growth in APM contracts, participation in risk contracts is not itself a guarantee of lowered spending.
h.	Factors leading to increased costs that are outside the CHIA-identified Entity's control	• MGB stated that pharmacy costs are a consistent cost driver in its TME. • However, HPC analysis of the 2017-2018 TME data did not identify pharmacy as a top driver in any of PCPO's contracts.
i.	Any other factors the Commission considers relevant.	• From 2013-2019, risk scores for PCPO's primary care patients grew in excess of network averages for all three of the largest payers. Cumulative growth ranged from 29.9% to 45.1% over that time period. • MGB stated that its primary care patients' health status was not worsening over time.

Next Steps: Filing of a Proposed PIP, Waiver Request, or Extension Request

- Within 45 days of receiving a PIP Notice, MGB must file:
  - A PIP proposal;
  - A request for a waiver; or
  - A request for an extension.
- The Board votes on whether to grant waivers or extension requests longer than 45 days.
- The Board must also vote on whether to approve a proposed PIP (see following slide).
- Proposals or requests must be filed using standardized forms, available on the HPC website. Entities are encouraged to partner with and utilize the assistance of the HPC during the development of the PIP proposal.
- Any final PIP proposal or waiver request, excluding certain nonpublic materials, shall be a public record and will be posted on the HPC's website.
- Please see the PIPs Webpage for further details.

SECTIONS OF A PIP PROPOSAL	
I	Description of Your Organization
II	Target
III	Causes of Growth
IV	Interventions and Evidence
V	Measures
VI	Reporting and Revising
VII	Impacts and Other Filings
VIII	Sustainability
IX	Timeline
X	Requests for Technical Assistance

Next Steps: Assessment of a Proposed PIP

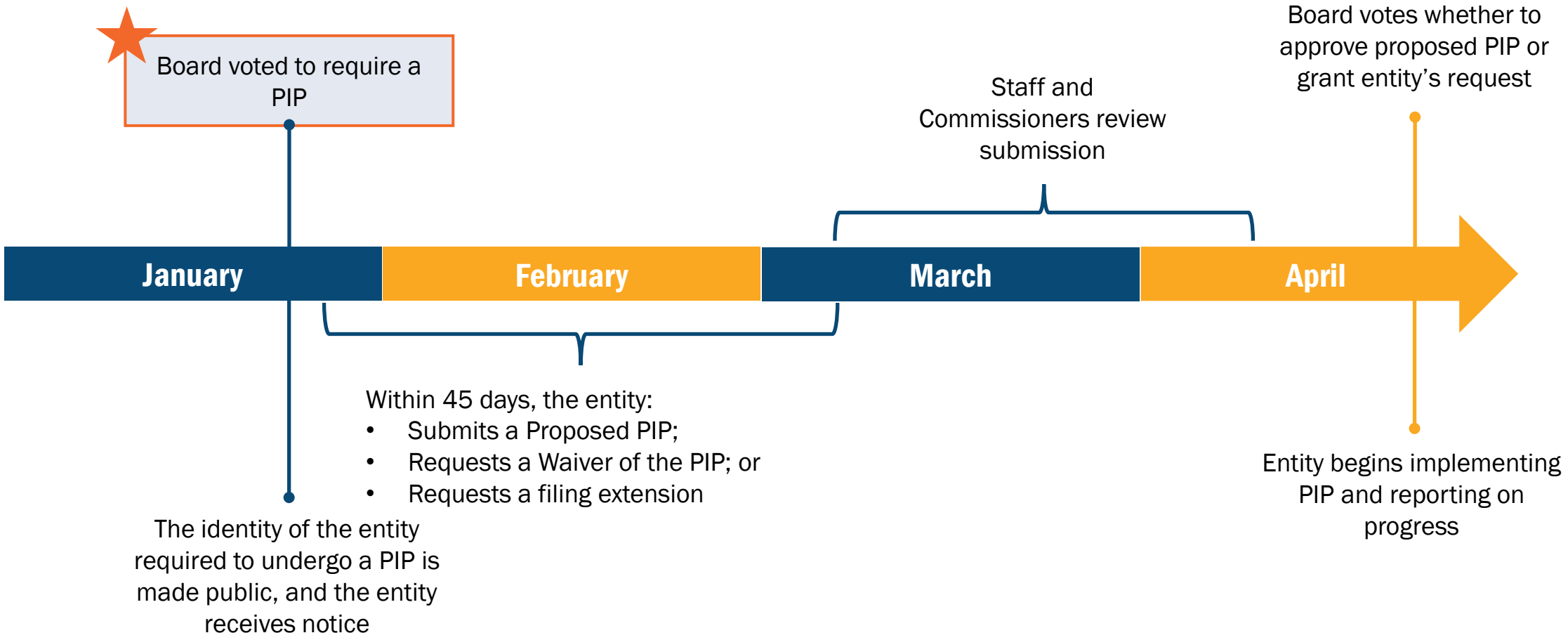
STANDARD FOR APPROVAL

- The Board shall approve a proposed PIP if it determines that the PIP:
  - Is reasonably likely to successfully address the underlying causes of the entity's cost growth; and
  - That the entity will be capable of successfully implementing the plan.

REGULATORY FACTORS FOR CONSIDERATION

- Whether the PIP proposes a strategy or activity that has a reasonable economic, business, or medical rationale with a sufficient evidence base;
- The scope and likelihood of potential savings and the potential impact on the Commonwealth's ability to meet the benchmark
- Whether savings and efficiencies are likely to continue after implementation
- The extent to which a proposed PIP carries a risk of negative consequences that would be inconsistent with other policy goals of the Commonwealth; and
- Any other factors the Commission determines to be in the public interest.

Timeline



All dates are approximate

Agenda

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EXECUTIVE SESSION **(VOTE)**

PERFORMANCE IMPROVEMENT PLAN PROCESS

MASS GENERAL BRIGHAM DETERMINATION OF NEED PROCESS: HPC PUBLIC COMMENT (VOTE)

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SCHEDULE OF UPCOMING MEETINGS

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MGB DETERMINATION OF NEED (DON) APPLICATIONS AND REVIEW PROCESS

OVERVIEW OF HPC FINDINGS

BACKGROUND: MGB AND THE CURRENT PROVIDER LANDSCAPE

HPC ANALYSIS: PROJECTED SPENDING IMPACTS OF EXPANSIONS

- Ambulatory Expansions
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- All Projects Combined

HPC ANALYSIS: MARKET FUNCTIONING, INCLUDING HEALTH CARE ACCESS AND EQUITY

CONCLUSION

Determination of Need (DoN) Review Overview

DETERMINATION OF NEED (DON) PROCESS

Providers must file a DoN application with the Department of Public Health (DPH) when they make substantial **capital expenditures**, make substantial **changes in services**, add **specific major equipment**, **change ownership**, or make other specific operational changes.

- Most DoNs **do not require a material change notice** and separate review by the HPC.
- The HPC is a "**party of record**" in the DoN process and receives all DoN filings.
- The HPC **may provide comment** to the DoN program.

DON REVIEW FACTORS

DoN applications are **evaluated based on DoN factors** in 105 CMR 100.210(A). Factors that are particularly relevant to the HPC's charge of developing policies to reduce overall cost growth while improving quality, including efforts to foster the continued development of a competitive, value-based health care market include:

- The applicant must demonstrate that the project aligns with the **needs** of its patient panel, will provide **public health value** including improved health outcomes for its patients and **reasonable assurances of health equity**, and will compete on the basis of **price**, **total medical expenses**, **provider costs**, and other recognized measures of **health care spending**.
- The applicant must also demonstrate that the project will meaningfully contribute to the Commonwealth's goals for **cost containment**, improved public health outcomes, and delivery system transformation.

For this factor, DPH may require an "independent cost analysis" (ICA), and HPC may also comment on the ICA.

Mass General Brigham DoN Filings and Process to Date

MASS GENERAL BRIGHAM DON FILINGS

On January 21, 2021, Mass General Brigham (MGB), filed Determination of Need applications for three substantial capital expenditures, totaling **$2.3 Billion** in Massachusetts:

- Expansion, renovation, and improvement of **Massachusetts General Hospital (MGH)**;
- Expansion, renovation, and improvement of **Brigham and Women's Faulkner Hospital (Faulkner)**; and
- Creation of three **new ambulatory sites** in Westborough, Westwood, and Woburn.

MGB also proposes creating a fourth ambulatory site in Salem, NH, which is not subject to review by the Massachusetts DoN program. It is understood that these proposed expansions are part of a larger multi-year ambulatory expansion plan across Eastern Massachusetts.

REVIEW PROCESS TO DATE

- The DoN program held public hearings and received numerous written comments. Many **ten taxpayer groups (TTGs)** also registered as "parties of record" (like the HPC) to the applications: 18 for the ambulatory sites, 11 for MGH, and 7 for Faulkner.
- The DoN program required ICAs for all three projects to demonstrate that the projects are "consistent with the Commonwealth's health care cost-containment goals." The ICAs were conducted by a third-party, Sean May, PhD, and released on December 28, 2021, triggering a 30-day period for parties of record to comment (i.e., by January 27, 2022).
- While the ICAs were pending, certain new information was made public regarding the ambulatory expansions from MGB's internal documents (summarized in later slides).
- The HPC also conducted its own review of the proposed projects, utilizing publicly available information including certain information disclosed from MGB internal documents, and building off of data sources and analyses it uses in other market reviews (e.g., CMIRs).

DoN Application Overview: Mass General Brigham Planned Expansions

$1.88B

MASS GENERAL HOSPITAL

- Add 54 new med/surg beds
- Add 40 new ICU beds
- Relocate and convert 388 semi-private med/surg beds to private rooms, freeing 30 to 50 beds per day that are “blocked” due to patient incompatibility, and potentially bringing 24 beds licensed but not operational back into service
- Add 21 outpatient oncology infusion bays and centralize and expand oncology services
- Add 7 cardiac operating rooms, 3 small procedure rooms, and 55 perioperative bays and centralize and expand cardiovascular and cardiac surgical services
- Add 2 MRI units, 2 CT units, 1 PET/MR unit and 1 PET/CT unit and centralize radiology services
- Other renovations and improvements

$150M

BRIGHAM & WOMEN’S FAULKNER HOSPITAL

- Add 78 new med/surg beds
- Add 8 observation beds
- Add 1 endoscopy procedure room and relocate and expand endoscopy services
- Add 1 MRI unit and centralize radiology services
- Shell space for future clinical additions

In total, these expansions increase inpatient beds at MGH by **16.6% to 18.9%** and beds at Faulkner by **45.6%**.

DoN Application Overview: Mass General Brigham Planned Expansions

$223.7M

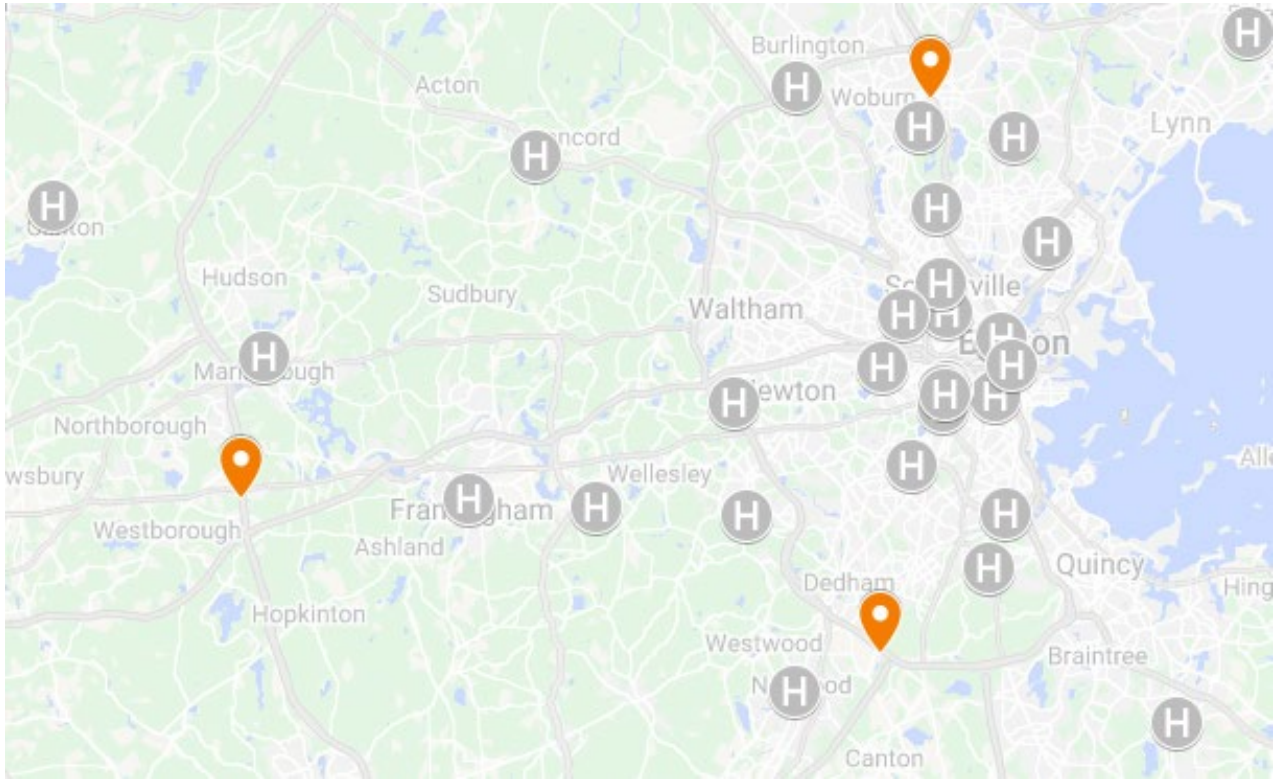
THREE NEW AMBULATORY SITES

Westborough, Westwood, and Woburn

Each to include:

- An independently licensed ambulatory surgery center (4 operating rooms per site).
- Physician services, including primary care, behavioral health, and specialty care.
- Imaging services, including CT and MRI units (total of 5 each in MA).

MGB is creating a similar site in Salem, NH. This site is not subject to review by the Massachusetts DoN program.



DoN Application Overview: Rationale and Goals

RATIONALE IN DON FILINGS

Mass General Brigham states in its applications that:

- The proposed projects are part of a "system-wide strategy… focused on improved patient outcomes and experience", are designed to meet the needs of MGB's patient panel, and will **address health care access challenges**;
- The projects will **lower costs** and **reduce total medical expenses (TME)** and **health care spending;**
- The ambulatory and Faulkner expansions, in particular, will shift care to **lower cost settings**, stating that the ambulatory sites will be priced **25% lower than MGB's community hospitals.**

ADDITIONAL INFORMATION ON MGB GOALS

- New information from MGB internal documents, disclosed publicly as part of the Attorney General's Cost Trends testimony, indicates that the ambulatory expansions are part of a **larger multiyear ambulatory expansion plan** across Eastern Massachusetts, which:
- MGB projects will ultimately contribute direct margins to the system of **$385M per year**, including both ambulatory volume and incremental hospital volume from the ambulatory sites;
  - MGB projects this **new hospital margin will outweigh any losses** from shifting care out of MGB hospitals to lower-priced sites; and
  - MGB projects **large market share increases** as a result of this larger multiyear ambulatory expansion plan: 1-2% for secondary inpatient admissions, 3-4% for tertiary inpatient admissions, and a 1-2% increase in covered lives in Eastern Massachusetts.
- In other contexts,[1] MGB has also stated that a goal of its ambulatory expansion plans in Westborough, Westwood, Woburn, and Salem, NH is to **grow commercial referral volume** at its hospitals **and increase network lives**.

1. MGB presentation to J.P. Morgan Healthcare Conference, 1/13/2020

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MGB DETERMINATION OF NEED (DON) APPLICATIONS AND REVIEW PROCESS

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HPC ANALYSIS: MARKET FUNCTIONING, INCLUDING HEALTH CARE ACCESS AND EQUITY

CONCLUSION

HPC Analysis: High Level Overview

- These proposals are likely to drive substantial new patient volume and revenue to the higher-cost MGB system—particularly commercially-insured volume—resulting in increased health care spending, increased commercial insurance premiums, and a negative impact on health care market functioning, including access and equity.
- Based on conservative projections for the subset of potential spending drivers that the HPC was able to quantify with available data and information, the projects are likely to **increase yearly commercial health insurance spending** in Massachusetts by **$46 million** to **$90.1 million** in total, with an approximate breakdown by project as follows:
  - **$9.3 million to $27.9 million** due to the proposed ambulatory expansion in Westborough, Westwood, and Woburn;[1]
  - **$6.4 million to $7.9 million** due to the proposed Faulkner expansion; and
  - **$30.3 million to $54.4** million due to the proposed MGH expansion.
- These projects are also likely to shift substantial commercial revenue to the MGB system and away from other providers in the Commonwealth, with a loss for other providers in the range of **$152.9 million to $261.1 million** in commercial revenue each year for the subset of proposed services that the HPC was able to quantify.
  - These providers have fewer financial resources and lower average prices for commercially-insured patients, and they generally serve larger proportions of MassHealth patients and communities with higher indicia of social need than MGB.
- Given these impacts, the projects are **not consistent with the Commonwealth's goals for cost containment**.

1. This figure assumes that MGB will achieve approximately 50% of its expected market share increases from the larger multi-year ambulatory expansion plan through the three sites currently proposed. If MGB achieves 25% of its market share increases instead of 50%, the commercial spending impact from the ambulatory expansion would be $7.1 million to $18.9 million, and the total would be $43.8 million to $81.2 million per year.

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Background: MGB and the Current Provider Landscape in Massachusetts

- MGB has the **highest share** of revenue and generally the highest share by volume for inpatient, outpatient, and physician services statewide, with **significant existing market share** in each of the service areas in which it is proposing to expand;
- MGB has commercial **prices that are already higher – often significantly – than nearly all other providers** in Massachusetts;
- MGB is a **high-quality provider system**, but much of the care that MGB provides—and the services it is proposing to expand—constitutes routine care that **can be provided by other high-quality Massachusetts providers**;
- MGB's primary care patients have **substantially higher health status adjusted spending** than primary care patients of other providers, and unadjusted spending for MGB's primary care patients is **growing faster than average**;
- MGB providers **generally serve higher proportions of commercially insured patients** and patients from wealthier communities, on average, as compared to other provider systems in Massachusetts; and
- MGB has **substantially more financial resources** than other Massachusetts provider systems, with net assets of $10.6 billion in 2020, more than that of the next four largest systems combined.

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MGB DETERMINATION OF NEED (DON) APPLICATIONS AND REVIEW PROCESS

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AMBULATORY EXPANSIONS

- MGH and Faulkner Expansions
- All Projects Combined

HPC ANALYSIS: MARKET FUNCTIONING, INCLUDING HEALTH CARE ACCESS AND EQUITY

CONCLUSION

MGB's ambulatory expansions would impact health care spending and revenue through several mechanisms, resulting in increased total spending.

1. **NEW MGB PRIMARY CARE PATIENTS:** Spending would increase as MGB recruits primary care physicians (PCPs) to the ambulatory sites from existing area practices or as patients switch to new MGB PCPs from prior local providers, reflecting differences in price, utilization, provider mix, and service mix between primary care patients managed by MGB versus those managed by other local providers.

2. **INCREASED UTILIZATION OF MGB HOSPITALS:** Spending would increase as MGB's hospitals draw increased inpatient and outpatient volume from areas surrounding the ambulatory sites.

3. **PATIENTS AT NEW AMBULATORY LOCATIONS AND BACKFILL OF OUTPATIENT CAPACITY AT MGB HOSPITALS:** Commercial prices at the ambulatory sites would be lower than those at some, but not all, local providers. While care shifts to the ambulatory sites may produce some net savings, impacts on total spending would depend on where patients would otherwise have received care. However, any care diverted to the ambulatory sites from MGB hospital outpatient departments (HOPDs) is likely to be backfilled, given that MGB is not proposing to reduce any existing HOPD capacity. This backfill, which the ICAs do not evaluate, would reduce any savings.

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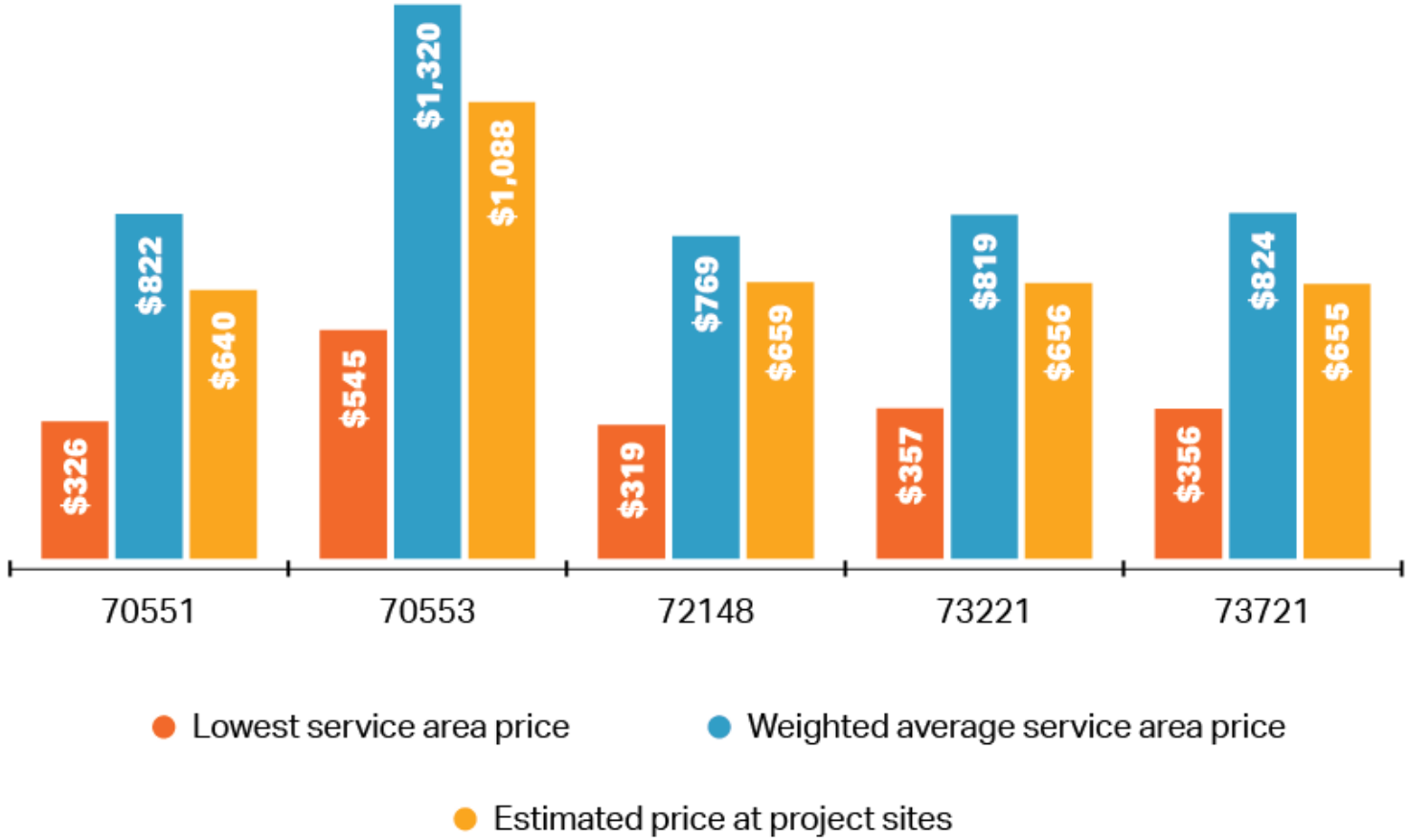
Example Commercial MRI Prices for Proposed Ambulatory Service Areas and Estimated MGB Ambulatory Prices (HPHC, 2018)



Source: HPC analysis of CHIA All-Payer Claims Database, HPHC 2018.
Note: CPT codes shown represent the highest volume outpatient diagnostic MRI codes for Massachusetts commercial patients.

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HPC Analysis: Summary of Spending and Revenue Impacts – Ambulatory Expansions

Spending Dynamic	Annual Commercial Spending Impact	Annual Commercial Revenue Gain by MGB	Annual Commercial Revenue Loss by Other Providers
1) New MGB primary care patients	$9.5M to $15.4M	Not modeled, but likely to increase revenue.	Not modeled, but likely to decrease revenue.
2) Increased utilization of MGB hospitals	Likely significant. If the three proposed sites allow MGB to achieve half of its market share expectations for the larger multiyear ambulatory expansion, $4.5M to $17.9M for inpatient care. Outpatient would further increase spending.	Likely significant. If the three proposed sites allow MGB to achieve half of its market share expectations for the larger multiyear ambulatory expansion, $19.1M to $76.5M for inpatient care. Outpatient would further increase revenue.	Likely significant. If the three proposed sites allow MGB to achieve half of its market share expectations for the larger multiyear ambulatory expansion, -$14.6M to -$58.6M for inpatient care. Outpatient would further reduce revenue.
3) Patients at new ambulatory locations and backfill of outpatient capacity at MGB hospitals	-$3.4M for ambulatory surgery, CT and MRI. Other services could further impact spending.	$24.2M to $28.2M for ambulatory surgery, CT and MRI. Other services would further increase revenue.	-$27.6M to -$31.6M for ambulatory surgery, CT and MRI. Other services would further reduce revenue.
4) Increased MGB prices as market concentration and MGB's commercial market shares increase	Not modeled	Not modeled	Not modeled
Total yearly commercial impact for modeled services and spending dynamics	**$9.3M to $27.9M**	**$43.3M to $104.6M**	**-$42.2M to -$90.2M**

Notes: When totaling spending impacts, the HPC discounts the spending impact in row 1 by the portion of total medical expense (TME) for MGB's primary care patients that represents spending on inpatient care received at MGB hospitals. Additional spending and revenue impacts are also likely for other payer categories, particularly for Medicare Advantage plans and MassHealth Managed Care Organizations, which do not operate with a standardized fee schedule. The HPC's calculations are likely to be conservative as they do not account for other dynamics likely to increase spending, such as differences in prices of physician visits and increased MGB prices as MGB's market share grows. Additional shifts of patients and revenue to higher-priced providers would be expected if projected revenue losses disrupt the operations of lower-priced providers.

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MGB DETERMINATION OF NEED (DON) APPLICATIONS AND REVIEW PROCESS

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HPC ANALYSIS: PROJECTED SPENDING IMPACTS OF EXPANSIONS

- Ambulatory Expansions
- **MGH AND FAULKNER EXPANSIONS**
- All Projects Combined

HPC ANALYSIS: MARKET FUNCTIONING, INCLUDING HEALTH CARE ACCESS AND EQUITY

CONCLUSION

The proposed expansions at MGH and Faulkner would also impact health care spending through several mechanisms.

1. **PATIENTS FILLING NEW INPATIENT CAPACITY:** Total spending would likely increase as MGH and Faulkner fill proposed new inpatient capacity. Most patients who receive inpatient care in new capacity at MGH and Faulkner would otherwise have been seen at non-MGB hospitals, each with different and often lower price points. This includes patients filling net new medical/surgical beds at MGH and Faulkner, new ICU beds at MGH, and new capacity at MGH as it moves beds from semi-private to private rooms[1] and potentially brings licensed beds back into operation.

2. **PATIENTS FILLING NEW HOSPITAL OUTPATIENT CAPACITY:** Most patients who receive outpatient services in new advanced imaging and procedure capacity MGH and Faulkner would otherwise have been seen at non-MGB hospitals, each with different and often lower price points. Commercial spending would likely increase as MGH fills proposed new outpatient capacity, while spending impacts of adding Faulkner outpatient capacity may be mixed.

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HPC Analysis: Summary of Spending and Revenue Impacts – Hospital Expansions

Spending Dynamic		Annual Commercial Spending Impact	Annual Commercial Revenue Gain by MGB	Annual Commercial Revenue Loss by Other Providers
1. Patients filling new inpatient capacity	MGH	**$23.7M** to **$40.6M**	**$91.3M** to **$156.3M**	-$67.6M to -$115.7M
	Faulkner	**$2.9M** to **$3.8M**	**$41.8M** to **$54.9M**	-$40.0M to -$51.1M
2. Patients filling new outpatient capacity	MGH	**$573K** for CT and MRI imaging only. Other services would further increase spending.	**$4.6M** for CT and MRI imaging only. Other services would further increase revenue.	-$4.1M for CT and MRI imaging only. Other services would further reduce revenue.
	Faulkner	-$91K for MRI imaging only. Other services could further impact spending.	**$788K** for MRI imaging only. Other services would further increase revenue.	-$879K for MRI imaging only. Other services would further reduce revenue.
3. Increased MGB prices as market concentration and MGB's commercial market shares increase	MGH & Faulkner	**$9.7M** to **$17.3M** due to inpatient volume increases. Outpatient market share increases are likely to drive further price increases.	**$9.7M** to **$17.3M** due to inpatient volume increases. Outpatient market share increases are likely to drive further price increases.	Not Modeled
Total yearly commercial impact for modeled services and spending dynamics	MGH	**$30.3M to $54.4M**	**$101.2M to $173.3M**	-$70.1M to $119.0M
	Faulkner	**$6.4M** to **$7.9M**	**$46.3M** to **$59.8M**	-$39.8M to -$52.0M

Note: Additional spending and revenue impacts are also likely for other payer categories, particularly for Medicare Advantage plans and MassHealth Managed Care Organizations, which do not operate with a standardized fee schedule. The HPC's calculations are likely to be conservative, and do not account for other dynamics likely to increase spending, such as expansions of non-imaging outpatient service lines and increased MGB prices as MGB's physician and outpatient hospital market share grow. Additional shifts of patients and revenue to higher-priced providers would be expected if projected revenue losses disrupt the operations of lower-priced providers.

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MGB DETERMINATION OF NEED (DON) APPLICATIONS AND REVIEW PROCESS

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HPC ANALYSIS: PROJECTED SPENDING IMPACTS OF EXPANSIONS

- Ambulatory Expansions
- MGH and Faulkner Expansions

ALL PROJECTS COMBINED

HPC ANALYSIS: MARKET FUNCTIONING, INCLUDING HEALTH CARE ACCESS AND EQUITY

CONCLUSION

The development of the three proposed projects together undermines MGB's claims that the ambulatory expansion will reduce health care spending and may result in total impacts greater than those the HPC has modeled for each project individually.

- MGB has stated that the ambulatory and hospital projects are part of a system-wide strategy to achieve its strategic goals. However, the proposed **hospital projects conflict with MGB's claim that the ambulatory project will reduce health care spending**.
  - The degree of any savings as outpatient care shifts out of hospitals and into ambulatory sites depends on which hospitals would have provided that care and whether the hospitals subsequently backfill newly available HOPD capacity.
  - MGB proposes to expand hospital services in the MGH and Faulkner expansions and has not suggested that total volume or capacity would decline at any of its facilities due to the ambulatory expansion.
  - The expansions, together, are therefore likely to increase the volume of care both at MGB's relatively high-priced hospitals and at the new ambulatory sites.
- If the ambulatory sites increase utilization of MGB hospitals by residents of the ambulatory service areas, more of the care filling new MGH and Faulkner beds may be **diverted from lower-priced hospitals outside of the Boston metro area**.
- The potential for these projects to **destabilize lower-priced providers is greater if all three projects proceed**, as the projected revenue losses (particularly for commercial revenue and traditionally higher-margin services) would be higher if MGB expands capacity across multiple projects.

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CONCLUSION

The proposed expansions raise significant concerns about potential impacts on health care access and equity.

1. **REVENUE SHIFTS:** Projected shifts in care as MGB fills new capacity would result in the loss of substantial revenue, especially commercial revenue, for other provider systems that already serve greater shares of public payer patients and communities with greater indicia of social need, leaving those providers with fewer resources to serve those populations.

2. **HIGH-MARGIN SERVICES:** The services on which MGB has provided the most detail in its ambulatory expansion plans are ones likely to generate substantial financial margin and drive additional volume to its system.

3. **UNMET NEED:** MGB's projections of future utilization at its facilities do not indicate that the projects are necessary to meet unmet need. The proposed ambulatory expansions are also located in areas that report already having good access to health care services.

4. **PAYER MIX:** The proposed ambulatory expansions are located relatively affluent areas with low MassHealth payer mix, consistent with MGB's stated goals of increasing network lives and commercial referrals, and are likely to reinforce MGB's already small share of MassHealth patients relative to other systems.

5. **STAFFING:** MGB will need substantial new staff for the proposed capacity, which could result both in increased staffing costs for some providers and staff being recruited away from others, particularly those providers with more limited financial resources.

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Shifts in care as MGB fills new capacity would result in the loss of substantial revenue for other provider systems that serve greater shares of public payer patients and patients with greater indicia of social need.

- In total, the HPC estimates that provider organizations other than MGB would lose **$152.9 million to $261.1 million of annual commercial revenue**, just from those aspects of the three proposed projects that we were able to quantify at, as a result of shifts in care due to MGB's proposed expansions.
  - Much of this shift is in relatively high-margin service lines like ambulatory surgery and imaging, which providers rely on to balance the cost of more resource-intensive and lower reimbursement care.
  - Shifts in public payer patients would also further reduce revenue for other provider organizations, regardless of whether those shifts would increase or decrease total spending.
- Most of these losses would represent a flow of health care dollars **away from providers serving higher proportions of traditionally underserved patients** than MGB.
  - Most other hospital systems serve higher proportions of MassHealth patients compared to MGB, MGB patients generally live in communities with higher median incomes and lower indicia of social need than patients of other provider systems, and other hospital systems generally serve higher proportions of inpatients who are Black, Indigenous, and People of Color compared to MGB hospitals.
  - Shifts in public payer patients would also further reduce revenue for other provider organizations, regardless of whether those shifts would increase or decrease total spending.
- If decreased revenue destabilizes other providers or diminishes their ability to invest in or maintain facilities and staff, that impact is likely to **increase health disparities**.

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HPC ANALYSIS: MARKET FUNCTIONING, INCLUDING HEALTH CARE ACCESS AND EQUITY

CONCLUSION

HPC Conclusions

- These proposals are likely to drive substantial new patient volume and revenue to the higher-cost MGB system—particularly commercially-insured volume—resulting in increased health care spending, increased commercial insurance premiums, and a negative impact on health care market functioning, including access and equity.
- Based on conservative projections for the subset of potential spending drivers that the HPC was able to quantify with available data and information, the projects are likely to **increase yearly commercial health insurance spending** in Massachusetts by **$46 million** to **$90.1 million** in total, with an approximate breakdown by project as follows:
  - **$9.3 million to $27.9 million** due to the proposed ambulatory expansion in Westborough, Westwood, and Woburn;[1]
  - **$6.4 million to $7.9 million** due to the proposed Faulkner expansion; and
  - **$30.3 million to $54.4** million due to the proposed MGH expansion.
- These projects are also likely to shift substantial commercial revenue to the MGB system and away from other providers in the Commonwealth, with a loss in the range of **$152.9 million to $261.1 million** in commercial revenue each year for the subset of proposed services that the HPC was able to quantify.
- These providers have fewer financial resources and lower average prices for commercially-insured patients, and they generally serve larger proportions of MassHealth patients and communities with higher indicia of social need than MGB.
- Given these impacts, the projects are **not consistent with the Commonwealth's goals for cost containment**.

1. This figure assumes that MGB will achieve approximately 50% of its expected market share increases from the larger multi-year ambulatory expansion plan through the three sites currently proposed. If MGB achieves 25% of its market share increases instead of 50%, the commercial spending impact from the ambulatory expansion would be $7.1 million to $18.9 million, and the total would be $43.8 million to $81.2 million per year.

VOTE

Mass General Brigham Determination of Need Process: HPC Public Comment

MOTION

That the Commission hereby authorizes the issuance of the attached comment to be made to the Department of Public Health pursuant to G.L. c. 111, § 25C(g) and (i) and 105 CMR 100.405(D), regarding the Determination of Need Applications submitted by Mass General Brigham Incorporated -- *Massachusetts General Hospital # MGB-20121612-HE, Brigham and Women's Faulkner Hospital # MGB-20121716-HE, and Multisite # Multisite-21012113-AS.*

Agenda

CALL TO ORDER

APPROVAL OF MINUTES **(VOTE)**

EXECUTIVE SESSION **(VOTE)**

PERFORMANCE IMPROVEMENT PLAN PROCESS

MASS GENERAL BRIGHAM DETERMINATION OF NEED PROCESS: HPC PUBLIC COMMENT **(VOTE)**

EXECUTIVE DIRECTOR'S REPORT

SCHEDULE OF UPCOMING MEETINGS

MASSACHUSETTS
HEALTH POLICY COMMISSION

2021: BY THE NUMBERS

RESEARCH AND REPORTING

12
new publications

2
DataPoints and

15
unique online interactive graphics

3
HPC research presentations showcased at national health policy conferences

PARTNER

$3.9 million
invested in innovative care delivery models

3
evaluation reports released

3
start-ups championed by the HPC through MCHT

7
new invesment program awardees

CONVENING

20
public meetings

931
slides presented

484
tweets

285,856
Twitter impressions

WATCHDOG

11
health market transactions reviewed

225
external review requests

223
open enrollment waiver requests

1,207
calls to the Office of Patient Protection hotline

Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	33	24%
Physician group merger, acquisition, or network affiliation	27	20%
Clinical affiliation	26	19%
Acute hospital merger, acquisition, or network affiliation	24	18%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	19	14%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

RECEIVED SINCE 9/15

The proposed joint venture between Baystate Medical Center and NEOS SurgCo, a group of approximately 18 orthopedic surgeons, to own and operate a freestanding ambulatory surgery center.

Market Changes Currently Under Review

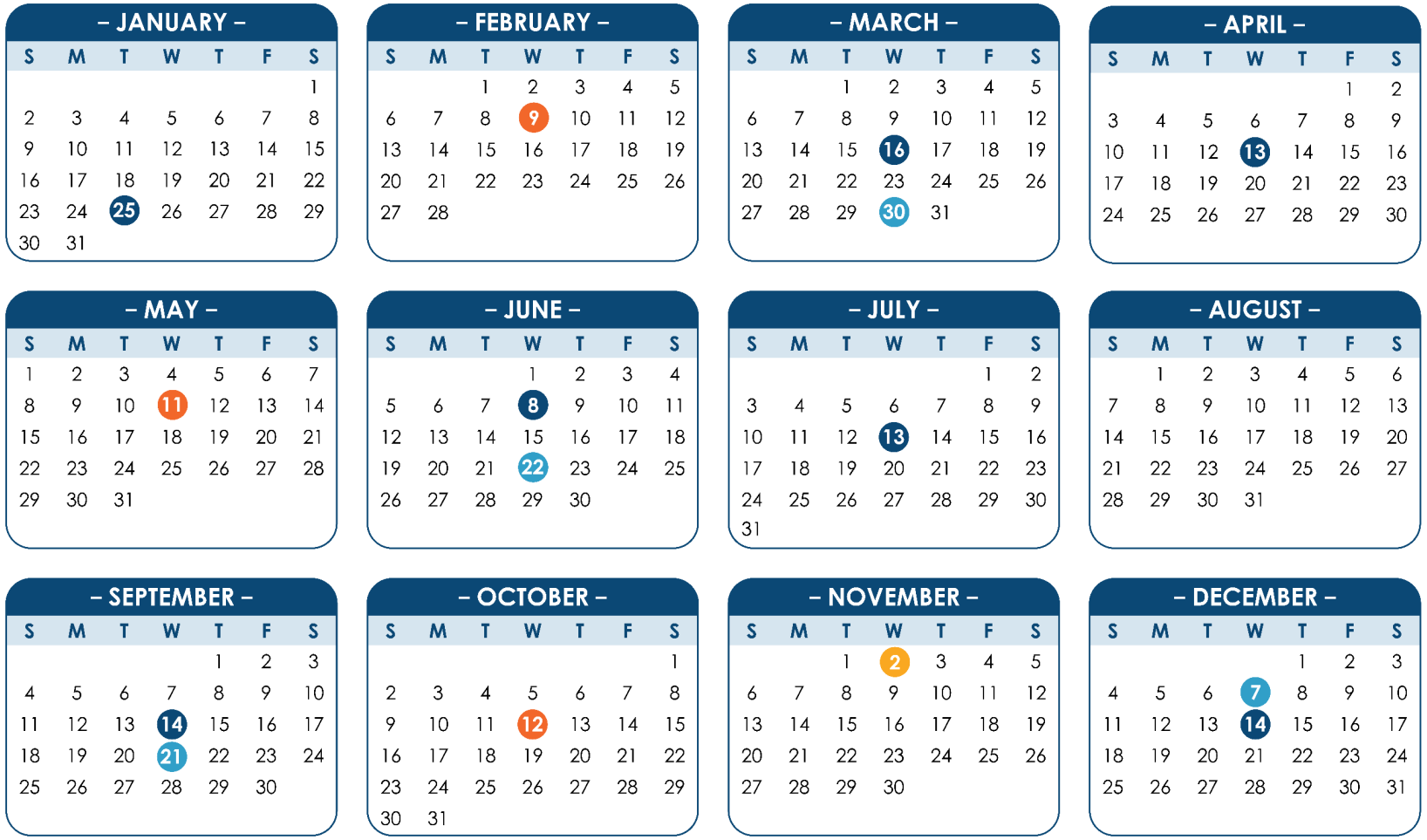
- A proposed joint venture between **BILH Surgery Center Plymouth Hospital Holdco**, a subsidiary of Beth Israel Deaconess Hospital - Plymouth, and **Pilgrim ASC** to own and operate a freestanding ASC in Plymouth.
- A proposed clinical affiliation between **Atrius Health** and **South Shore Hospital** under which South Shore would be designated as a preferred hospital provider for Atrius patients.
- A proposed transaction between **Spire Orthopedic Partners** (Spire) and **Sports Medicine North Orthopedic Surgery** (SMN), a physician group practice on the North Shore, under which Spire would acquire certain non-clinical assets of and provide administrative services for SMN.
- A proposed transaction between **Signature Healthcare**, **South Shore Health System**, **Sturdy Memorial Hospital**, and **Southeast Massachusetts Behavioral Health**, a subsidiary of US HealthVest, to own and operate a new psychiatric hospital in Southeastern Massachusetts.
- A proposed joint venture between **NEBSC Hospital Holdings**, comprised of NE Baptist and Constitution Surgery Alliance MA, and **NEBSC Surgeon Holdings**, comprised of orthopedic surgeons on the medical staff at NE Baptist, to own and operate a freestanding ASC in Dedham.

New Releases: Certified Nurse Midwives and Maternity Care in Massachusetts

New Chartpack and HPC Short on Certified Nurse Midwives and Maternity Care in Massachusetts

https://www.mass.gov/service-details/hpc-policy-and-research-reports for more info

2022 Public Meeting Calendar



BOARD MEETINGS

Tuesday, January 25
Wednesday, March 16 – Benchmark Hearing
Wednesday, April 13
Wednesday, June 8
Wednesday, July 13
Wednesday, September 14
Wednesday, December 14

COMMITTEE MEETINGS

Wednesday, February 9
Wednesday, May 11
Wednesday, October 12

ADVISORY COUNCIL

Wednesday, March 30
Wednesday, June 22
Wednesday, September 21
Wednesday, December 7

COST TRENDS HEARING

Wednesday, November 2

All meetings will be held virtually unless otherwise noted. This schedule is subject to change, and additional meetings and hearings may be added.

Agenda

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APPROVAL OF MINUTES **(VOTE)**

EXECUTIVE SESSION **(VOTE)**

PERFORMANCE IMPROVEMENT PLAN PROCESS

MASS GENERAL BRIGHAM DETERMINATION OF NEED PROCESS: HPC PUBLIC COMMENT **(VOTE)**

EXECUTIVE DIRECTOR'S REPORT

SCHEDULE OF UPCOMING MEETINGS

Schedule of Upcoming Meetings

BOARD

April 13

June 8

July 13

September 14

December 14

COMMITTEE

February 9

May 11

October 12

ADVISORY COUNCIL

March 30

June 22

September 21

December 7

SPECIAL EVENTS

March 16
Benchmark Hearing

November 2
Cost Trends Hearing

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MASSACHUSETTS
HEALTH POLICY COMMISSION

Appendix

Independent Cost Analyses

The HPC's conclusions differ from those of the ICAs, which concluded that all three projects are consistent with the Commonwealth's cost containment goals. The HPC has identified a number of key limitations of the ICAs:

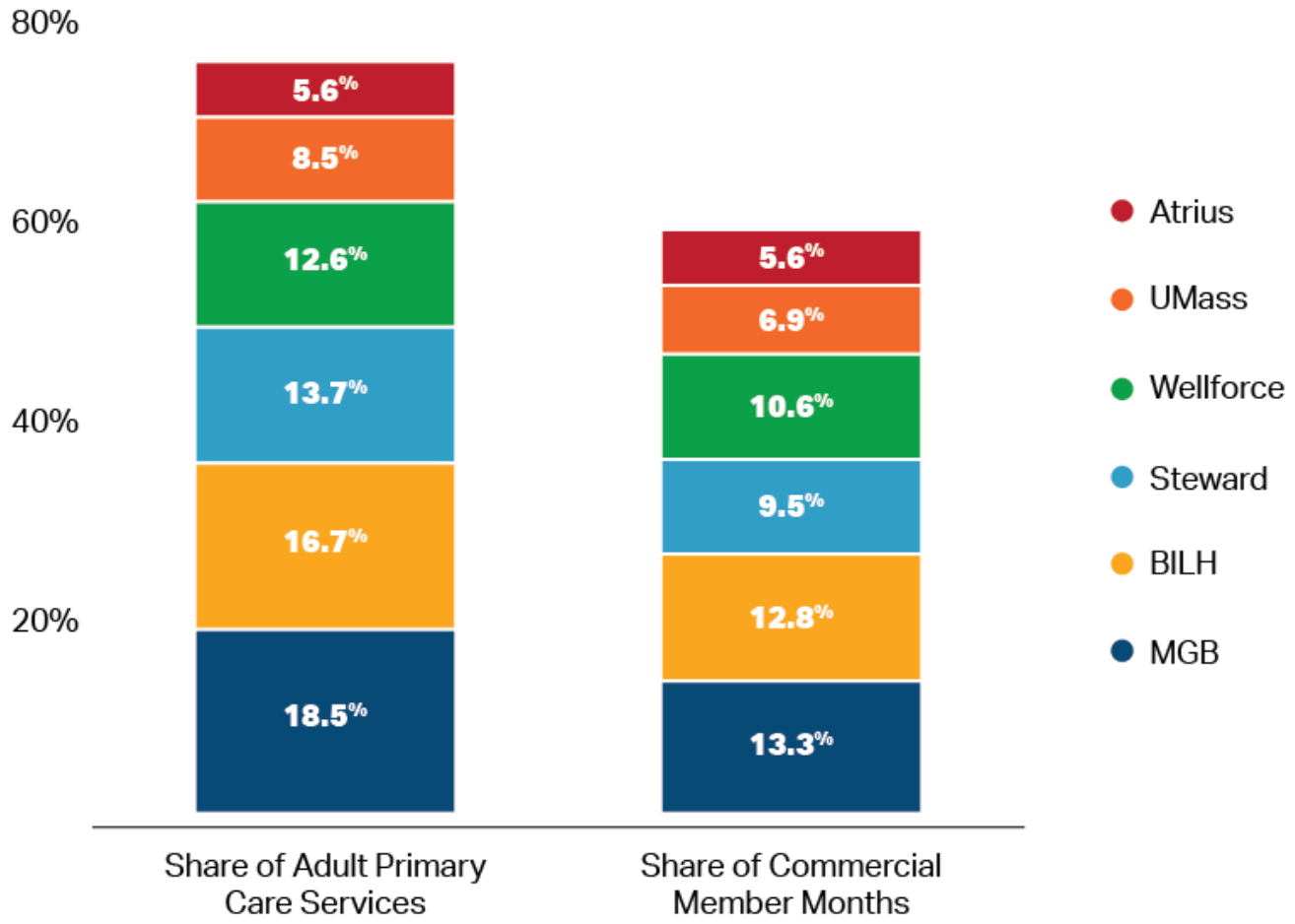
- The ICAs **fail to address major drivers of spending for the three projects that would negate any projected savings**. These include the **potential for MGB to backfill care** that may shift to the ambulatory sites or Faulkner from its other hospitals, the likelihood that the ambulatory expansion will **drive new inpatient and outpatient hospital volume** into MGB hospitals, the likelihood of spending impacts for **services at the ambulatory sites other than ambulatory surgery and advanced imaging**, and **impacts on professional spending** from care that would shift to MGB (the ICAs generally evaluate only differences in facility prices).
- The ICAs **minimize significant cost impacts identified within their own findings**, dismissing large spending increases as insignificant, particularly for the hospital expansions, and presenting spending impacts as percentage changes generally calculated within specific service lines and often averaged across payer categories;
- The ambulatory expansion ICA **does not incorporate the publicly available information from the MGB Internal Document Disclosures** showing MGB expects its larger multi-year ambulatory expansion plan, of which the three ambulatory sites are part, to result in substantial increases in inpatient hospital market share and covered lives, as well as significant new revenue to its system; and
- Finally, the ICAs are **missing key context about the current state of the health care market in Massachusetts**, including MGB's position as the largest and generally highest-priced provider system in Massachusetts, with significant current market share in the ambulatory service areas, and which has already been expanding in recent years with persistently higher price differentials.

Spending impacts and revenue shifts would likely be far greater than HPC is currently able to model.

- The HPC anticipates significant additional impacts on spending and on revenue that could not be quantified, due to the lack of detailed information in public filings (even after limited disclosures by the AGO), such as:
  - Increased outpatient, physician, and other market share increases for MGB that would allow it to negotiate even higher prices, beyond those calculated for the inpatient expansions at Faulkner and MGH;
  - Net new utilization for supply-sensitive care (i.e., supply-induced demand);
  - Increased outpatient volume at MGB hospitals as a result of the ambulatory expansions; and
  - Shifts of care from certain smaller providers (e.g., independent physician licensed sites) and generally lower priced providers for which more limited data are available.
- The HPC has modeled spending impacts based on the three largest commercial payers and used them to generalize spending impacts for other commercial payers. Price differentials (and therefore spending impacts) are likely larger for smaller payers with less bargaining leverage, meaning that market-wide commercial spending impacts are likely understated, and spending impacts for other payers are generally not included.

MGB has the highest market share of adult primary care services and share of commercial member months in the Commonwealth.

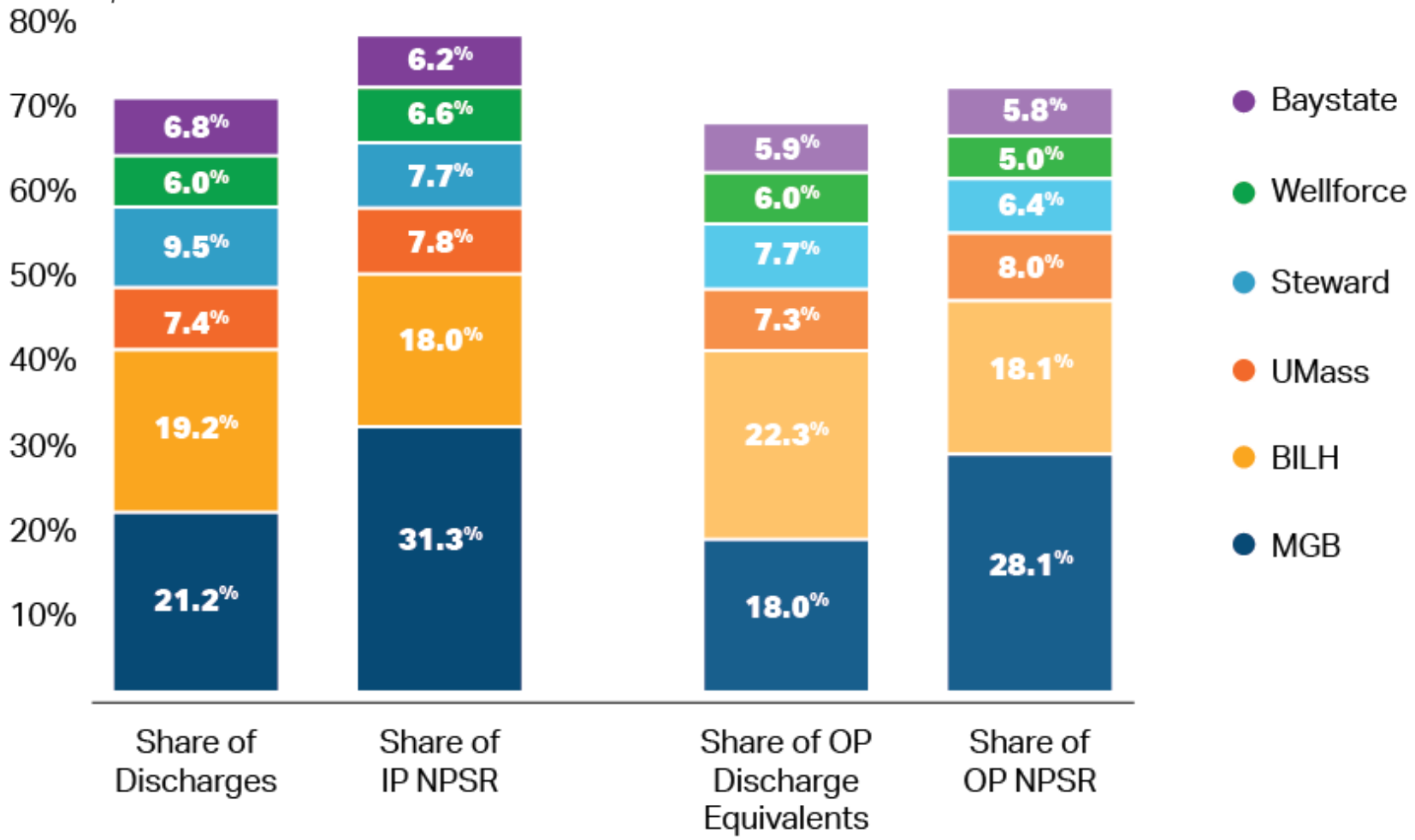
System Share of Adult Primary Care Services and Member Months (2018)



Notes: Reflects physician group affiliations and alignments as of December 2021.
Source: HPC analysis of All Payer Claims Database 2018 and Registration of Provider Organizations 2019; HPC analysis of CHIA 2018 TME data

MGB generally has the greatest shares of commercial inpatient and outpatient volume and revenue in the Commonwealth

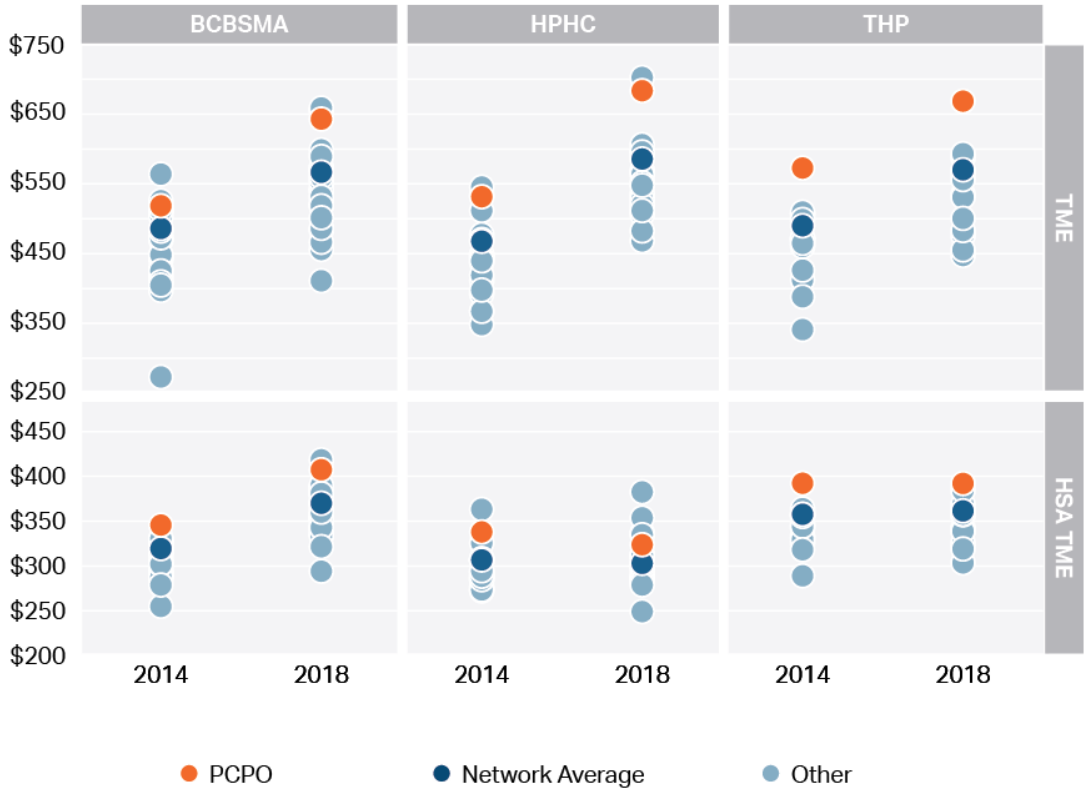
System Share of MA FY19 Hospital Volume and Revenue



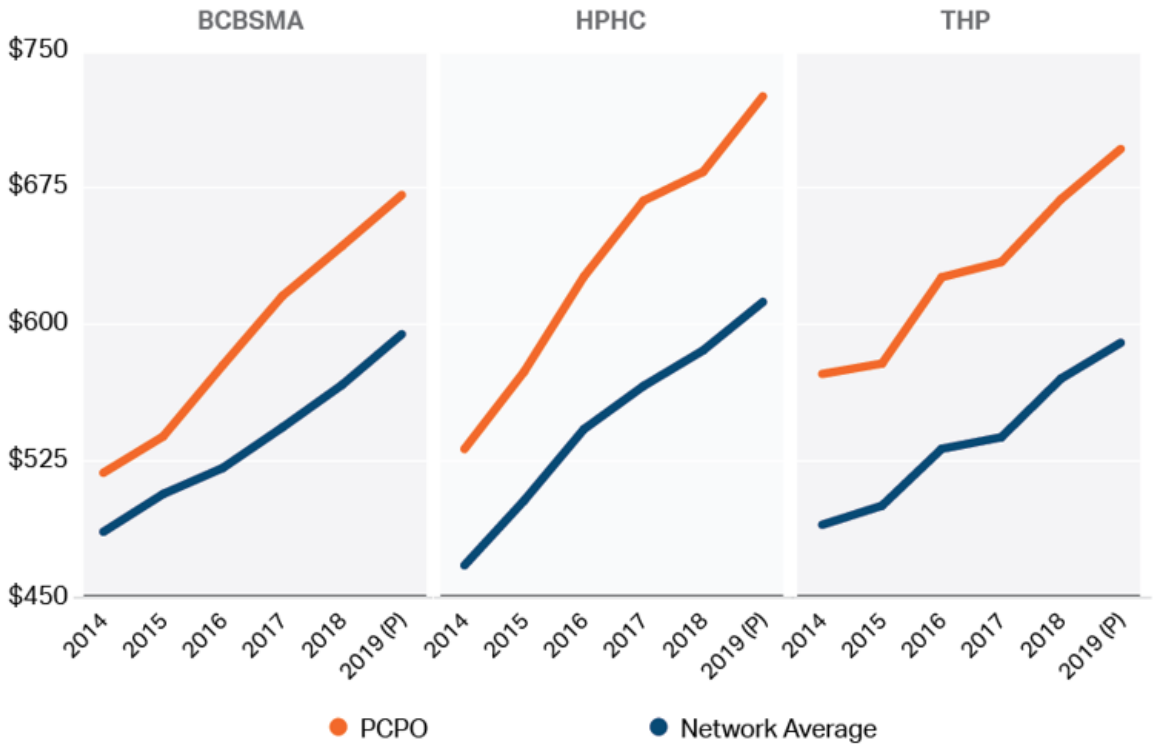
Source: HPC analysis of 2019 CHIA Hospital Cost Reports; HPC analysis of 2019 CHIA Hospital Relative Price data (raw)
Notes: Current affiliations (as of December 2021); affiliations include corporate and contracting affiliations; includes general acute care hospitals only.

Primary care patients of PCPO (MGB's affiliated provider group) have higher unadjusted and health status adjusted spending than average and spending is growing faster.

Unadjusted TME and HSA TME Levels, 2014 & 2018

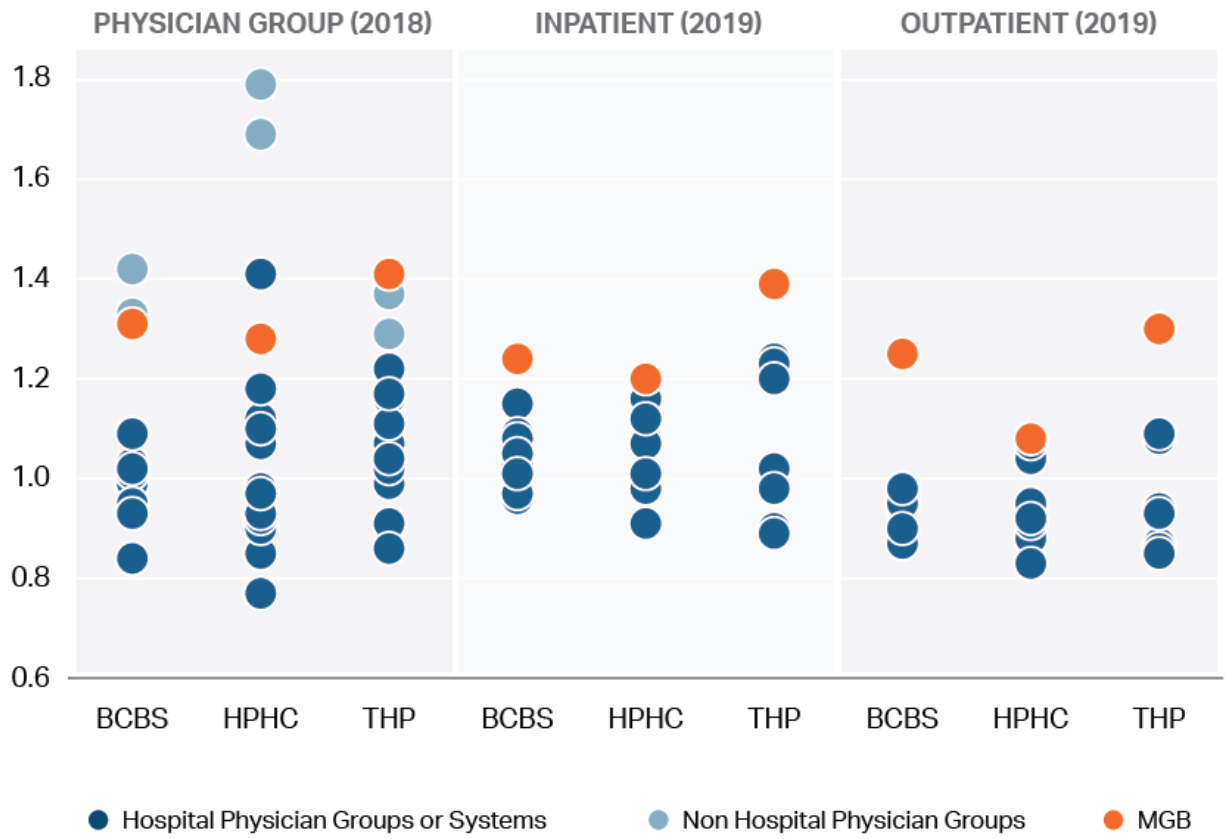


Unadjusted TME Growth of PCPO Compared to the Payer's Network Average (2014-2019)



MGB's prices are generally higher than most other hospitals and physician groups in the Commonwealth, both averaged across the system…

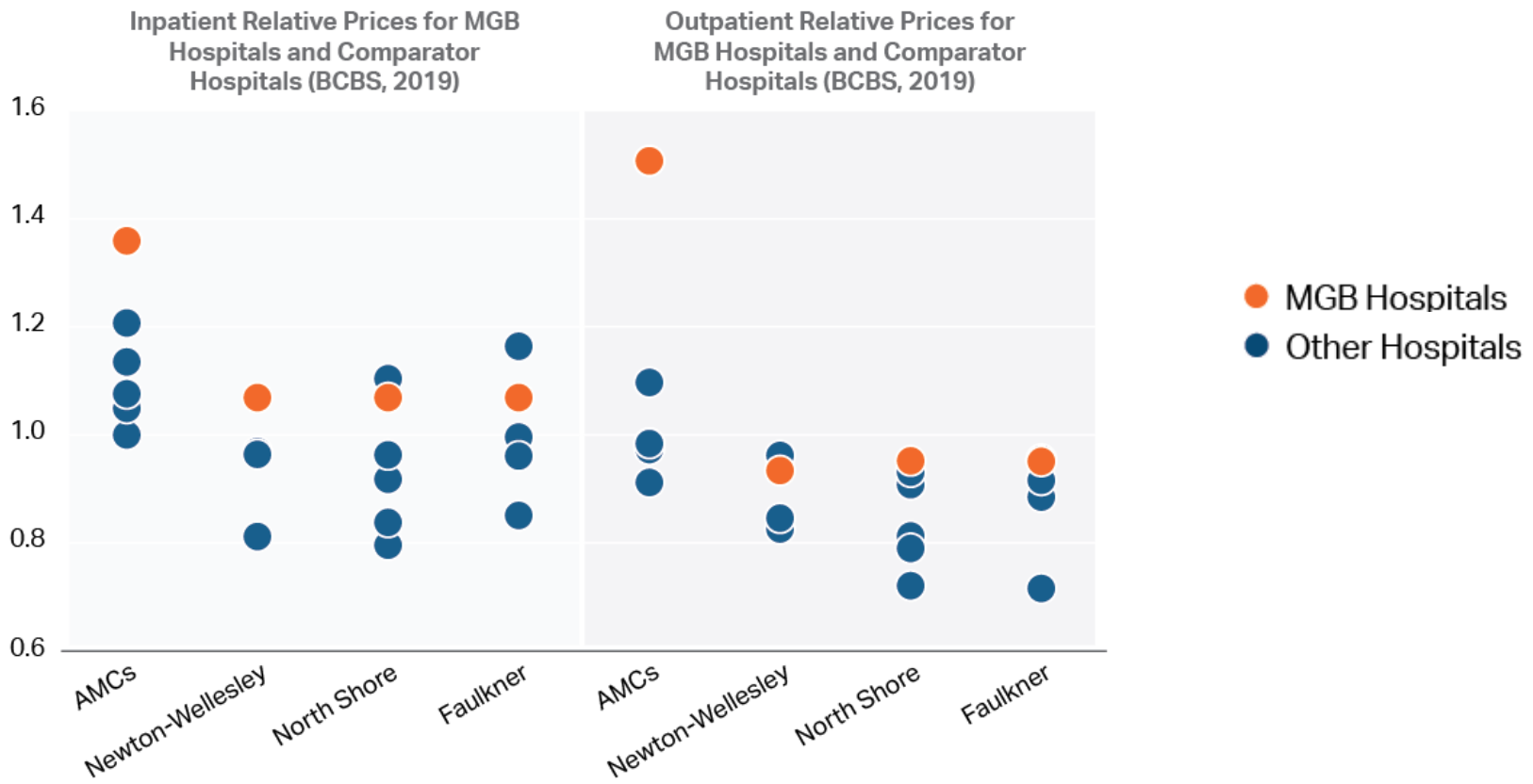
Physician Group and System Average Hospital Relative Price



Notes: Physician Groups include: Atrius, BIDCO, Boston Medical Center Mgt Service, Lahey Clinical Performance ACO/Physician Community Organization, Lawrence General IPA, Lowell General PHO, Mt. Auburn IPA, New England Quality Care Alliance (NEQCA), Partners Community Physician Organization, Reliant Medical Group, Signature Healthcare Medical Group, South Short PHO, Southcoast Physicians Group (/Network), Steward Network Services and UMass Medical Group.
Inpatient and Outpatient RP excludes specialty hospitals. The CHIA RP Databook includes Inpatient and Outpatient RP for each hospital but does not provide system level data. To calculate inpatient RP for each System, we used hospital level discharge data to calculate the hospital level volume as a percent of systemwide volume, and then calculated a weighted average RP for the System. To calculate OP RP for each System, we used hospital cost reports to calculate the hospital level outpatient Net Patient Service Revenue (NPSR) as a percent of the systemwide OP NPSR, and then calculated a weighted average OP RP for the systems.

...and for its individual hospitals relative to comparable local hospitals.

MGB and Comparator Hospital Relative Price

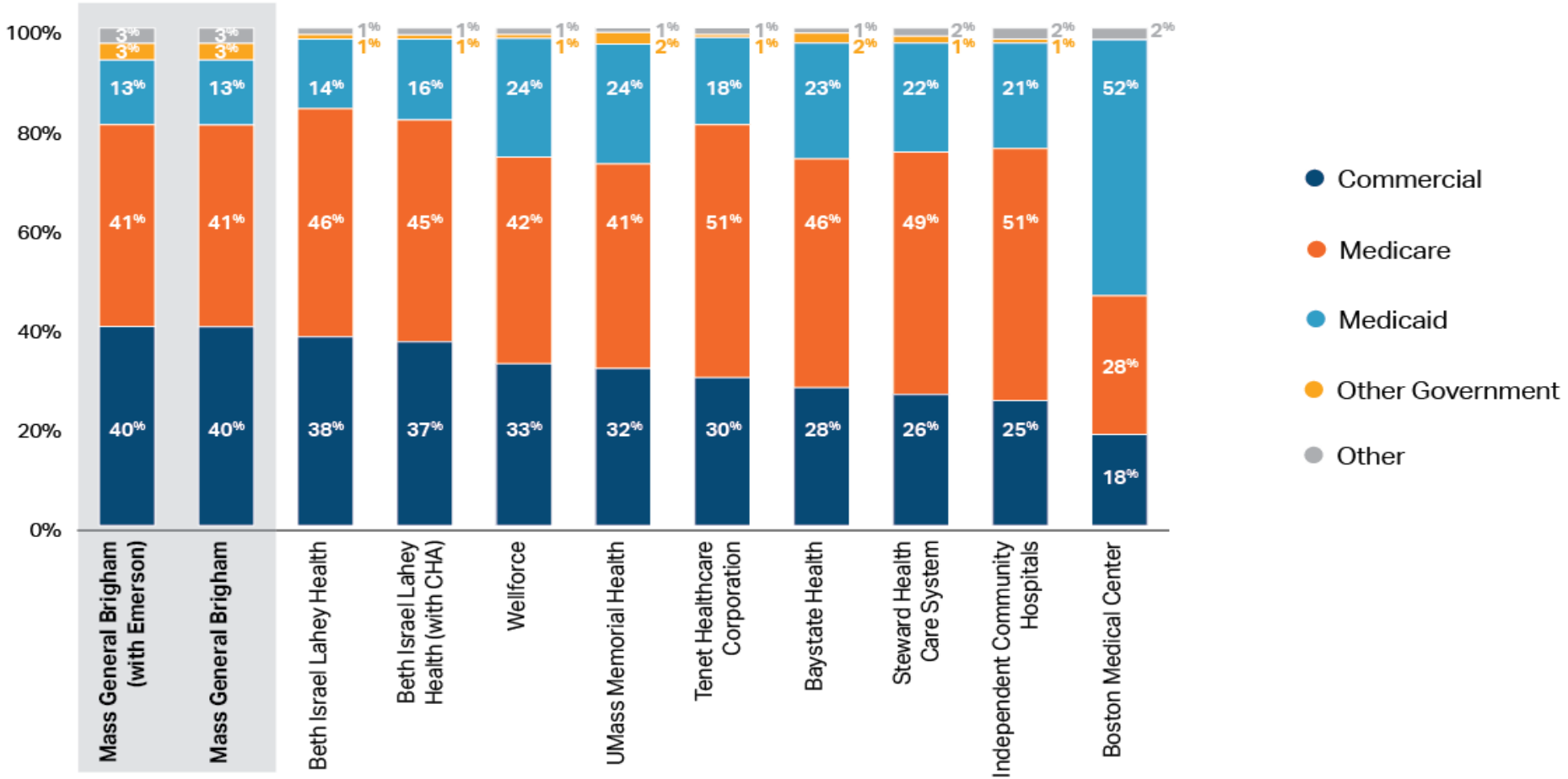


Sources: : HPC analysis of CHIA RELATIVE PRICE DATABOOK, 2019

Comparators : AMC (Beth Israel Deaconess Medical Center, Tufts Medical Center, Boston Medical Center, Lahey Hospital and Medical Center, UMass Memorial Medical Center, Brigham and Women's Hospital, Massachusetts General Hospital), Community Hospitals Comparators: Newton-Wellesley Hospital (Beth Israel Deaconess Hospital – Needham, MetroWest Medical Center, Mount Auburn Hospital), North Shore Medical Center (Northeast Hospital (Beverly Hospital), MelroseWakefield Healthcare (formerly Hallmark Health), Cambridge Health Alliance, Winchester Hospital, Lawrence General Hospital) Brigham and Women's Faulkner Hospital (Steward Carney Hospital, Steward Norwood Hospital, Beth Israel Deaconess Hospital – Milton, Steward St. Elizabeth's Medical Center)

Mass General Brigham has the highest mix of commercially insured inpatient and outpatient care compared to other MA provider systems.

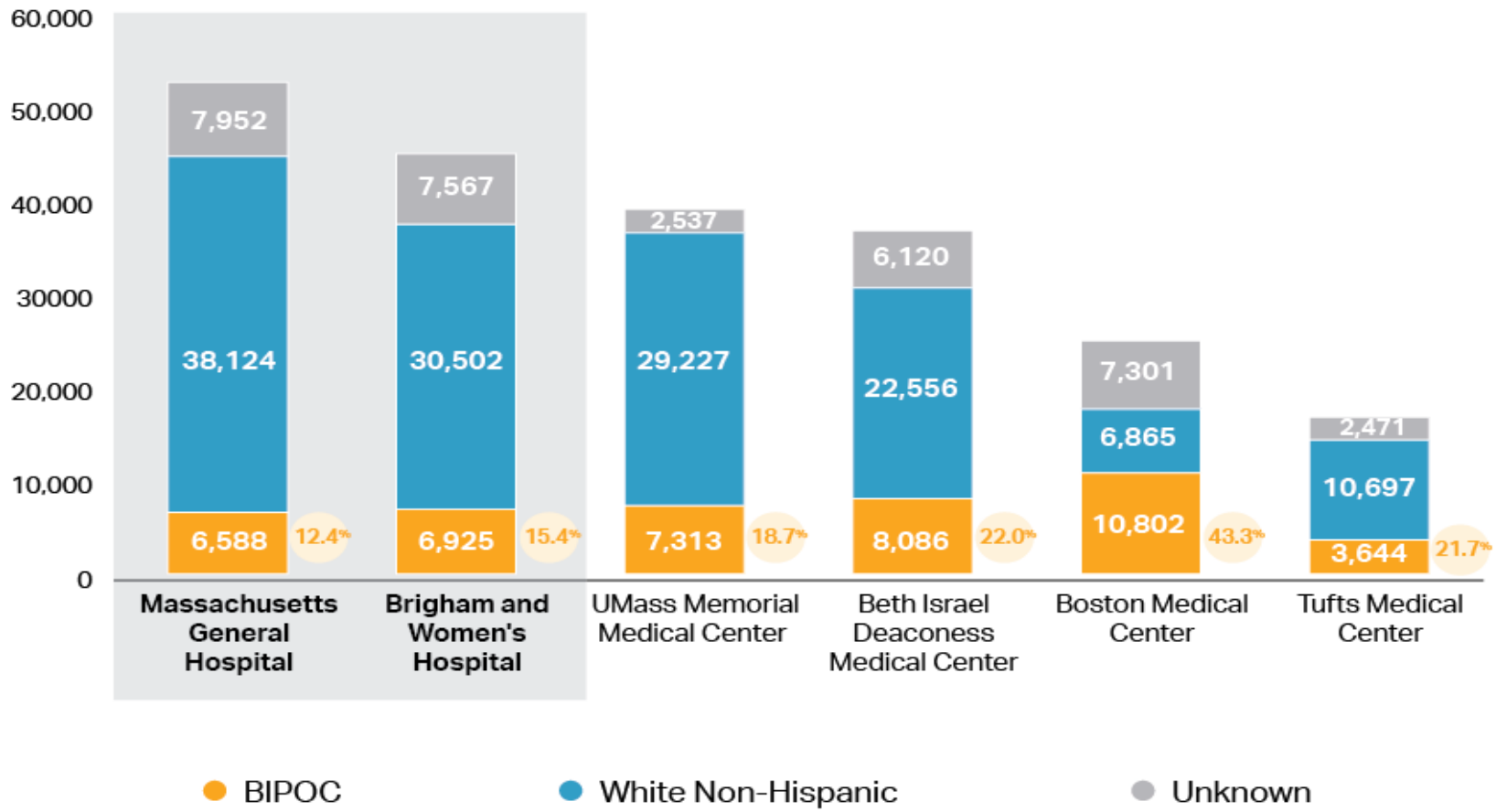
Weighted Average System Inpatient and Outpatient Payer Mix (2019)



Source: HPC Analysis of 2019 CHIA Hospital Cost Reports; Notes: hospital GPSR (charges) data is weighted by inpatient discharges and outpatient discharge equivalents to calculate a weighted average for each system; current affiliations (as of December 2021); affiliations include corporate and contracting affiliations; includes general acute care hospitals only.

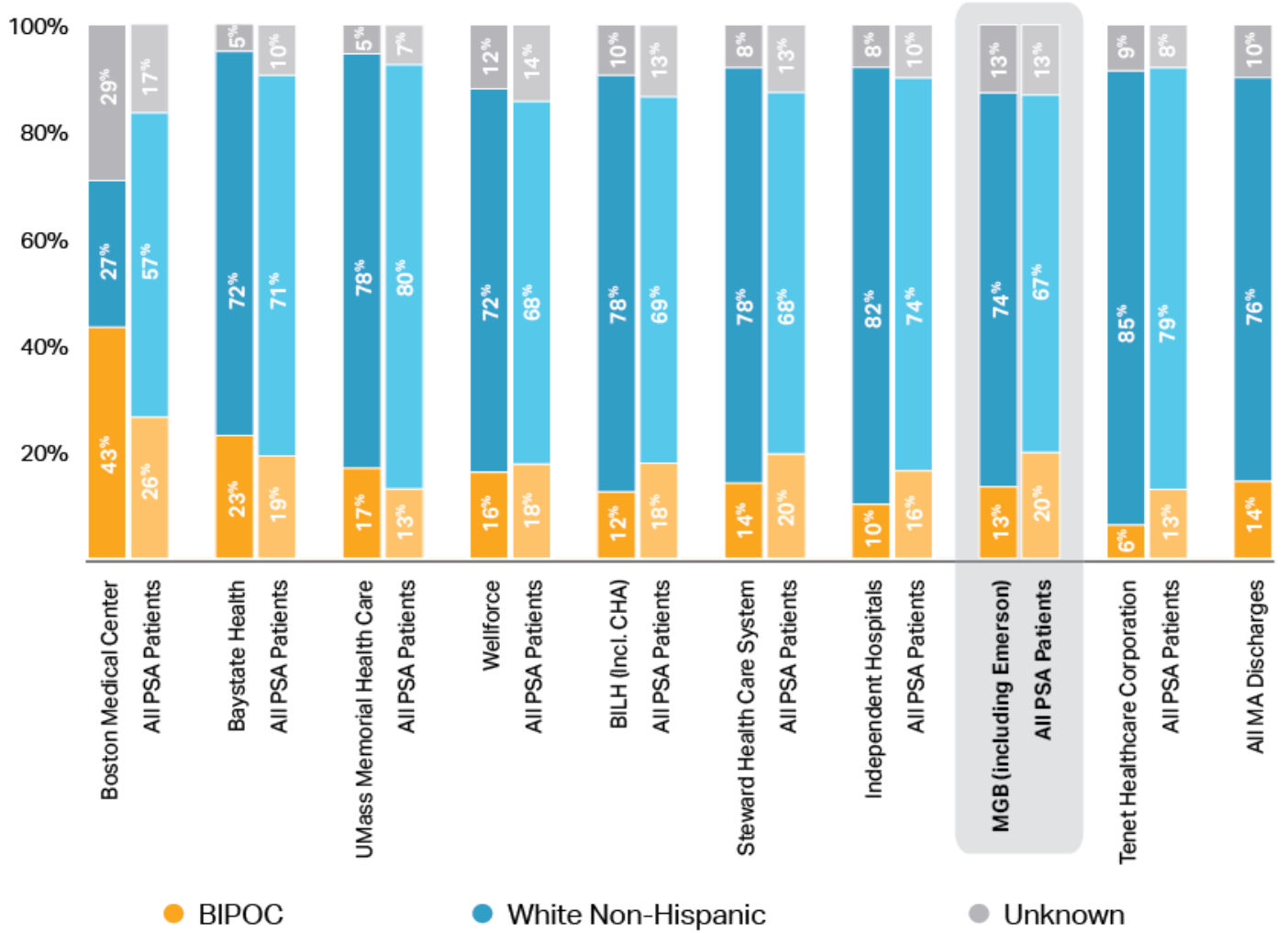
Among Massachusetts AMCs, MGH and Brigham and Women's Hospital serve a relatively low proportion of BIPOC inpatients.

Discharges by Race/Ethnicity at AMCs (2019)



Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2019.
Notes: Hospitals report categorical data to CHIA on race in the following categories: Asian, Black, Native Hawaiian, Unknown, White. Hospitals separately report if the patient is Hispanic with a binary indicator (yes/no). White Non-Hispanic patients include those patients marked as White without a 'Hispanic' indicator. NA represents those with unknown race. BIPOC patients represent all other racial categories combined and all patients with the Hispanic indicator.

As a whole, MGB system hospitals also serve a lower proportion of BIPOC inpatients compared to the mix of patients in their service areas.



Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2019.
Notes: Hospital affiliations are based on 2021 affiliations. Systems include contracting affiliates. Hospitals report categorical data to CHIA on race in the following categories: Asian, Black, Native American, Native Hawaiian, Unknown, White. Hospitals separately report if the patient is Hispanic with a binary indicator (yes/no). White Non-Hispanic patients include those patients marked as White without a 'Hispanic' indicator. NA represents those with unknown race. BIPOC patients represent all other racial categories combined and all patients with the Hispanic indicator.

Patients attributed to MGB primary care physicians also come from more affluent and less socioeconomically disadvantaged areas.

Provider Organization	Median Zip Code Income of Attributed Patients (2016)	Area Deprivation Index (2018)
MACIPA	$105,065	10.7
MGB (with Emerson)	$103,738	17.2
MGB	$103,738	17.2
Children's Medical Center Corporation	$103,337	17.3
BILH (with contracting affiliates)	$101,397	15.2
Wellforce	$100,693	19.6
Atrius	$100,680	15.4
South Shore	$99,381	17.3
BILH (corporate system)	$98,978	16.0
Reliant	$91,706	29.0
Steward	$83,346	24.9
UMass	$80,943	34.3
Southcoast	$80,221	32.9
BMC	$74,069	23.1
Baystate	$68,042	42.2

Sources: APCD 6.0, 2014-2016; MA-RPO and SK&A data, 5-year ACS demographic and housing estimates, 2019, Neighborhood Atlas Area Deprivation Index (ADI) 2018.
Notes: Income and ADI are reported at the zip-code level for primary care patients attributed to the provider organization's physicians.

MGB has significantly more resources than other MA provider systems.

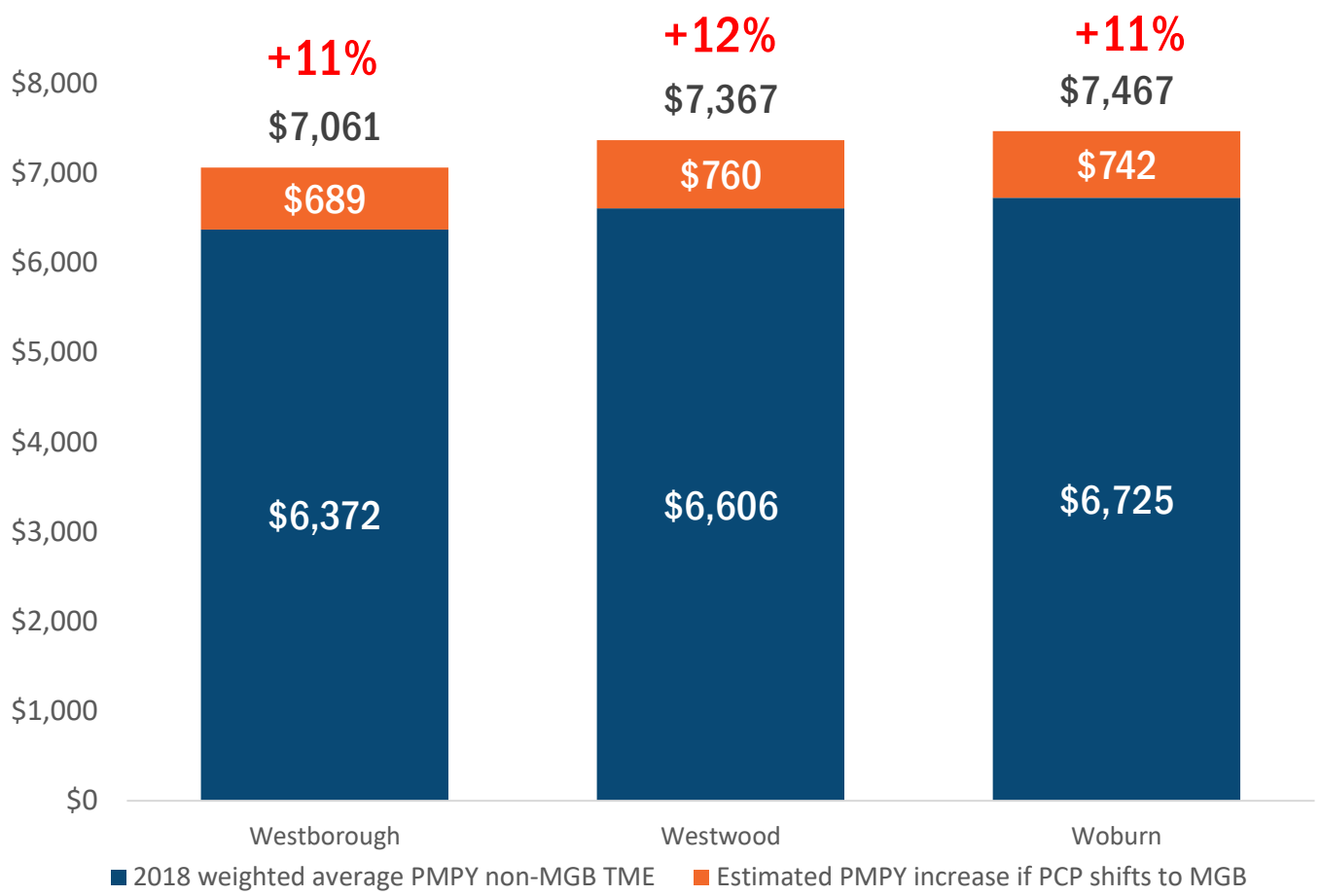
The system's net assets are **greater than the next four largest systems combined**, and its average total margin over the past three fiscal years has been higher.

Metric	Year	MGB	BILH	Wellforce	UMass	Baystate
Total net assets (millions)	2018	$8,973	$3,139	$621	$1,016	$1,102
	2019	$9,748	$3,065	$693	$1,077	$1,085
	2020	$10,620	$3,053	$727	$1,055	$1,132
Net assets to total assets ratio	2018	49.00%	50.50%	34.00%	41.00%	50.70%
	2019	45.90%	48.20%	33.60%	40.40%	49.00%
	2020	42.40%	41.60%	26.70%	32.30%	39.80%
Operating revenue (millions)	2018	$13,307	$5,668	$1,936	$2,487	$2,382
	2019	$13,951	$3,638	$2,055	$2,825	$2,376
	2020	$14,059	$6,274	$2,137	$2,811	$2,507
Operating margin	2018	2.20%	-0.20%	0.20%	-2.80%	2.20%
	2019	3.50%	1.20%	0.00%	4.60%	2.30%
	2020	-2.40%	0.50%	-0.50%	-2.00%	1.40%
Total margin	2018	6.00%	1.70%	2.00%	-0.80%	2.80%
	2019	3.50%	2.80%	5.90%	7.50%	3.00%
	2020	1.80%	1.20%	1.40%	-0.80%	1.80%

Notes: 2020 revenue and margin figures include state and federal relief funding received by each provider organization. 2019 case flow metrics for BILH represent partial year data from March 1 through Sept. 30. 2018 figures for BILH represent a combination of CareGroup and Lahey predecessor organization financials. Steward Health Care omitted due to noncompliance with state reporting requirements.
Source: CHIA Annual Acute Hospital and Health System Financial Performance Reports, FY2018 – FY2020.

Patients switching to MGB PCPs from other local providers (via PCP recruitment or patient choice) would increase total spending.

Spending Impact PMPY Based on % Difference of HSA TME Between PCPO and Comparator Physician Groups (2018)



Sources: HPC analysis of confidential CHIA Total Medical Expense data for BCBS, THP, and HPHC, CHIA 2018 All Payer Claims Database, and MGB physician payer mix data submitted to the HPC Registration of Provider Organizations Program.

MGB internal projections state that it **expects to staff 22 new PCPs** across the three sites, while the ICAs identify 14 PCPs at two of the sites. Many of these PCPs are likely to be recruited from existing local practices, as MGB has done to staff its primary care offices in Westwood and Woburn in recent years.

This would **increase annual commercial spending by $9.5 million to $15.4 million** depending on the number of new PCPs. These impacts may partially overlap with the spending impacts of inpatient care referrals from the ambulatory sites. When totaling spending impacts, the HPC has backed the portion of TME for MGB's primary care patients that represents spending on inpatient care received at MGB hospitals.

MGB hospitals would likely receive increased volume from the ambulatory service areas, increasing health care spending.

- The HPC used an econometric model based on historical Massachusetts discharge and claims data to confirm that commercial patients living in areas where a **hospital system has higher primary care or specialist physician market share** are **significantly more likely to use the affiliated system's hospitals** for inpatient care, even when those patients do not live near a system hospital.
- MGB's planning materials as described in the Internal Document Disclosures estimate an **increase in inpatient market shares** of 1 to 2% for secondary admissions and 3 to 4% for tertiary admissions in Eastern Massachusetts as a result of MGB's larger planned multi-year ambulatory expansion.
- It is unclear what proportion of this expected increase would be driven by the three ambulatory sites currently proposed. However, if MGB were to achieve **half** of its expected inpatient market share increase through these three sites, it would translate to approximately **712 to 2,849 additional commercial discharges per year across the MGB hospitals**.
  - Because MGB hospitals generally have higher commercial inpatient prices than other hospitals, HPC projects an **increase in annual commercial spending of approximately $4.5 million to $17.9 million** if these admissions are seen at MGB hospitals rather than at hospitals of other systems.[1]
- These figures reflect the likelihood of increased *inpatient* care at MGB's hospitals from the ambulatory communities. MGB's hospitals **would also likely see increased outpatient care** from the ambulatory communities, which we were not able to quantify.

1. If MGB achieves 25% of its market share increases instead of 50%, the commercial spending impact from new inpatient volume at MGB hospitals as a result of the ambulatory expansion would be half of these figures: $2.2 million to $8.9 million.

Commercial prices at the ambulatory sites would likely be lower than some, but not all, local providers. Impacts on total spending would depend on where patients would otherwise have received care. Care diverted from MGB HOPDs is likely to be backfilled, reducing any savings.

- MGB's application **assumes virtually all care at the ambulatory sites would be diverted from MGB HOPDs**, estimating commercial savings of $7.9M per 1,000 surgery cases shifted and $1.75M per 1,000 advanced imaging cases shifted.
  - In making this assumption, MGB **refers to its consumer research**, but does not reference assessments of actual site of care choices by patients living near MGB's many existing ambulatory sites.
  - The HPC reviewed utilization patterns for MGB patients living near an existing MGB clinic-licensed imaging site (Waltham) and found that nearly three-quarters of MGB patients living near that site continued to use MGB's hospitals, rather than the clinic, for advanced imaging.
- Given current utilization patterns for patients living near MGB's clinic-licensed imaging sites, as well as the number of other providers serving substantial shares of patients in the proposed service areas, the HPC considers it more likely that capacity at the new ambulatory sites would be filled by **volume shifting from both MGB hospitals and other area providers**.
  - If MGB's ambulatory sites receive commercial rates 25% lower than MGB's community hospital rates as MGB states, commercial prices at the proposed sites would likely be lower than those at some, but not all, other local providers.
  - In particular, smaller providers and non-hospital providers tend to have lower price points than the proposed MGB ambulatory sites, meaning that any care diverted from those providers to MGB sites would increase, not decrease, spending.
  - The spending impacts of patients seeking care at the proposed ambulatory sites would depend on the mix of existing providers that would have otherwise provided that care.
- MGB does not identify any expected reduction in volume or capacity at any of its HOPDs as a result of care being diverted to the proposed ambulatory sites. Thus, to the extent care shifts from MGB HOPDs to the ambulatory sites, **the HPC expects that MGB would backfill any newly available HOPD capacity**, likely reducing any commercial savings from shifting outpatient care from its hospitals to the ambulatory sites.

Spending impacts depend on where patients would otherwise have received care; in no case would savings per case approach the figures that have been projected by MGB.

Commercial Spending Impacts per Imaging and Ambulatory Surgery Case at Proposed Ambulatory Sites				
		CT scans	MRI scans	Surgeries
	MGB claimed savings per case (DoN application)	-$1,750		-$7,900
HPC Modeling	**Scenario 1:** All care diverted from MGB hospitals/not including any backfill (MGB claim)	-$221	-$402	-$691
HPC Modeling	**Scenario 2: Care diverted proportionally from MGB and existing area providers**	-$152	-$309	-$52
HPC Modeling	**Scenario 3:** All care diverted from existing area providers except from MGB	-$128	-$285	+$463
HPC Modeling	**Scenario 4:** Care at ambulatory sites reflects new volume rather than diverted care	+$530	+$771	+$3,187

	CT scans	MRI scans	Generic HOPD visit
Weighted average per-case spending impact of **backfilling at MGB HOPDs**	+$64	+$58	+$150

Assuming that cases at the ambulatory sites would otherwise have been provided at the current mix of providers serving the areas, annual commercial spending for the service lines examined above would likely **decrease by approximately $3.4 million**. These estimates **do not incorporate several factors that would tend to increase rather than reduce spending** that the HPC could not quantify, including the impact of specialist physician visits not directly related to ambulatory surgery or advanced imaging.

Total spending may further increase as MGB gains commercial market share, increasing its leverage to obtain higher price increases in the future.

- As patients fill MGB's ambulatory sites, MGB backfills its HOPD capacity, MGB hospitals receive increased inpatient and outpatient hospital volume, and MGB's primary care population grows, **MGB's commercial market shares would grow** across inpatient, outpatient, and physician service lines.
  - Filling new capacity at the proposed ambulatory sites providers currently serving the area in proportion to their current market shares would increase MGB's share of commercial visits within the proposed service areas by **26% for MRI, 40% for CT, and 31% for ambulatory surgery**.
  - MGB expects its multi-year ambulatory expansion project to **increase its market share** for physician and hospital services. The Ambulatory ICA also models increases in MGB shares of outpatient services if patients come to the ambulatory sites from all providers.
- Increases in commercial market share, particularly in a highly concentrated market, are **generally associated with greater leverage** for a provider organization to negotiate **higher prices with commercial payers**. Additional commercial volume at MGB would likely allow MGB to obtain higher commercial rate increases, while decreased commercial volume at other provider organizations means that those providers are likely to receive lower rate increases.

The HPC has not included spending impacts from this increased bargaining leverage in its estimated spending impacts.

Total spending would likely increase as MGH and Faulkner fill proposed new inpatient capacity.

The hospital projects would represent a **net increase in medical/surgical bed capacity of 16.6% to 18.9% at MGH** (depending on whether the 24 additional beds are included) and **45.6% at Faulkner**.

Based on the HPC's econometric models, approximately **3,825 to 5,893 commercial discharges would shift to MGH and Faulkner** each year if MGB fills the new beds as expected.

Commercial Discharge Shifts to Fill New MGB Inpatient Capacity		
	Lower volume assumptions	Higher volume assumptions
MGH	2,161 to 2,579	3,182 to 3,712
Faulkner	1,664	2,181

Impact on Commercial Hospital Spending		
	Lower volume assumptions	Higher volume assumptions
MGH	$23.7 million to $28.3 million	$34.8 million to $40.6 million
Faulkner	$2.9 million	$3.8 million
Total annual	**$26.6 million to $31.2 million**	**$38.7 million to $44.5 million**

Note: Range of impacts shown for MGH reflects the omission or addition of 24 beds licensed but out of service.

Commercial spending would likely increase as MGH fills proposed new outpatient capacity, while spending impacts of adding Faulkner outpatient capacity may be mixed.

- Because of MGH's high commercial prices for outpatient care relative to other providers, **outpatient care filling new capacity at MGH is likely to increase commercial spending**. Because Faulkner competes for outpatient care with some higher-priced providers, including AMCs, **commercial spending may decrease as some services, like MRI, shift to Faulkner**.

Average commercial spending impact per case	MRI scans	CT scans
MGH	$176	$126
Faulkner	-$113	N/A

- The HPC estimates that annual commercial spending on advanced imaging would **increase at MGH by approximately $573,000** and **decline at Faulkner by approximately $91,000** based on available volume and payer mix information.
- The HPC was not able to quantify spending impacts for the expansion of other outpatient service lines at the hospitals
  - However, there **may be small spending increases for some other services at Faulkner** given that Faulkner's commercial prices for some relevant outpatient services (e.g. endoscopy procedures) are relatively high.
  - We also note that **the ICAs predict spending increases for both commercial and public payer care for every outpatient service line** being expanded at both MGH (CT, MR, PET/CT, cardiovascular procedures, and oncology visits) and Faulkner (MR).

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2018

Total spending would likely further increase as care shifts to MGH and Faulkner and MGB gains commercial market share, increasing its leverage to obtain higher price increases in the future.

- **MGB's commercial market share would likely substantially increase** as it fills the new capacity proposed in its hospital expansion projects. Specifically:
  - The new beds would represent a 7.1% to 7.9% increase in bed capacity for the MGB system;
  - MGB's inpatient commercial market share in Eastern Massachusetts would likely increase by 2.7% to 3.8% as those beds are filled, based on the HPC's inpatient diversion models, raising market concentration for inpatient services in already highly concentrated markets; and
  - MGB would also increase its outpatient hospital market shares for the relevant services.
- Increases in commercial market share, particularly in a highly concentrated market, are **generally associated with greater leverage** for a provider organization to negotiate **higher prices with commercial payers**.
- A multivariate regression model similar to that utilized in prior HPC provider price analyses suggests that the proposed hospital expansions would be expected to result in system-wide inpatient prices at MGB that **are 0.9% to 1.7% higher** than current pricing.
  - This translates to an annual increase in commercial spending of **$9.7 million to $17.3 million** from the inpatient component of the hospital expansions alone.
  - This could exacerbate the existing, extensive variation in provider prices for similar services and increase spending impacts above the figures modeled in this section.
  - These changes would be magnified if revenue losses destabilize other local provider organizations, leading to further market consolidation and more patients shifting to higher-priced systems.

The services on which MGB has provided the most detail in its ambulatory expansion plans are ones likely to generate substantial financial margin and drive additional volume to its system.

- MGB's ambulatory expansion applications and supplemental filings provide relatively **granular detail on advanced imaging and ambulatory surgery services** MGB proposes at the sites.
- Both advanced imaging and ambulatory surgery are generally identified as generating **relatively high margin per case**, and diagnostic imaging is both a component of and **driver of follow-up care**.
- MGB has stated that it will provide behavioral health services at the proposed sites, and the HPC recognizes the acute need for expanded behavioral health services. However, MGB has provided **fewer details on its plans for behavioral health**, a generally lower-margin service, at the ambulatory sites.
  - For example, MGB does not address capacity or staffing expectations, or project behavioral health service volumes as it does for surgery and advanced imaging.
  - MGB also emphasizes behavioral health integration, noting that it will strongly encourage behavioral health patients to have an MGB primary care provider. While behavioral health integration has significant benefits, this approach could pose a barrier to patients seeking behavioral health services who have primary care providers with other systems.

MGB's projections of future utilization at its facilities do not indicate that the projects are necessary to meet unmet need.

- MGB asserts that the proposed expansions will **serve growing need** for its services based on current utilization at its facilities, projected population demographic shifts, expected changes in utilization of specific services, patient preferences for MGB, and the assumption that the projects will be approved and constructed as described.
- MGB asserts the need for additional capacity **without assessing current capacity** at other area providers.
  - However, public testimony and hospital occupancy data indicate there is likely **available capacity at other providers.**
  - Residents of the proposed ambulatory service areas also indicate that **access to health care services is a key strength** of their communities.
- Health care utilization is heavily influenced by factors such as health care payment policies, technology advances, and provider supply, behavior, and beliefs. **These factors typically outweigh demographic and other demand-side changes**.
  - For example, the Massachusetts population grew by 6% and aged substantially (37.9% growth in residents 65 years or older) over the past decade. A 2010 projection based on those trends and contemporary utilization rates would have predicted an increase in statewide bed days of 19.4%, but bed days actually increased by 0.7% statewide from 2010-2019, and only 3% across hospitals in the MGB system.
- MGB's utilization projections also exceed those predicted by demographic shifts, suggesting that MGB's plans reflect more than incremental increases in need for services by an aging population, but rather an effort to grow its market share relative to other providers.

Community Health Needs Assessments in the ambulatory site communities show general access to medical services is a community strength across all three areas, with mental health and the cost of services being key concerns.

ACCESS TO MEDICAL SERVICES

Access to medical services **is generally already considered to be a strength of these communities**.

- In Westborough, **68.9% of respondents listed "accessible medical services" as a strength of their community;** 10.4% of respondents listed "accessing health and social services" as a perceived need;
- In Westwood, **60.7% of respondents listed access to medical services as a strength** of their community; 14.1% listed it as a perceived need; and
- In Woburn, **64.5% reported access to medical services as a strength;** 10% reported it as a perceived need.

EQUITY

Equity was a significant theme in all communities. Respondents indicated that COVID-19 has exacerbated long-standing issues of equity.

BEHAVIORAL HEALTH

In all communities, **"mental health issues" were the most frequently reported perceived need** in their communities.

- 49.1% listed "mental health issues" as a perceived need in Westborough
- 50.6% in Woburn; and
- 49.8% in Westwood.

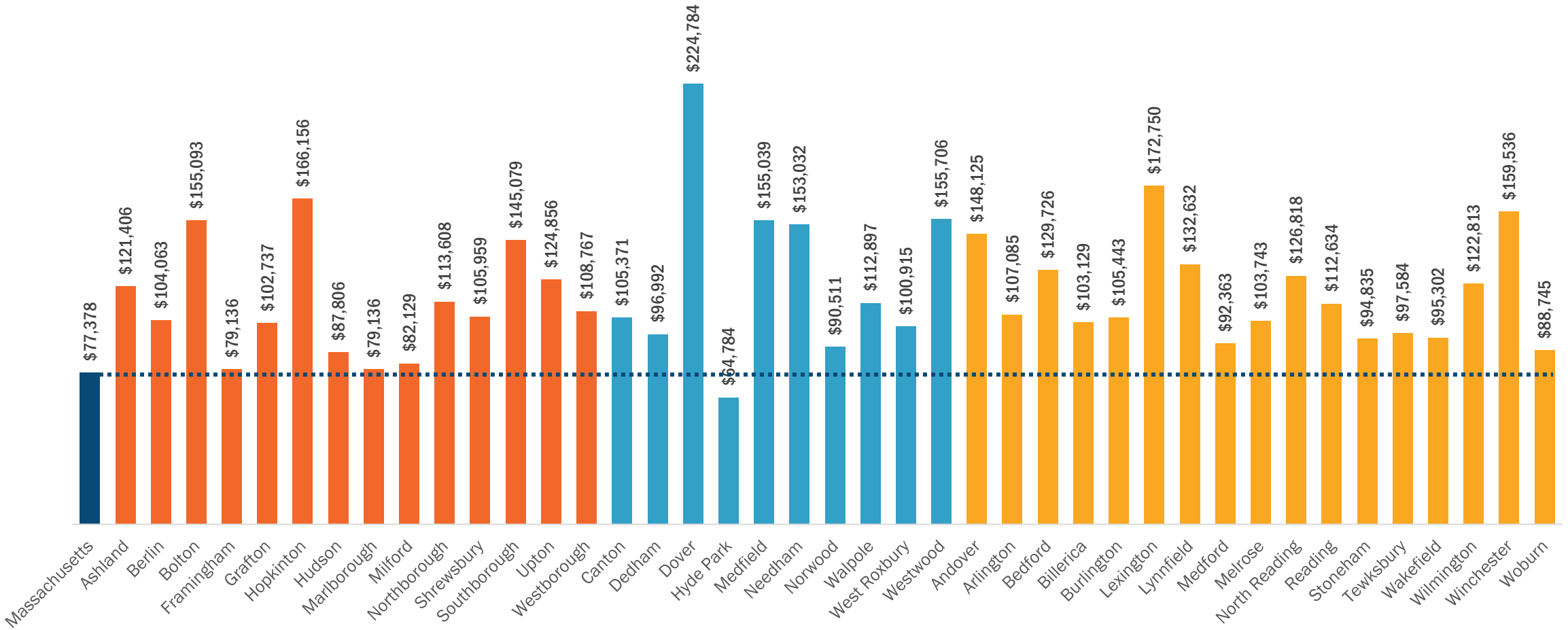
COST AS A KEY BARRIER TO HEALTH CARE

While other barriers were also listed, **significant percentages of respondents in all three communities listed the cost of services as a key barrier** to accessing medical, mental health and social services (28.2% in Westborough, 27.4% in Westwood, 34.5% in Woburn)

Financial insecurity was also high among listed areas of concern and perceived need in all three communities. (44.4% in Westborough, 43.3% in Westwood, 40.8% in Woburn).

Nearly all towns in the service areas for the proposed ambulatory sites have median income above the statewide average.

As shown in MGB's CHNAs for the proposed ambulatory service areas, nearly all the towns in the service areas have median income above statewide average.



Data Source: U.S. Census Bureau, American Community Survey 5-Year-Estimates, 2014-2018

The communities closest to the proposed ambulatory sites also generally have a lower mix of MassHealth patients and lower indicia of social need than their regions or the state as a whole.

	Social Determinant of Health Indicators	Zip codes ≤10 min drive	HPC Region	Statewide
WESTWOOD	Limited English Speaking Households	2%	2%	6%
	Population Reporting as Non-White Race	15%	12%	22%
	Population that was Unemployed (Ages 16+)	3%	3%	4%
	Population with any Medicaid/Means-Tested Public Coverage (Ages ≤64)	9%	10%	20%
	Population with Income to Poverty Ratio <1.24 (%)	5%	7%	14%
WOBURN	Limited English Speaking Households	4%	4%	6%
	Population Reporting as Non-White Race	17%	20%	22%
	Population that was Unemployed (Ages 16+)	2%	3%	40%
	Population with any Medicaid/Means-Tested Public Coverage (Ages ≤64)	10%	13%	21%
	Population with Income to Poverty Ratio <1.24 (%)	8%	9%	14%
WESTBOROUGH	Limited English Speaking Households	3%	5%	6%
	Population Reporting as Non-White Race	26%	16%	22%
	Population that was Unemployed (Ages 16+)	2%	4%	4%
	Population with any Medicaid/Means-Tested Public Coverage (Ages ≤64)	7%	21%	20%
	Population with Income to Poverty Ratio <1.24 (%)	6%	14%	14%

Social Determinant of Health Indicators

Higher % Represents Greater SDOH Burden

Statewide or regional indicator higher than immediate area near site

Statewide or regional indicator lower than immediate area near site

SDoH data from AHRQ dataset, Drive times provided by Bates-White Consulting

Staffing Implications

- MGB has provided little data about the expected staffing needs of the proposed expansions, but it would need **substantial new clinical and support staff** for the capacity proposed across the three expansions, which includes a 7% - 8% increase in MGB system-wide inpatient capacity, 12 new ambulatory operating rooms, 17 new advanced imaging units, and new cardiology procedure and oncology care capacity.
- The market for health care workers in Massachusetts has been highly competitive for years, with recent reports identifying a growing deficit in nurses and other clinical and non-clinical health care workers in Massachusetts. The COVID-19 pandemic resulted in **unprecedented instability** in the Massachusetts healthcare labor market, which was **already facing existing widespread health care staffing shortages**:
- Even small percentage shifts may have significant impacts in a health care labor market as strained as the current health care labor market in the Commonwealth. MGB's efforts to staff its new capacity may result in **further disruption of other providers**, particularly for those with fewer financial resources to retain current staff or compete for new workers.
  - This too would likely represent a further shift of resources away from providers that, in general, have lower prices for commercial patients, larger proportions of public payer patients, and serve communities with higher indicia of social need.